chapter 4

Achieving Permanency

Achieving Permanency

Timely Permanency and Healthy Child Development

- Plan for permanency from day one.
- Consider the rapid and multifaceted development of a very young child when determining permanency goals.

Preliminary Protective Hearings

- Determine the relative harm of nonremoval versus the potential psychological harm of removal.
- Determine if the child-placing agency has made reasonable efforts to prevent removal.
- If the child will be removed, identify appropriate caregivers.
- Seek the least disruptive, most family-like setting.
- Evaluate child care/early education options for the child.
- Devise a plan for parent-child and sibling contact.
- Request the child's medical records and order screening to identify the child's health needs.
- Identify services for the parent.

Disposition and Case Planning

- If a placement change is needed, identify the safest, most family-like placement.
- Revisit reunification.
- Identify the child's needs and available family resources.
- Assess caregiver supports.
- Require comprehensive individualized case planning in each case.
- Encourage family group conferencing.
- Ensure concurrent planning begins early in the case.
- Identify the family's service needs.
- Ensure a comprehensive visitation plan is developed.

Review Hearings

- Assess whether the issues that caused the child's removal are being addressed.
- Order additional services or reassessments for the child.
- Evaluate safety and risk factors if the child will return home.

- Determine if the substitute caregiver supports the parent toward reunification.
- Assess the visitation plan and whether changes are needed.

Permanency Hearings

- Determine if reunification is a viable permanency plan.
- Identify how reunification will affect the child in the short term.
- Ensure transition planning is part of a reunification plan.
- Determine if adoption is a viable permanency plan.
- Determine if the current caregiver can adopt the child.
- Consider ordering mediation to resolve adoption-related concerns.
- Determine if legal guardianship is a viable permanency plan.
- Determine if relative placement is a viable permanency plan, only after exploring more desirable options.
- In most cases, APPLA should not be a permanency goal for very young children.
- Hear the child's views regarding the permanency plan.
- Observe preverbal children in court to inform your decision making.
- Consider the child's developmental stage during courtroom observations.
- Determine if there is cause to extend the goal of reunification.

Postpermanency Support for Young Children and Their Families

- Ensure supports are in place to sustain reunification.
- Identify adoption disruption factors.
- Identify postadoption supports.
- Ensure postadoption supports and services are equally available to permanent guardians or long-term relative caregivers.
- Maintain family connections.

Very young children in the child welfare system require stable and nurturing caregivers and environments to encourage their healthy development. As the judge, you can promote permanency and healthy development for these children by ordering placement, services, and visitation arrangements that support their primary attachments and relationships.

Research reveals that very young children, especially infants, enter care in greater numbers than older children. Very young children are less likely to reunify with their parents, are more likely to be adopted, and experience longer stays in care.[1] Moreover, very young children reenter the child welfare system after reunification in higher numbers, especially within the first 90 days.[2]

Your leadership from the bench is essential to:

- achieve timely permanency,
- decrease foster care reentries, and
- enhance overall well-being outcomes for very young children in the child welfare system.

Timely Permanency and Healthy Child Development

The Adoption and Safe Families Act of 1997 (ASFA)[3] shortens the timeframes for making permanency decisions for children in foster care. It also requires termination of parental rights proceedings for those children in foster care for 15 out of 22 months and includes special protections for abandoned infants. Permanency is a focal point, requiring heightened reviews by judges and less opportunity for foster care drift. ASFA's push for timely permanency responds to the very young child's sense of time—especially for infants under one year old—by supporting key attachments and relationships during early child development. ASFA's requirement to advance the multiple goals of permanency, child safety, and child well-being is best approached by focusing on the child's specific developmental and emotional needs.[4]

ASFA emphasizes child well-being and the Child and Family Services Review (CFSR) measures states' performance in this area.[5] This focus on well-being is critical for very young children in the child welfare system. You can meet ASFA's requirements by using the court process to ensure early intervention and infant mental health services are provided that promote child well-being and timely permanency from the onset of the case.

Resources on Cultural Competence

Cultural competence within the dependency court allows judges, attorneys, court personnel, social workers and other stakeholders to work effectively with people from different cultures to improve decision-making and services designed to meet the needs of children and families. The cultural context of a case is more than race and ethnicity, but also includes economic status, education level, gender, age, sexual orientation, language, immigration status, disabilities, and many more factors. Cultural competence enables individuals to expand the scope of what they view as relevant facts to include the total life experiences of the children and families before the court.

Resources that can help you consider culture when making decisions for children and families include:

- **Courts Catalyzing Change: Achieving Equity and Fairness in Foster Care**
  www.ncjfcj.org/content/blogcategory/447/580/
  The National Council of Juvenile and Family Court Judges' Courts Catalyzing Change Initiative brought together judicial officers and other systems' experts and set a national agenda for court-based training, research, and reform initiatives to reduce the disproportionate representation of children of color in dependency court systems.

- **National Center for Cultural Competence**
  www11.georgetown.edu/research/gucchd/nccc/
  The National Center for Cultural Competence at the Georgetown University Center for Child and Human Development seeks to increase the capacity of health care and mental health care programs to design, implement, and evaluate culturally and linguistically competent service delivery systems to address growing diversity, persistent disparities, and to promote health and mental health equity.

- **Child Welfare Information Gateway: Cultural Competence**
  www.childwelfare.gov/systemwide/cultural/
  This site offers resources to help professionals in the child welfare system better understand and enhance their cultural competence. It provides information on working with children, youth, and families; disproportional representation of minority groups in the child welfare system; culturally competent services; training for child welfare staff; and the specific role of cultural competence in child maltreatment, out-of-home care, and adoption.

- ***Making Differences Work* (ABA Center on Children and the Law, 1996)**
  www.abanet.org/abastore/ (Search product code 5490051)
  This book by Karen Aileen Howze seeks to help attorneys and judges question the assumptions and perceptions that play an important role in how determinations about the best interests of children in the dependency court are made.

Plan for permanency from day one.

When determining permanency goals and approaches, consider the rapid and multifaceted development of a very young child discussed in Chapters 2 and 3, as well as the prevailing research about permanency outcomes and length of time in care for very young children. Your decisions at key points and hearings during the child's time in care are essential to promoting positive permanent outcomes that consider the very young child's cognitive, physical, and social-emotional development, and well-being.

The National Council of Juvenile and Family Court Judges' *RESOURCE GUIDELINES: Improving Court Practice in Child Abuse & Neglect Cases*[6] (*RESOURCE GUIDELINES*) identify key decisions and questions that judges should focus on at each stage of the court process. The following discussion about permanency for very young children looks at these and other key decisions and how they affect infants, toddlers, and preschoolers involved with the dependency court process.[7]

Preliminary Protective Hearings

Key decisions and questions for the judge:[8]

- Should the child return home immediately?
- What services will allow the child to remain safely at home?
- Will the parties voluntarily agree to participate in such services?
- Has the agency made reasonable efforts to avoid protective placement of the child?
- Are responsible relatives or other adults available?
- Is the placement proposed by the agency the least disruptive and most family-like setting that meets the needs of the child?
- Is the child placed with adults who could become the child's permanent caregivers if reunification efforts fail?
- Will the service plan and the child's continued well-being be monitored on an ongoing basis by a guardian ad litem (GAL) or court appointed special advocate (CASA)?
- Are restraining orders, or orders expelling an allegedly abusive parent from the home appropriate?
- Are orders needed for examinations, evaluations, or immediate services?
- What are the terms and conditions for parental visitation or family time?
- What are the financial support needs of the child?

Removal & Placement

Determine the relative harm of nonremoval versus the potential psychological harm of removal.

Because they are physically defenseless and in a state of rapid development, very young children are at great risk of suffering harm from maltreatment. Even so, removal from biological parents, even when fully justified and necessary, forever alters a young child's life.[9] Thus, both the maltreatment *and* the resulting removal can disrupt the very young child's development and overall well-being. When determining the need for removal, always balance safety concerns with the potential psychological and developmental harm of removal.

Determine if the child-placing agency has made reasonable efforts to prevent removal.

When removal is being recommended or has occurred, determine whether reasonable efforts to prevent the removal were made. For the very young child, these efforts should include intensive, in-home, or residential services that promote an infant's safety while allowing him to remain in the care of his parents. For families with substance abuse issues, some communities have residential drug treatment programs for mothers and their young children that support a mother's recovery and the parent-child relationship, while providing the structure and supervision to protect the child. Domestic violence shelters and transitional housing programs are often designed for a mother and her young children. These programs may have child care centers on-site or an affiliated center so mothers can work on their recovery and self-efficacy. Although less common, some jurisdictions also offer residential services for fathers and their children.[10] In these cases, the court can still take jurisdiction and closely monitor the parent's compliance with treatment and the well-being of the infant.

If the child will be removed, identify appropriate caregivers.

If reasonable efforts have been made to prevent removal or if a child's safety requires removal, finding an appropriate caregiver is essential. Whether a relative, nonrelative, or licensed foster parent, the caregiver must be physically and emotionally prepared to care for the special needs of an infant.

Ensuring Substitute Care Meets the Needs of Infants

Infants who enter foster care are vulnerable due to the maltreatment and trauma they have experienced. The type of substitute care in which they are placed, often for long periods, creates added risks when the caregivers are physically, psychologically, or financially unprepared to provide quality care. Kinship caregivers have high levels of psychosocial challenges such as stress, depression or trauma, and may face greater problems than nonrelative foster parents.

Opportunities exist to enhance the skills and understanding of caregivers and tailor caregiving environments to each infant's needs. This approach emphasizes promoting infant development through their relationships with their caregivers. Even when those caregivers are temporary, they can positively or negatively affect the infant's development.

Family foster parents and kinship caregivers should:

- Understand infant and child development and the infant's developmental needs.
- Develop infant-centered home environments.
- Partner with the child welfare agency by participating in planning meetings and advocating for the infant's needs.
- Empathize with infant experiences, past and present, and understand that infants remember and respond to memories of past trauma.
- Respect, honor, and support the multiple familial connections that infants have to their parents, former foster parents, and others. Acknowledge that these connections may affect their ability to attach to new caregivers (especially if the infant has endured multiple moves).
- Be willing to reflect on their attitudes and behaviors about children and be open to developing new skills and challenging previous assumptions and beliefs.
- Be flexible enough to adapt to an infant's irregular eating and sleeping schedules and be physically capable of lifting, carrying, feeding, diapering and bathing an infant.
- Be able to handle *dysregulated* infants (excessive crying and feeding challenges, typical of maltreated infants) and be able to respond when the infant is in need.
- Be willing to play with the infant and follow her lead and nonverbal cues.
- Be supportive of the infant's placement in a permanent home.
- Take advantage of available resources to support placement.

Child welfare agencies should:

- Provide caregivers with specific infant-oriented support to ensure an infant-centered home environment (e.g., age-appropriate toys, care items, books).

- Engage caregivers as advocates and partner with them in seeking services and interventions through other social service systems.
- Develop foster parent training that teaches how to meet the multiple needs of infants in their care and addresses knowledge, attitudes, and beliefs.
- Select foster parents based on their ability and willingness to meet the requirements in the above list. Screenings and home studies should look carefully at their ability to care for infants.
- Provide intervention programs to support the caregiver-infant relationship when they experience challenges, rather than instantly moving the infant to another foster home.
- Provide ongoing caregiver education programs that address parenting infants, with special attention to supporting maltreated or traumatized infants and creating developmentally appropriate environments for each child in their home.
- Clearly assess the substitute caregiver's ability to support reunification or become an adoptive parent or permanent guardian if reunification becomes untenable.
- Support smooth and thoughtful transitions between caregivers if such transitions become necessary for the child's ultimate permanency.

Source:
Adapted from Jones Harden, Brenda. *Infants in the Child Welfare System: A Developmental Framework for Policy & Practice*. Washington, DC: Zero to Three, 2007, 223-240. This section focuses on infants, those children birth to 12 months of age. Infants four months and younger are more likely to enter foster care and stay in care longer than any other population.

On a practical level, *all caregivers of very young children* must have:

- a crib or safe bed for the child;
- a safety-proofed home—especially for infants who are crawling and walking;
- appropriate food/formula;
- infant-safe bathing and changing areas;
- appropriate clothing and diapers;
- age-appropriate toys and books; and
- ability to meet the demanding physical and emotional needs of very young children.

Caregivers for *infants* must be prepared to:

- be woken up at night;
- change many diapers;
- wash a lot of laundry; and
- tolerate long periods of crying.

Caregivers for *toddlers and preschoolers* must:

- be able to keep up with physically active and emotionally unpredictable children;
- support toddlers' language development;
- provide safe environments in which children can exercise their new skills; and
- monitor health and behavioral signs necessary to appropriately identify potential developmental delays.

Seek the least disruptive, most family-like setting.

Early in the case, a plan for the child's 24-hour care must be laid out. A typical infant in care, especially those in kinship care, will spend some of the day with relatives, child care center staff, and/or parents. Never underestimate the importance of siblings to very young children. Thus, placement arrangements that can accommodate the very young child's siblings should be sought, especially if there is an established bond and the siblings do not act in ways that harm the infant.

Shelter or group care is not recommended for infants who have been taken into care. Not only is it not *the most family-like* setting, the shelter environment is contrary to the emotional and developmental needs of very young children.

If a relative is being considered:

- Determine from the onset whether the relative:
  - knows about the needs of very young children;
  - can manage the physical demands of caring for an infant;
  - will facilitate visitation and the parent-child bonding and attachment process;
  - is aware of the parents' challenges and any limitations placed by the court;
  - is able and willing to become a permanent caregiver if the need arises.
- Ensure the relative has help obtaining the financial support (i.e., relative caregiver funds) and/or child care services they will need to meet the infant's needs.
- Explore the possibility of the relative taking in a teen parent and the infant, especially in cases in which the parent lacks parenting skills but is interested in the infant and wants to learn how to be a responsible parent.
- Ensure a home study is completed if required. Some jurisdictions require a preadoptive home study of any relative being considered to provide substitute care to a child under age three.

- Ask about the number of children in the home, their ages, and any potential risks they may pose to the infant or toddler. While having many children in a home is not necessarily a cause for concern, be sure the caregiver can care for the intensive needs of a young child on top of other obligations.
- Assess the noncustodial parent, often the father and/or the child's paternal relatives, as potential caregivers for a very young child. Involving the noncustodial parent and his/her relatives early is an important step towards ensuring future permanency.

If foster parents are being considered:

- Assess their ability to care for very young children and their potential as long-term adoptive parents.
- Find out about the number of children in the home, their ages, and any potential risks they may pose to the infant or toddler.
- Determine the foster parent's ability to provide frequent visitation to the biological parent(s).
- Get assurance from the child-placing agency that the foster parent will support and involve the biological parents, to the extent possible, in reunification efforts. Experienced foster parents can be strong parent educators if they have the right mindset towards the biological parents.
- If the parent is a youth in care, explore whether the foster caregiver will accept the youth together with her infant.

Evaluate child care/early education options for the child.

At the preliminary protective hearing, assess the quality of any proposed child care setting and early education programs. Many jurisdictions use county or state quality rating systems with Web-based access to a child care center's rating. (See Chapter 3 for more information.)

Devise a plan for parent-child and sibling contact.

Maintaining contact between very young children and their parents helps them develop attachments during the child's first year of life. While frequent contact between a child and parent may be perceived as a burden by caseworkers and foster parents, it is one of the best predictors for successfully reunifying very young children.[11] If a very young child is not placed with his or her siblings, consider sibling visits and opportunities to support the sibling bond, especially for toddlers and preschoolers who may perceive their older siblings as caregivers.

Consider requiring an immediate 'contact conference' or meeting where parents, caregivers, family members, child care providers, service providers, GALs/CASAs and case managers develop a plan for visitation and family time that spreads the supervision and transportation responsibilities among multiple individuals. This plan should also account for preexisting formal or informal visitation agreements between the child and his noncustodial parent, siblings, and relatives.

Research shows breastfeeding can enhance the bond between mother and child and has some health benefits. Nursing mothers should be encouraged to continue nursing their infants, if possible. Parent-child contact and placement arrangements should support their efforts to breastfeed, if the safety of the infant is not jeopardized. Additionally, nursing mothers who wish their infants to have breastmilk should be able to provide it to the substitute caregiver and expect it to be fed to the infant when feasible and safe unless it is not advised for medical reasons.

Request the child's medical records and order screening to identify the child's health needs.

Many infants and young children enter the child welfare system with significant medical and/or developmental delays and challenges, or such issues emerge while they are in the system. Achieving permanency requires addressing these needs early. As discussed in Chapter 3, all states have early intervention systems that identify and address developmental needs of very young children.

At the first point of contact with a very young child, order:

- records of all screenings performed at birth as well as a Part C screening for children ages zero to three (see Chapter 3 discussion of developmental screenings);
- screenings for fetal alcohol spectrum disorders and any other effects of in utero substance exposure; and
- medical and dental screenings and oral health care for the child (see Chapter 2).

Identify services for the parent.

As the *RESOURCE GUIDELINES* suggest, services to address a parent's most pressing issues should be offered from the onset of the case. Typically, substance abuse, mental illness and/or domestic violence cause the need for removal. Often, these issues co-occur, requiring intensive, sometimes residential, interventions. Once a parent is screened and engaged in treatment to address specific needs, he or she may require further skill building or support related to parenting their very young child. Parenting courses, support groups, or parent coaches/mentors can help.

Disposition and Case Planning

Key decisions and questions for the judge:[12]

- What is the appropriate statutory disposition of the case and long-term permanency goal for the child?
- Is the child placed with adults who could become his permanent caregivers?
- Does the agency-proposed case plan reasonably address the problems and needs of the child and parent?
- Has the agency made reasonable efforts to eliminate the need for placement or prevent the need for placement?
- What, if any, child support should be ordered?
- When will the case be reviewed?

Placement

If a placement change is needed, identify the safest, most family-like placement.

Ideally a very young child will remain in the same placement while in care, and beyond if reunification is not achieved. However, sometimes it is necessary to change a child's initial placement at the disposition hearing or at other points during the child's time in care. Assess why the placement is changing. Is the change for convenience or to better meet the child's needs? Could the placement be preserved if the child and/or caregiver received more support or services?

Revisit reunification.

Before moving an infant or toddler to another foster or relative placement, assess whether reunification is safe. Evaluate whether the parent is engaged in services, consistent and attentive during visitation, and capable of caring for the child's daily needs. Also assess the special needs of the child—does he have multiple treatments or therapies and/or special medical needs? Can the parent handle these needs now or does the parent need further training, support, or services? Have the safety issues and risks been significantly reduced or eliminated?

Identify the child's needs and available family resources.

Determining the best placement depends on the specific needs of the child and the family resources available. For infants, toddlers, and preschoolers, any placement in a 24-hour group setting is not appropriate.[13]

One tool for identifying family resources is *family finding*. In this intensive process, caseworkers and/or dedicated staff search for family members or family-like connections for children in foster care. This process often involves reading every paper in a child's file and performing targeted internet searches to identify relatives. Meetings between family and the children are arranged to develop family connections. Often, these family members did not know the infant existed and are willing to step forward as potential permanent caregivers or to support the biological parents. Even when placement does not take place, the contacts are critical for young children in care and may be key to maintaining connections to their family and cultural heritage and traditions.[14]

Assess caregiver supports.

Because very young children have intensive needs, substitute caregivers will need supports. Ask these questions:

- Does the caregiver need time away from the child and respite care?
- If available, have relative caregiver funds been applied for?
- Is the infant receiving all entitlements for which she is eligible?
- Are parents providing financial assistance or support in other ways (e.g., purchasing diapers, infant care products, furniture, and clothing)?
- Is child care needed and/or established?

These supports help maintain a very young child's placement and enhance her ability to form healthy attachments, feel safe, and receive consistent and positive care.

Case Planning

Require comprehensive individualized case planning in each case.

Effective case planning achieves positive outcomes for all children in the child welfare system, especially very young children who are likely to have long stays in care. The more comprehensive and inclusive the case planning, the more likely the plan will address the family's deficits and improve its strengths.[15] For parents of very young children in care, many of whom are just becoming adults themselves, full engagement in the process is essential to achieving reunification. Assessments and screenings should be the starting point for what a child and family need, but the case plan embodies the family's strengths, behaviors, needs, conditions and contributing factors.

Encourage family group conferencing.[16]

Family group conferencing (FGC) or another structured process often aids successful reunification and speeds permanency for very young, vulnerable children. FGC brings together extended family, friends, and others to help the parents develop a plan to protect children and strengthen their caregiving abilities.

Benefits of FGC include:

- increased parent motivation and buy-in to the service planning and implementation process;
- more stable placements;
- improved case-processing times;[17]
- fewer children living in out-of-home care; and
- increased kinship placements.

Although special skills and efforts to engage the family and community are required for effective FGCs, the investment in training and expertise often speeds permanency outcomes for very young children.[18]

Ensure concurrent planning begins early in the case.

ASFA encourages concurrent case planning in permanency planning practice. Originally developed for younger children who were at risk for foster care drift, concurrent planning replaces the sequential approach to case planning.[19] An alternative permanency goal is pursued at the same time as reunification. In some jurisdictions, foster parents are specially trained to serve as *resource parents*—able to support the biological parents' efforts towards reunification, but also able and willing to become adoptive parents if reunification efforts are unsuccessful.[20]

Concurrent case planning works well with young children.[21] Resource parents of very young children are often positioned to become role models for the biological parents, serving as parenting coaches and mentors. Because the lines of communication and interaction are much more open, parents can be more involved in the daily lives of their infants and can learn from more seasoned foster parents. When reunification is not possible, the foster parent or relative is prepared to care for the child long term and essential attachments to primary caregivers are not interrupted by a change in permanency goal. Additionally, the relationship between substitute caregiver and parent may diminish the need for litigation and increase voluntary relinquishments. Optimally, when reunification is not feasible, this less acrimonious process allows the infant to maintain relationships with the key people in his life, even after adoption.

How Concurrent Planning Benefits Very Young Children[1]

Very young children are the least likely to be reunified and the most likely to be adopted. They also remain in care longer than their older counterparts. Concurrent planning, encouraged by ASFA, can support timely permanent outcomes while reducing young children's time in care. For concurrent planning to succeed, foster/adoptive families (also called resource families), must understand and distinguish between their multiple roles. They must be willing to make a long-term commitment to the child and mentor the birth family toward reunification. Two successful approaches to concurrent planning are discussed below.

Increasing Timely Permanency

Colorado's concurrent planning model began in the early 1990s and involves caseworkers who are intensively trained on concurrent case planning. Legislation supports expedited permanency, and state procedures and financial supports encourage frontloading services to families. Some jurisdictions use these supports to implement family group conferencing, family team meetings, or to purchase substance abuse or mental health services. Some jurisdictions assign two caseworkers to each family—one for the child and one for the parents.

Outcomes are favorable:

- 82% of children served attain permanency in one year.
- An additional 18% of children achieve permanency in around 15 months.
- Of 522 children for whom placement data was available:
  - 77% were permanently placed within their family system, with more than 41% returning to the parent from whom they were removed;
  - 9% were placed with another parent; and
  - 26% were placed permanently with relatives.[2]

Decreasing Length of Stay

San Mateo County, California's concurrent planning practices developed from a family preservation model that the county began in 1980. Recognizing the growing numbers of very young children who were not being reunified, the county began using the foster/adoptive parent model. This model emphasizes identifying permanency resources early, fully involving the birth family, and committing to strong reunification efforts, including assessing the family's prognosis for reunification.

Data show that San Mateo County attains permanency for its children faster than the state as a whole:

- 74% of children were reunited within 12 months, compared with 65% statewide during 2003-2004.
- Equally important, 47% of adopted children achieved permanency within 12 months compared with 27% across the state.

The success of this model is attributed to buy-in from the child welfare administration and staff, the courts, and the community. Program managers stress that involving court and agency staff when designing and implementing the process is key.[3]

Sources:

1. This discussion was drawn from Child Information Gateway. *Concurrent Planning: What the Evidence Shows*, Washington, DC: U.S. Department of Health and Human Services, April 2005. Available at www.childwelfare.gov/pubs/issue_briefs/concurrent_evidence/index.cfm.
2. For more information about the Colorado model, contact the Child Welfare Division of the State Department of Human Services, 303/866-3278.
3. For more information about the San Mateo County model, contact San Mateo County Human Services, Children & Family Services—East Palo Alto Office, 650/363-4185.

Services

Identify the family's service needs.

Families and young children in the child welfare system have different strengths, challenges, and support systems. Thus, services will vary and should be tailored to each family's circumstances. Most very young children and their families involved with the child welfare system need services beyond those for substance abuse, domestic violence, or other critical needs. Such services may include child development and trauma reduction services, and treatments or interventions for the child. Because infants develop within the context of their primary relationships, interventions related to bonding and attachment, such as Child-Parent Psychotherapy, may be necessary for both the infant and parent. Many services for very young children are discussed in other chapters of this book.

Assessment-driven services

As with case planning, service needs should be driven by early assessments and screenings. It should be clearly stated who is responsible for taking an infant to therapies, treatments, doctor appointments, etc. The primary substitute caregiver and/or the parent should be required to support the infant during treatments and procedures and provide the treating professional with up-to-date information about the child.

Parenting courses

Once a parent has begun engaging in services to address the issues that brought the child into care, she can benefit from a comprehensive evidence-based parenting course. Parenting programs come in many shapes and sizes. Ideally, a parent of a child under age five should be enrolled in an evidence-based parenting program that includes a parent-child interactive component. Structured preservice and postservice behavioral observations and paper/pencil pre/post standardized and validated measures (e.g., the Adult Adolescent Parenting Inventory—AAPI) are useful tools for determining strengths and weakness and measuring growth over time.[22] Learning how to be a nurturing and safe parent is a dynamic process. An evidence-based parenting program can significantly improve a parent's caregiving abilities. Parents must be aware of basic child development as well as their roles and responsibilities in their child's life.

Features to look for in a parenting program for parents of very young children include that it:

- addresses areas specific to parenting very young children;
- uses a variety of teaching methods to accommodate different adult learning styles;
- emphasizes hands-on experiences (e.g., roleplaying, structured interaction with their child);
- assesses whether a parent is internalizing the information and can put what she has learned into practice rather than simply reporting on parent attendance;
- uses parenting facilitators to identify and build upon strengths and identify where a parent's lack of skills or knowledge can potentially harm a very young child; and
- respects the family's cultural identity.

Parenting programs geared for parents of very young children will target the skills and concepts needed to nurture, care for, and cope with the rapidly changing physical and emotional state of children ages zero to five. If a parent has other children over age five, the professionals in the case should consult and determine whether it is best to refer a parent to a parenting program that addresses the needs of each age range or focuses on younger children. The best programs tailor the course to the individual needs of the parent and his/her children.

Services for parents should target challenges that brought the family into the system and support their ability to connect with and care for their very young child. Despite the constraints of ASFA's timeframes, it is essential that parents of young children are not overburdened with multiple services and case plan

requirements simultaneously. Rather, stagger services and ensure high quality, effective interventions are in place. Meanwhile, encourage parents to focus on quality interactions and visits with their child, and their ability to develop a safe, stable home environment.

Visitation and Family Time

Ensure a comprehensive visitation plan is developed.

Children develop within the context of their relationship with their primary caregivers. Children who are placed in care when they are between birth and three years of age are unable to use words to express their distress over losing their parents and often experience emotional disturbances.[23] Consistent contact between the parent and child increases the possibility of reunification, promotes healthy parent-child attachment, and mediates the negative effects of removal.[24] Visitation, or supervised visitation if appropriate, should be permitted unless the court determines that such visitation would place the child's life, health, or safety at risk. Family visits should take place in the least restrictive, most natural setting that can ensure the safety and well-being of the child.[25]

Quality visitation plans between young children, their parents, siblings, and extended family members directly relate to ASFA's requirement of timely permanency and reasonable efforts requirements. Visitation helps develop and support a parent's ability to care for the child. Consistent and positive interactions between a child and his or her parents indicate that a family is moving towards reunification. Likewise, inconsistent and negative parent-child contact shows a need for further service planning and interventions, addressing barriers to visitation, or reevaluating the permanency goal for the child. A well-crafted and supported visitation plan is essential to achieving permanency.[26]

Contact between parents and young children must be:

- frequent (multiple times a week);
- long enough to allow a range of experiences for the parent and child;
- consistent;
- connected to daily activities;
- in the least restrictive, most home-like setting; and
- conducive to meaningful parent-child interaction.

Because a normal parent-child relationship develops during daily activities such as diaper changes, dressing, bathing, and trips to the grocery store, visitation should not be the only activity to encourage a normal parent-child relationship. Judges should encourage parents to participate in scheduling and attending their child's doctor or specialist appointments and to interact with child care

Visitation and Permanency Planning

Visitation—"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.

Source:
Excerpted without citations from Smariga, Margaret. *Visitation with Infants and Toddlers in Foster Care: What Judges and Attorneys Need to Know*. Washington, DC: ABA Center on Children and the Law & Zero to Three, 2007. Available at www.abanet.org/child/policy-brief2.pdf.

providers. This supports reunification and helps the parent develop working relationships with health and child care providers.

When there are concerns about healthy attachment between a very young child and his parent, therapeutic visitation or Child-Parent Psychotherapy (CPP) may be appropriate. CPP is a relationship-based psychotherapy facilitated by a trained infant mental health clinician. It uses a structured therapeutic process to support healthy attachment and reciprocity between a parent and her very young child.[27]

A parent's incarceration should not prevent parent-child contact. If contact is in the child's best interests and can be safely arranged, especially if the parent is not a threat and is a potential long-term caregiver, efforts should be made to promote visitation. Some correctional institutions have units that allow mothers and their infants to stay together or special areas for very young children and their

parents to visit in person. At the very least, photographs should be exchanged. Telephone, video conferencing, or other creative uses of technology may be appropriate depending on the child's age or developmental level.[28]

Visitation plans must be clearly described in the case plan and all involved in the case need to understand one another's roles and responsibilities regarding visitation. Parents, caseworkers, relatives, foster parents, and other providers of family support should be expected to help develop the visiting arrangements and support the plan.

Review Hearings

Key decisions and questions for the judge:[29]

- Is there a need for continued placement of the child?
- Does the court-approved, long-term permanent plan for the child remain the best plan?
- Is the agency making reasonable efforts to rehabilitate the family and eliminate the need for placing the child?
- Do services set forth in the case plan and the responsibilities of the parties need to be clarified or modified due to new information or changed circumstances?
- Is the child in an appropriate placement that adequately meets all physical, emotional, and educational needs?
- Do the terms of visitation or family time need to be modified?
- Do terms of child support need to be set or adjusted?
- Are additional orders needed to move the case toward successful completion?
- What timeframe should be set to achieve reunification or another permanent plan for the child?

Assessing the Permanency Plan

Assess whether the issues that caused the child's removal are being addressed.

The review hearing evaluates whether the parent is sufficiently engaged in remedial and supportive services and if those services continue to be appropriate. Although much focus is on parents and their compliance with the case plan, it is important to assess whether the child-placing agency has offered appropriate services to remedy the problem that caused the child to enter care.

Obtain information from service and treatment providers who have assessed the parent's progress and who can give information about the quality of parent-child interactions. If structured parent-child observations are occurring through therapeutic visitation or CPP, request the professional's assessment of the parent's ability to read the infant's cues, respond to the verbal child's request, or to follow their child's lead during play time. For example, ask case managers or relatives who supervise visits and other contact whether the parent talks to her infant, sets limits for the active preschooler, and responds appropriately and safely to a toddler's temper tantrums. This information will help determine whether the parent has internalized the skills and knowledge from her parenting program, therapy, or anger management course.

Therapists and other service providers should be encouraged to attend the review hearings or to submit a report detailing the parent's progress. At review hearings, directly address the parents and ask them to share what they have learned through their courses and any insights they have gained through their therapeutic interventions about how their choices and behavior affect the well-being of their young child.

Order additional services or reassessments for the child.

At each review hearing, determine whether the child is receiving necessary services and interventions to mitigate the impact of the maltreatment and support healthy growth and development while in care. Specific recommendations regarding these services are covered in previous chapters. An infant who entered care at two months of age is a completely different child at the first review hearing. By this point in the infant's development, he may be sitting up, starting to eat solid foods, or even be crawling. Deficits in performing normal developmental tasks may become more pronounced than when the case plan was first created and the infant was first assessed. Thus, judges can use the review hearing to order another developmental screen—such as the Ages & Stages questionnaire[30]—to identify developmental delays.

Evaluate safety and risk factors if the child will return home.

If reunification is being considered at this stage, safety and risk factors surrounding the return must be evaluated. Some tools to help focus the inquiry when very young children are involved include:

- **Quality observations of parent-child interactions and reports** from substitute caregivers, caseworkers, and service providers about

the parent's ability to respond to the infant's needs and cues are essential. If no structured process for observing parent-child interactions (discussed earlier) exists, consider ordering such an observation by a skilled infant mental health specialist.

- **Observations regarding the parent's knowledge, skills, and ability to put these into practice** from all who observe the parent and child together. Their insights are good indicators of whether the infant will be safe and cared for upon his return to his parent.
- **Information about availability and use of intensive home-based services to support reunification.** A prereunification family group conference (discussed above) can identify and assess the family and community supports a parent can use when feeling overwhelmed or in need of assistance.
- **A clear plan identifying family and community resources that will support reunification** if intensive home-based services are not available.

If risk factors are present at the review hearing, evaluate the family's engagement in services and the kind of support they have been offered.

Seek information about why a parent is not engaged in services:

- Is transportation or logistics an issue?
- Do the services conflict with the parent's employment or education?
- Are the services still appropriate or have the parent or child's needs changed?
- Is the substitute caregiver working with and mentoring the parent or is she impeding the reunification process? If so, what are the substitute caregiver's concerns and suggestions to remedy them?

Parents of young children are also in a constant state of transition—learning new skills and modifying old ones—and they may need different services and supports than those anticipated five or six months ago.

Determine if the substitute caregiver supports the parent toward reunification.

Assuming a concurrent case plan is in effect, the review hearing offers an opportunity to address whether the caregiver supports the parent toward reunification. Seek assurance that the substitute caregiver remains able and willing to be a permanent caregiver if reunification is not likely. Address any service and support needs of the substitute caregiver as well. As an infant grows and develops into an active toddler, a caregiver who enjoys caring for infants may not be able to

Infant Visiting Checklist for Family Court Judges

Visiting Plan

- What is the current visiting arrangement? (Where? How frequent? How long? Who is present? Level of supervision?)
- Is this visiting plan frequent enough to build attachment between the infant and parent?
- Does this visiting arrangement allow the parent to parent? This includes changing and feeding the infant; learning about the infant's cries, habits, and growth; and keeping the child safe in real-life situations.
- Was the purpose of visits clearly communicated to the parent (meet the infant's needs, stimulate the child's growth and development, communicate love for and enjoyment of the child to the child, ease the toddler's adjustment to separation)?
- What are the beginning and the end of the visits like (infant's response, parent's response, source of this information, possible reasons for assessment if any negative reports, changes over time, efforts to ease the transition)?
- If there are other children living separately from the infant, have sibling visits been set up?

Evolution

- How long has this visiting arrangement been in place? If more than three months, why hasn't the arrangement progressed? Answers should be child-related (e.g., safety or developmental concerns) or related to the parent's ability to meet the child's needs—not punitive (e.g., parent has not followed through with referrals or completed service plan, parent relapsed three months ago).

Permanency

- Is this visiting plan moving the court closer to achieving the permanency goal? Whenever possible, are the visits close to real-life situations that will allow the parent to address real-life parenting challenges?

Parental Participation in Child's Life

- Is the parent participating in the infant's medical appointments, early intervention services, and other activities?
- Has attention been paid to arranging visits on birthdays, holidays, anniversaries, and other special occasions that may be important to the child, parent, and family?
- Is mutual communication facilitated between the parent and the foster parent regarding the infant's habits, routines, behavior, preferences, and development/growth?

Limiting, Suspending, or Terminating Visits

Unless there is imminent risk to the infant's safety or well-being or evidence of visit-based harm, before suspending or limiting visits, consider the following:

- What is the basis of this request?
- Has adequate time and explanation of attachment building been given to the parent? Has the parent been encouraged to persistently, actively, and patiently build attachment with the infant? Have efforts to slowly wean the foster parent out of the visits been tried?
- For parents with substance abuse issues: Has the caseworker or substance abuse counselor discussed the expectations, parameters, and purpose of visits with the parent? Have they discussed relapse prevention to address the difficult underlying issues visits may present?
- If due to the parent's inconsistent attendance at visits: What efforts have been made to identify the reasons for irregular attendance? Have there been efforts to engage and support the parent to build an attachment with and parent her/his infant?
- If parental ambivalence toward resuming full-time care of the infant is assessed (including cases where the parent has prior termination of parental rights), has a referral for counseling about options been made?

Source:
Adapted with permission from Dicker, Sheryl and Tanya Krupat. "Permanent Judicial Commission on Justice for Children Infant Visiting Checklist for Family Court Judges." Unpublished draft. New York State Permanent Judicial Commission on Justice for Children, 2006.

supervise or care for a bustling two year old. She may require assistance enrolling the toddler in a quality early care and education program or financial assistance to buy a bed when the crib is no longer safe (especially for those toddlers who like to climb out in the middle of the night).

Modifying Visitation

Assess the visitation plan and whether changes are needed.

Review hearings are a good time to assess the quality of visits and explore whether changes are needed. Suspending visits between a developing infant and the parent when the parent is not participating consistently in visitation may significantly impact the relationship. Unless the child is at risk of harm or the visits have already harmed the child, it is important to understand why a parent is inconsistent with visitation. If a parent is ambivalent towards visitation after efforts to engage, encourage the parent to discuss available options with a therapist and attorney.[31]

If safety issues are not a concern, unsupervised contact or a living arrangement that allows around-the-clock contact (i.e., teen mother living in foster care with her infant; a residential treatment program; or a grandparent who has custody of the child and is allowed to have the parent reside in her home) may be the best way to support the infant's attachment to her primary caregiver while ensuring her safety. However, because many children in the foster care system generally do not experience healthy attachment relationships, visitation is ideally understood as a 'planned, therapeutic intervention' and should be constructed as such.[32]

If parent-child contact must be supervised for the safety of the child, such visits should be in as natural an environment as possible with age-appropriate toys that encourage parent-child interaction.[33] The supervisor should model appropriate parenting when a parent is struggling to interact with the child or behaving inappropriately. Supervisors need to be sensitive to the emotional needs of the infant and the parent related to their separation. If a parent does not understand his infant's needs or does not respond to the infant's cues, CPP should be considered.

Visitation logistics should be reassessed often. Is the parent struggling with visiting three different children in three locations? Is the visitation time interfering with the toddler's nap time? Is the parent able to juggle older children who are seeking her attention and a new infant who needs her focus as well? Because visitation is key to promoting attachment and bonding, extra care and attention should be devoted to ensuring the arrangements are feasible and promote successful parent-child interactions.

Permanency Hearings

ASFA prioritizes permanency options for children as follows:

1. reunification
2. adoption
3. guardianship
4. placement with a fit and willing relative
5. another planned permanent living arrangement (APPLA)

At the 12-month permanency hearing, judges must make key decisions about a child's permanent custody and specific dates for finalizing those arrangements. Judges must also determine whether to extend a child's stay in care for a specific period while continuing to pursue reunification with the parent(s).

Making a permanency determination for very young children after 12 months in care can be difficult. If permanency planning begins at the start of the case, the answer should be clear. For example:

- A parent who has engaged in services, visited intensively with her infant, and participated actively in her infant's early intervention and early care and education services should have already regained physical custody of her child by this stage. If not, the parent should be ready to regain custody at the permanency planning hearing.
- Adoption is optimal when a parent has not engaged in services or visitation or remedied the circumstances that brought the child into care. Ideally, the infant or toddler's substitute caregiver supports reunification and is willing to adopt if reunification becomes implausible. Often in this circumstance, a parent voluntarily relinquishes her parental rights and the adoptive parent allows ongoing contact.

These are the easy scenarios, when things fall into place naturally because planning, services, and supports started early and were reassessed and updated regularly. What is the best decision-making process when it is not as clearcut as these scenarios?

Reunification

Determine if reunification is a viable permanency plan.

Reunification is the preferred permanency option if the parent can keep the child safe and well. There is little research about the decision-making process related to reunification and what contributes to a *successful* reunification, especially when very young children are involved.[34] We do know that infants have the highest rate of postreunification maltreatment, with one in five reentering foster care, usually within 90 days.[35] These findings underscore the need to be careful and clear about carrying out this permanency option.[36] Factors that impact decisions to reunify a parent with a very young child include:

- quality of relationship between the parent and child;
- quality and frequency of parent-child interactions;
- parental compliance with services and benefits attained;
- long- or short-term special medical or developmental needs of the young child;
- parent's demonstrated understanding of the infant's needs;
- parent's capacity to meet the infant's needs;
- family and community supports available to support a parent and child;
- if there are siblings, the parent's track record in assuring the siblings' school attendance, medical appointments, and any required treatment;
- parental mental health and addiction issues;

- length of time out of the parent's care; and
- point at which the infant was removed (e.g., at birth, six months).

Identify how reunification will affect the child in the short term.

Research shows that for infants, changing caregivers is traumatic.[37] Reunification, or any transition, can have harmful short-term effects on the child, especially for those children between the ages of six and 24 months old.[38] Infants often form secure attachments to substitute caregivers who have loved them and have attended to their daily needs. The person an infant trusts most to continue caring for him is naturally the person who has been changing his diapers, feeding him, bathing him, putting him to bed, and so forth. Because an infant cannot understand why things have changed, removal from his substitute caregiver—even to a parent with whom there is a healthy attachment and relationship—may cause distress similar to the initial removal. Removal from substitute care often changes the infant's daily routine—a common source of security for the child. The longer the infant has been in out-of-home care and the more intense the attachment and sense of security associated with that placement, the more psychologically difficult the reunification process.[39] Supportive therapeutic services and transition planning must be considered to promote a successful reunification.

Ensure transition planning is part of a reunification plan.

To avoid another traumatic life event for the infant, *transition planning* should be part of any plan for reunification. Ideally, when reunification is the goal, parents and substitute caregivers will have developed a working relationship, allowing the young child to attach with both caregivers and to observe her primary caregivers connecting with each other.[40]

Any effort to increase the parent's daily caregiving and to nurture the relationship between the child and parent will support a smooth transition. The parent should begin taking on more tasks of daily care through increased visitation or involvement in the substitute caregiver's home. If comfortable, the substitute caregiver could visit the parent's home with the infant on the first few in-home visits, if those have not yet started. Maintaining the status quo in other aspects of the infant's life during the transition phase—child care, therapists, babysitters, doctors—can ease the process and minimize any distress. Finally, ensuring that the parent is aware of the infant's schedule and routine and has a plan to reinforce some of this structure may help the infant better cope with the changes.

Adoption

Determine if adoption is a viable permanency plan.

When a child will not reunify with a parent, adoption is the next best permanency option. In fact, infants represent 48% of adopted children.[41] For an infant who is attached to a foster parent or relative, adoption can formalize this primary relationship in the infant's life. Data on outcomes for infants adopted from the child welfare system are scarce.[42] That said, infants who have been adopted from the child welfare system exhibit better outcomes than their counterparts who remain in care, although this may be due to the instability of foster care rather than the adoptive family.[43]

For infants not already placed with caregivers who are able and willing to adopt (or take some other form of long-term legal guardianship), legally freeing the infant for adoption through a termination of parental rights (TPR) proceeding often extends the time he will spend in care. Once the TPR is finalized, children without an identified adoptive parent may remain in legal limbo while one is identified. One study found that "a surprising number of infants who are placed in child welfare care are neither reunified with their families nor readily placed in alternative permanent homes."[44]

These findings speak to the need to concurrently plan for reunification and possible long-term permanent placement with a specific substitute caregiver from the start of the case. After a TPR, the court should hold frequent review hearings—every two to three months—to determine whether sufficient efforts are being made to identify and secure an adoptive home for a legally free young child.

Determine if the current caregiver can adopt the child.

If adoption is the desired permanency option, confirm that the current caregiver:

- is willing to adopt, and
- would be approved as an adoptive parent.

If concurrent planning was implemented on day one, and if an adoption quality home study was conducted at the start of the case, these critical questions will already be answered. Furthermore, if an extensive search and review of relatives took place early in the case, as some state laws and now federal law require,[45] the child's 'preadoptive' placement should not be disrupted by relatives who step forward after the TPR stage. Remember, there is great psychological risk to disrupting a child's secure attachments without compelling evidence that doing so is clearly in the child's best interest.

If the current caregiver no longer wishes to adopt, determine whether she would be willing to be a permanent guardian through a legal guardianship proceeding (see below). Also assess the caregiver's ability and desire to adequately care for the infant as he grows. If the current caregiver is unwilling or unable to care for the child permanently, require the state to provide a full analysis of other immediate permanency options through adoption or guardianship with family members or nonrelatives.

Consider ordering mediation to resolve adoption-related concerns.

Once a TPR petition is filed, it may be beneficial to order the parties to attend mediation. Mediation can clarify issues in the case, help parents decide whether voluntarily relinquishing their parental rights is in their best interest, and explore whether open adoption will take place. If an infant is with a relative or foster parent who is willing to permit informal or formal (through an open adoption) postadoption contact between the biological parent and/or family, a voluntary relinquishment will speed the TPR process and allow for adoption.

Legal Guardianship

Determine if legal guardianship is a viable permanency plan.

Legal guardianship is defined by the ASFA regulations as "a judicially created relationship between child and caretaker which is intended to be permanent and self-sustaining as evidenced by the transfer to the caretaker" of certain parental rights, "with respect to the child" including "protection, education, care and control of the person and decision making."[46] A relative or nonrelative can become a legal guardian and, according to ASFA, that legal guardianship must be binding beyond the jurisdiction of the court hearing the dependency case. In some states, legal guardianship dissolves the dependency court's jurisdiction altogether.[47]

Legal guardianship is a good alternative to adoption when there are no grounds for TPR and a caregiver is willing to serve in this capacity permanently. Establishing a permanent legal guardianship for a very young child rather than a nonpermanent arrangement with a relative benefits an infant or toddler in the long run. Many relative caregivers prefer this option over adoption because they do not want the parent's rights to be severed or to be a part of an adversarial termination of parental rights process. Judges can ask about the relative's ability—physically and emotionally—to care for a very young child through the age of majority.

Federal law now permits states to enter into kinship guardianship assistance agreements with relatives who are serving as foster parents to their kin using Title IV-E funds.[48] This means that relative caregivers in this circumstance could continue to receive foster care maintenance payments, even after a permanent guardianship is established.

Permanent guardianship may be a good alternative for a developmentally delayed or very young parent. This option supports permanency, but allows a parent who is incapable of change for reasons beyond their control (e.g., cognitive delay) to retain her rights and to actively contribute to her child's upbringing. Additionally, children of parents with disabilities may be entitled to certain benefits, and terminating the legal relationship would end the child's right to receive such benefits (e.g., social security disability payments).

Placement with a Fit and Willing Relative

Determine if relative placement is a viable permanency plan, only after exploring more desirable options.

If neither reunification, adoption, nor legal guardianship is in the best interests of the child, next consider a placement with a fit and willing relative. Although the relative must commit to caring for the child until the age of majority, this option is akin to legal limbo for very young children. In fact, the preamble to ASFA states that "relative placements should not preclude consideration of legalizing the permanency of the placement through adoption or legal guardianship."[49] State statutes typically do not allow this permanency option unless certain conditions are met. States must continue to supervise the placement and the court must review the case regularly (i.e., every six months) and conduct permanency hearings to reevaluate the possibility of adoption or legal guardianship.

For very young children, placement with a fit and willing relative should only be accepted when a more legally permanent arrangement is not in the child's best interest. Judges should require regular updates on efforts to identify an adoptive parent or to help the relative seek a legal guardianship. Additionally, because this option does not preclude a parent from regaining custody, judges should closely consider the same questions that would be asked when assessing reunification.

Another Planned Permanent Living Arrangement (APPLA)

In most cases, APPLA should not be a permanency goal for very young children.

ASFA was developed to prevent children from living their lives in foster or group homes. The preamble advises that long-term placement in a licensed foster home should be the very last resort, and the regulations require the state to document a 'compelling reason' for choosing APPLA as a permanency option.[50] These compelling reasons as applied to very young children may include:

- when a parent and child share a significant bond, but the parent is unable to care for the child due to an emotional or physical disability, or
- when an Indian tribe has identified another planned permanent living arrangement for the child.[51]

APPLA is not a suitable permanency outcome for a very young child. Even when the parent is disabled and unable to care for a child to whom there is a significant bond, the judge should ensure the foster parents are informed of the benefits of becoming the child's adoptive parent and/or legal guardian. Parent-child relationships may be maintained through open adoptions or visitation agreements in a guardianship order. If a foster parent has concerns about covering the costs of a medically fragile or special needs infant and requires the foster care payment to offset certain costs, request that a state and federal benefits and entitlements expert meet with the foster parents and caseworker to secure financial support so a more permanent legal arrangement is possible.

Note that under the Indian Child Welfare Act (ICWA), the permanency preferences of ASFA are not the same. Relatives and *extended families* are preferred over adoption, and many tribes do not value adoption in the same way as ASFA does. Additionally, APPLA can be more easily used as a permanency option for children who are covered by ICWA.[52]

Consulting the Child

Hear the child's views regarding the permanency plan.

The Social Security Act, which includes Title IV-E funding to the states for children in foster care, requires that the court holding a permanency hearing conduct an age-appropriate consultation with the child.[53] This requirement is met when the court obtains the *views of the child in the context of the permanency hearing*.[54] In other words, while it may not be possible for a court to hear testimony from a very young, preverbal child, the court should hear about the child's views on his

or her permanency plan and incorporate this information into the overall decision-making process.

A report written by a nonattorney or CASA, a caseworker's testimony, and communications by the legal representative for the child may present the child's view; however, information relating to the child's best interests alone is not enough to satisfy this 'consultation' requirement.[55] Some states provide guidance to attorneys and other child welfare professionals about determining a child's view on his or her permanency plan. Generally, *age appropriate* means "meeting the cognitive level of a child for their developmental age" unless a child is cognitively delayed.[56]

Observe preverbal children in court to inform your decision making.

Even when a very young child is preverbal, there are many benefits to bringing an infant or toddler to hearings on a regular basis. The information gained from simply observing a child at a court hearing is invaluable. You can gain tremendous insight from seeing the young child interact with her parent and caregivers, and it gives the parent and child an opportunity to visit if the child is placed out of the home. Having a child present in the courtroom can also highlight how quickly she is growing and just how important speedy, decisive action towards permanency is. Courtroom observations can also help inform decisions about placement, visitation, or therapeutic services.

Consider the child's developmental stage during courtroom observations.

It is important to be familiar with developmental milestones when observing very young children. For infants and young children from birth to 12 months old, permanency observations might include:[57]

- How does the child interact and respond to caregivers, parents, and guardians?
- Is the child meeting developmental milestones?
- Does the child appear healthy and well-cared for?

Observations of toddlers and preschoolers in the courtroom might also include:[58]

- How does the child act when answering questions (if verbal)?
- Who does the child look to for help answering questions?
- Is he scared? Anxious? Avoidant?
- Does he look to the caregiver for the "right" answer?

A verbal child's presence in the courtroom also provides an opportunity to ask her questions. Use simple language, speak slowly, and allow the child time to process the question. Younger children can better understand concrete terms and will recognize names better than pronouns. Possible questions to ask might include:

- How old are you?
- Do you like where you are staying now?
- Do you go to preschool or daycare? What things do you like to do at school?
- Do you feel sad or miss anyone? (e.g., brother, sisters, grandparents)
- Have you been to the doctor?
- Do you like the doctor?[59]

Extending the Goal of Reunification

Determine if there is cause to extend the goal of reunification.

It may be that by the time of the permanency hearing a parent is progressing towards reunification, but barriers to taking physical custody of the child are still present (e.g., housing). The federal regulations state that if a child has been placed in out-of-home care for 15 of the preceding 22 months, the state must file to TPR unless there is a compelling reason not to file. While ASFA's reduced timeframes and required permanency hearings stress that time is of the essence for children, overcoming addiction and becoming stable, even when diligently pursued, takes time—often more than 12 months.

When there is cause to extend the timeframe for reunification, evaluate the probability of reunification by assessing a parent's progress with their key services and the consistency and quality of the parent-child interactions. When extending the goal of reunification past the permanency hearing is necessary, the time given to a parent to complete case plan tasks and establish that they have remedied the circumstances that brought the child into care should be consistent with the child's developmental needs.[60] Thus, for an infant placed in foster care, the extension would be short—a matter of weeks. For a preschooler in the care of his grandmother, it may be appropriate to allow the parent several months to finalize reunification-related tasks.

Unless a parent was simply not offered services, refrain from continuing the goal of reunification when a parent has only become engaged in services and visitation in the months or weeks leading up to the permanency hearing. Rather, look for a "genuine, sustainable investment in completing the requirements of the case plan in order to retain reunification as the permanency goal."[61]

Postpermanency Support for Young Children and Their Families

The ability of permanent caregivers to maintain a safe and nurturing environment is critical to achieving sustainable outcomes for very young children exiting the child welfare system. Certain circumstances make infants highly vulnerable to reentry into care for even longer periods. Infants who are reunified in a fairly short period (three months) are more likely to reenter care than older children and other infants who remain in care longer.[62] In addition, infants who return to care a second time stay longer in care than their first experience.[63] Appropriate postpermanency supports can help avoid such reentries. Supports for permanent caregivers should be developed, ideally through a family group conferencing or decision-making process, early in the case and updated regularly as circumstances for the child and her family change.

Sustaining Reunification

Ensure supports are in place to sustain reunification.

Before reunification and during the postplacement supervision period, require case managers and family members to:

- Identify barriers to successful reunification.
- Identify supports to address and overcome reunification barriers.
- Develop a safety or emergency plan to help the parent cope with parenting stressors and challenges that could compromise successful reunification.

Other reunification supports that should be in place before discharge/termination of supervision:

- Connect the birth family with a medical and dental home (as discussed in Chapter 2) and promote the family's *health literacy* (their ability to understand health information).
- Ensure the parents and other family members are aware of the child's special needs and special treatments or appointments. Connections should be made between the parent and the provider well before case closure.
- Develop a visitation plan if only one parent is given custody but the other is permitted to maintain contact with the child.
- Enroll the family in financial assistance programs (e.g., Medicaid, food stamps, Temporary Aid to Needy Families (TANF)).
- Ensure all entitlements and subsidies are in place before case closure.

- Confirm that the parent has identified people or agencies to turn to for respite care, babysitting, and general parenting questions. These should be written down and include specific names and contact numbers.
- Confirm that a parent is linked to neighborhood supports through a community or neighborhood center (e.g., YMCA); link with possible afterschool/summer supports.
- Ensure the parent is engaged in peer support groups for chronic issues such as substance abuse or domestic violence. Some parenting programs offer 'booster sessions' and support groups once a parent completes the program.
- Ensure the child is enrolled in child care or Early Head Start/Head Start and the enrollment package is completed before exiting care. A meeting between the director and child care center caregivers should be facilitated if contact has not already been made.
- Confirm the parent has secured stable housing and employment or a source of income (e.g., child support, Supplemental Security Income) before the case is closed. Make sure he has a backup plan if housing or employment plans do not work out.
- Ensure the parent is connected with the early intervention provider well before reunification and case closure.
- Devise a placement plan if there is a relapse, another incident, or the parent is incarcerated.
- Determine a safety plan for the adult victim and for the child in domestic violence cases.

Sustaining Adoption

Identify adoption disruption factors.

Adoptions are generally highly successful permanency arrangements, although some adopted children and their families confront difficulties.[64] Even so, adopting a very young child from the foster care system can be challenging due to the impact on the child's development by the initial maltreatment, trauma, and resulting stay in foster care.

Research shows several factors increase the risk of adoption disruption:

- **Child's age**—The older the child is when adopted, the higher the likelihood for disruption—an encouraging finding for families who adopt very young children.[65]
- **Alcohol/drug exposure**—Adoptions of children with prenatal alcohol exposure are at risk for placement disruptions because these children are

more likely to experience multiple psychiatric symptoms as they mature. However, low placement disruptions have been found in drug-exposed children adopted early in life (before eight years old).[66]

- **Inexperienced/unknown adoptive caregivers**—Adoptions by strangers or families without adoption or foster care experience are at higher risk of disrupting.[67] Thus it is important for child-placing agencies to be upfront with prospective adoptive parents about a child's special needs and the treatment for those needs. Adoption by someone unknown to a very young child can be frightening. Adoptive parents of very young children should not be lulled into a false sense of security by believing the infant will "just adjust" because she does not understand what is going on. Those adopting very young children must understand early child development and the potential for a very difficult transition phase with a lot of crying, anxiety, rejection, and sleepless nights.

Identify postadoption supports.

Although there is minimal research on postadoption support services, evidence suggests that a family-focused, long-term intervention is a more effective form of postadoption support than short-term interventions.[68] Self-help and adoptive parent support groups fit the needs of many adoptive parents.

Judges should ensure the child-placing agency provides the following postadoption services to families:[69]

Educational/informational:

- full disclosure of information about the infant, including medical, developmental/mental health, social, and genetic history;
- literature related to the infant's specific needs and about adopting very young children;
- lectures, trainings, workshops to help build skills around parenting an infant and about adoption issues;
- support groups and adoptive parent mentors to help them address their child's specific needs;
- Life Book (if available)—a record of an adoptive child's life told through photos, artwork, mementos, and stories that is developed starting when the child enters care.

Clinical:

- couple or family counseling to help cope with the impact of adoption;
- reliable, high quality respite care.

Material:

- adoption subsidies should be applied before the final adoption order (one study found that adoptive families who received higher subsidies were more likely to be maintained than those who received lower subsidies and that families that did not receive any subsidy were more likely to experience a disrupted adoption);[70]
- medical care and a medical home;
- educational opportunities (e.g., Head Start/Early Head Start; child care subsidies).

Permanent Placement with a Relative or Nonrelative

Ensure postadoption supports and services are equally available to permanent guardians or long-term relative caregivers.

Many of the child-focused supports for reunification and adoption apply to sustaining any permanent placement.

Maintain family connections.

The child benefits from maintaining as many connections as possible—to child care, primary care doctors and dentists, infant mental health and early intervention therapists. Nonrelative permanent caregivers should consider the infant's connection with her family of origin and her cultural heritage. A nonrelative should be willing to commit to sibling visits and family contact when feasible and in the infant's best interest. Even very young children benefit from exposure to their cultures of origin. When they grow up and have questions and concerns about where they come from, early exposure to food, music and customs will provide a framework. Contact with the birth family can also support this and maintain important sibling ties.

Conclusion

With ASFA providing the legal framework and the *RESOURCE GUIDELINES* advising on key questions and decisions during each step of the process, you have promising tools to promote timely, stable permanency for very young children in the child welfare system. By understanding early child development principles and research about how very young children experience removal, placement, reunification, and adoption, you can ensure the child welfare system holistically meets their physical, cognitive, and social-emotional needs.

Young children in care should always be viewed through an early child development lens. When possible and safe, keep children with their parent with intensive supports, education, and interventions. If removal is essential, require that every effort is made to ensure the young child's first placement will be the only placement if reunification becomes untenable. Using concurrent case planning is one element of that process. Require thoughtful, comprehensive visitation plans and hold all parties—parents, caregivers and state agencies—accountable for following such plans.

Whether your jurisdiction has a formal family group conferencing structure or not, expect parents, family members, and service providers to participate in case planning, fully support the goals, and increase the potential for successful reunification. Emphasize to parents, family members, and caseworkers that they are all responsible for the very young child's experience in the child welfare system, whether she achieves permanency in a timely manner, and whether her involvement in the system enhances her overall well-being.

Endnotes

1. Wulczyn, F., K.B. Hislop and B.J. Harden. "The Placement of Infants in Foster Care." *Infant Mental Health Journal* 23(5), 2002, 454-475, 456.

2. Jones Harden, B. *Infants in the Child Welfare System: A Developmental Framework for Policy and Practice.* Washington, DC: Zero to Three, 2007, 107.

3. P.L. 108-36

4. Jones Harden, 2007, 17.

5. Ibid.

6. *RESOURCE GUIDELINES: Improving Court Practice in Child Abuse & Neglect Cases.* Reno, NV: National Council of Juvenile and Family Court Judges, 1995. The *RESOURCE GUIDELINES* have been endorsed by the American Bar Association and the National Conference of Chief Justices.

7. For further guidance, the *ADOPTION AND PERMANENCY GUIDELINES: Improving Court Practice in Child Abuse and Neglect Cases*, published by the National Council of Juvenile and Family Court Judges, 2000, is an excellent resource that delves more deeply into considerations for timely permanency and adoption.

8. Ibid., 37. Some questions include changes to reflect a more specific focus on very young children.

9. Lillas, C., Judge L. Langer and M. Drinane. "Addressing Infant and Toddler Issues in the Juvenile Court: Challenges for the 21st Century." *Juvenile and Family Court Journal*, Spring 2004, 92.

10. For example, Promise Home in Tucson, AZ (http://thegivingtreeoutreach.org/id15.html) and the FACT (Fathers and Children Together) Program in Minneapolis, MN provide transitional housing for men and their children, and The Village South in Miami, FL provides residential substance abuse treatment to fathers or mothers with their children (www.villagesouth.com/fit.html).

11. Smariga, Margaret. *Visitation with Infants and Toddlers in Foster Care: What Judges and Attorneys Need to Know*. Washington, DC: ABA Center on Children and the Law & Zero to Three, 2007. Available at www.abanet.org/child/policy-brief2.pdf.

12. *RESOURCE GUIDELINES*, 1995, 57-58. Some questions include changes to reflect a more specific focus on very young children.

13. Jones Harden, 2007, 86.

14. Jurisdictions in California, Florida and Washington have instituted family finding as a standalone program or have implemented some of the tools. Visit www.senecacenter.org for more information about family finding and to request training for your jurisdiction.

15. Buie, J. and G.P. Mallon. "Achieving Permanency for Children & Youth Through Skillful Case Planning: Some Lessons Learned from Child & Family Service Review Final Reports." *Permanency Planning Today*, Summer 2002, 2-3.

16. This is also referred to as family team decision making or family group decision making.

17. Robinson, Judge S.D. et al. "Family Conferencing: A Success for Our Children." *Juvenile and Family Court Journal*, Fall 2002, 43-47, 45-46.

18. Ibid., 43-44.

19. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. "Concurrent Planning: What the Evidence Shows." *Child Welfare Information Gateway Issue Brief*, April 2005. Available at www.childwelfare.gov/pubs/issue_briefs/concurrent_evidence/index.cfm.

20. Ibid.

21. Ibid.

22. This model has been developed in Miami-Dade County, FL as a collaboration between the child welfare community advisory committee, the dependency court (Judge Cindy Lederman), the child welfare system leadership and community parenting program providers in partnership with Dr. Lynne Katz (University of Miami) and Dr. Joy Osofsky (Louisiana State University). For more information about the AAPI, visit www.nurturingparenting.org.

23. Smariga, M., 2007, 5.

24. Ibid., 6.

25. Ibid., 11.

26. Ibid., 8.

27. Child-Parent Psychotherapy is discussed more fully in Chapter 3.

28. "Connecting Children with Incarcerated Parents." *Child Protection Best Practices Bulletin: Innovative Strategies to Achieve Safety, Permanence and Well-Being*. Available at www.f2f.ca.gov/res/pdf/ChildProtectionBPBulletins.pdf.

29. *RESOURCE GUIDELINES*, 1995, 70.

30. The Ages and Stages Questionnaire is a standardized parent report tool used for developmental surveillance for children 4–60 months of age. The parent-completed instruments address children's skills in four domains: language, personal-social, motor, and cognition. D. Bricker and J. Squires. "Ages and Stages Questionnaire." Available at www.brookespublishing.com/tools/asq. For other common developmental screening tools, see www.dbpeds.org/articles/detail.cfm?textid=539.

31. Smariga, 2007, 21.

32. Ibid., 7.

33. Ibid., 13.

34. Jones Harden, 2007, 104.

35. Ibid., 107.

36. U.S. Department of Health and Human Services, Administration on Children, Youth and Families. *Child Maltreatment 2006* (Washington, DC: U.S. Government Printing Office, 2008).

37. Jones Harden, 2007, 242.

38. Ibid.

39. Gauthier, Y., G. Fortin and G. Jéliu. "Clinical Application of Attachment Theory in Permanency Planning for Children in Foster Care: The Importance of Continuity of Care." *Infant Mental Health Journal* 25(4), 2004, 379-396, 386.

40. Jones Harden, 2007, 244.

41. Administration for Children and Families, 2006b.

42. Jones Harden, 2007, 108.

43. Ibid., 110.

44. Kemp, S.P. and J.M. Bodonyi. "Infants Who Stay in Foster Care: Child Characteristics and Permanency Outcomes of Legally Free Children First Placed as Infants." *Child and Family Social Work* 5, 2000, 102.

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46. 45 C.F.R. § 1355.20(a).

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48. Fostering Connections to Success and Increasing Adoptions Act of 2008, P.L. 110-351.

49. 65 C.F.R. § 4060.

50. 45 C.F.R. §§ 1355.20(a) and 1356.21(h)(3).

51. 45 C.F.R. § 356.21(h)(3)

52. Ratterman Baker et al, 2001, 103; Jones, B.J., M. Tilden and K. Gaines-Stoner. *The Indian Child Welfare Act Handbook: A Legal Guide to the Custody and Adoption of Native American Children*, 2d ed. Chicago, IL: American Bar Association, 2008.

53. Social Security Act, § 475(5)(C)(ii).

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58. "Engaging Toddlers and Preschoolers in the Courtroom: Judicial Bench Card." Washington, DC: ABA Center on Children and the Law, 2008. Available at www.abanet.org/child/empowerment/youthincourt.shtml.

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68. Ibid., 450.

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