

Frequency of Visits:

Are one hour weekly visits enough to achieve reasonable effort to reunify children and parents?

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Introduction:

There are two purposes for children and their parents to visit when the child is in an out-of-home placement.

1. The first and primary reason is to help children maintain and enhance their attachment with their parents, siblings and others with whom they have emotional connections. Healthy attachments are an essential part of the child's developmental progress and is essential to the child's sense of permanency.
2. The second is to enable the parent to learn, practice and demonstrate improved parenting skills related to the substantiated maltreatment. This is essential, as the ability of the parent to meet the child's safety and well-being needs are the key factors in determining the child's permanency plan.

This paper will provide guidance for professionals in determining the appropriate frequency of visits to adequately meet the child's needs and to enable an adequate assessment of the parent's skills, while aligning with Federal permanency time-line requirements. Additionally, this paper will review the key elements of effective Connections Plans and how these elements progress on continuums to meet reasonable efforts requirements. The Connection Plan that uses the progressive method will be introduced herein. Its elements include: frequency, length, location, who attends visits, activities, parenting responsibilities, time of day/day of week and level of supervision.

Executive summary:

When a child is removed from his home it is likely that the first visits will be held in the agency office within the first week in out-of-home care, perhaps an hour long and most definitely will be supervised by an agency worker. Though this form of first visit

Connection Plan – The written plan that describes how the child's connections will be maintained and enhanced. This includes parent/child visits as well as contact with siblings, extended family, support to stay in the same school, and cultural and community connections. The plan contains progressive steps to assess the parent's ability to effectively meet the child's needs.

usually does not meet best practice standards (see Best Practice Standards on pages 35-37), it is the most common form of initial visit.

Prior to a child being returned home, it is prudent to have had multiple and successful overnight visits, in the parent's home, unsupervised, with all of the people the child will live with and during times and circumstances that mimic when the substantiated maltreatment occurred. Visit plans that do not progress to this level place the child in danger after reunification as it cannot be known how the parent and child will interact during daily stresses and whether the safety plan will be adequate to protect the child from repeat maltreatment.

One hour per week during a year represents only 52 hours of contact. It is not realistic to think that this level of contact is sufficient to meet both purposes of visits. The Progressive Visit method is to make slow and safe steps in the Connection Plan from the initial visit to the overnight visits.

Connection planning is a complex decision process based on the following factors:

1. The developmental age of the child, how to meet the child's attachment needs and what the child desires;
2. The type of maltreatment that the child experienced;
3. The length of time in care the child has been in care and the focus of the agency's work with the family (stages of care: initial placement and assessment, reasonable efforts work, making final permanency decision and post permanency decision, and the rest of the child's life);
4. Family culture; and
5. Special needs of parent or child: addiction, mental illness, domestic violence, educational or developmental delays, behavioral problems, medical conditions, etc.

*Safety Plan:
A plan developed by the child, parents, worker and family support system that provides a method for the child to signal to ask for help, for the visit to end early or to have someone come to help if the child is alone with the parent.*

This paper will address some of these factors, showing how research and best practice can help to guide the development and implementation of Connection Plans and to determine if the parent is making substantial progress.

Purpose One – The child's rights:

Let's be clear - visits are intended to meet the child's needs. All too frequently adults tend to view visits from the perspective of meeting the needs of the adults including, how to make visits convenient for the adults or how to schedule visits based on the agency's resources.

Children have a right to have a relationship with their parents, siblings and other family members. This is a culturally accepted norm that is validated by the Geneva Conventions.ⁱ Additionally, Federal laws support this right for all children separated from their family.ⁱⁱ A child has the right to visit and have a relationship with a parent, sibling and other family member, even if the parent has been convicted of a crime against the child and is incarcerated.ⁱⁱⁱ

Most children who are placed in care will reunify with their parent(s).^{iv} Many children who do not reunify will continue to have or reestablish a relationship with their parents and family members at some point in their life.^v Child Welfare interventions with family are not just about “fixing” the parent but require us to maintain and enhance the emotional connections between the parent and child if reunification is to be successful.^{vi} Providing safety for the child today is not enough. We know we have been successful when the maltreated child is an adult and has healthy permanent relationships, is able to take care of himself or herself, and knows how to manage unhealthy relationships.

Visits must encourage and support the parent/child attachment, allow them to interact frequently, and in locations and doing activities that occur in healthy parent and children relationships. Attachment develops when a parent helps the child meet challenges, show affection, learn new skills and handle life’s stresses. This requires having visits that actively enable and support activities that cannot easily occur in an hour or when the visit only occurs once a week. The parent must be involved in the daily life of the child including such activities as; getting ready for school, preparing meals and setting rules about eating, enforcing appropriate consequences for not following family rules, comforting the child who just fell down and the multitude of small events in a day. That is what creates healthy attachments and demonstrates healthy attachments.

Purpose Two – The parent’s rights:

Federal and state laws require the agency to provide reasonable/active efforts to help a family reunify.^{vii} To meet this requirement, the court-ordered case plan usually requires the parent to participate in a litany of services and to accomplish a variety of tasks in order for reunification to occur. A typical neglect case, when the parent is addicted to a drug, is likely to require services such as drug treatment and parenting classes and tasks such as passing drug tests, obtaining appropriate housing, and attending visits with their child and staying away from drug associates. (The author does not endorse these services as correct, given this neglect case example, but as the ones most likely to be court ordered.)

Coordinating the services and treatment plans with the Connection Plan is an effective means of more quickly determining if these services are helping the parent develop the skills and

resources needed for successful reunification. As the parent begins to learn new behaviors or skills they will need to practice using those skills with their child. For example, when the parent is learning how to supervise and discipline a two year old, a well planned visit would then incorporate opportunities for the parent to practice these skills through coaching and feedback. A progressive Connection Plan would allow the parent to successfully demonstrate her skills under low stress situations such as a short visit in an environment with no distractions and a well-rested child. Progressively the visits would change; the same skills would be practiced in more and more challenging situations until the parents are supervising the child in the family home, while cooking dinner and the child is tired and hungry, and the parent is struggling with the relapse cycle. (See page 27 for definition of relapse cycle.) If this parent is also attending drug treatment a “relapse plan” would be developed. The parent and the people identified in the relapse plan, as the support system, would practice using the plan during visits. This would include the adults and older children learning from the parent’s drug treatment services the triggers and warning signs that signal a need for the relapse plan to be activated. First under low, controlled stress situations the family would practice activating the relapse plan. Progressively the visits would move towards more stressful situations such as visits on a weekend night when the parent has a history of using drugs. By slowly increasing the length and frequency of visits the professionals allow for an assessment of the relapse plan and the parenting skills. Eventually, for successful cases, the child is returned home with proof, beyond completion of services certificates, that the parent and her support system can maintain the child’s safety and well-being even if a relapse were to occur.

Parents must be provided a reasonable amount of contact that will support healthy attachment and an opportunity to learn new parenting skills. If needed, the parent should be provided training or treatment to learn how to attach to the child or to help overcome attachment problems. Not providing this opportunity and then recommending adoption to the family the child has attached to while in care, is a “Catch 22” argument. It is the responsibility of the child welfare system to be able to say to every child: We provided your parents (and other relatives) every reasonable opportunity to maintain their relationship with you.

Guiding Rules for Visits

The court, agency, parents and all the adults must work together to make visits safe and healthy experiences for the child. The guidelines presented in this paper should never be used as absolutes, as each child and family is unique. The golden rule of all visits should be: Visits will always be safe, non-traumatizing and encourage healthy attachments. Additionally it is recommended that the following rules be used in developing and evaluating visits.

1. Both children and parents have rights and needs, but when it is not possible to meet everyone’s needs, the child’s rights and needs must come first.

2. Visits are designed so the child and parent (sibling and other family members) maintain and enhance a healthy attachment.
3. No child should ever be forced to attend or complete a visit when by her behaviors or words it is clear that the child does not want to be there.
4. If the parent and child cannot have healthy interactions during a visit, even after being provided coaching or redirection, that visit should end early. Visits are not to be used to catch a parent doing it wrong.
5. When a child is upset by visits there are many possible explanations and many possible solutions. Terminating visits should only be used when all other solutions have been tried. It is essential to try other solutions as a child should not continue to have visits that are upsetting. Many children are upset by visits as they are experiencing the grief and loss of not living with their family and increasing the frequency of visits may be the most appropriate response. Example: Child cries for many minutes at the end of a visit. Determine how to make visits end in a manner that will not upset the child rather than terminate future visits.
6. Visits should occur in the most home-like locations where families usually interact. The balance is that the location must provide adequate safety for all parties. Children should not have to wait until reunification occurs to visit their home or see their pet.
7. Visits should be making regular progressive steps towards the goal of overnight, unsupervised visits in the family's home. If safe progress cannot be made, a case planning meeting or court review should occur to determine the reason and possible solutions.
8. Every child will should have a Connection Plan that includes the highest level of contact that is possible for the child that meets these rules. The plan must include contact with siblings and other people important to the child including the non-custodial father and his family.
9. Children should be allowed to have contact with the people he or she identifies as important even if that person has not started treatment or has abused the child. It is the adults' responsibility to find a way to have safe contact (not necessarily face-to-face) with this person the child wishes to see and not to just deny the child's request.
10. The need to terminate or limit contact with one family member should not mean terminating contact with other family members.
11. Terminating all forms of contact with a parent is likely to mean that termination of parental rights must occur. The decision to terminate all contact requires careful consideration and court reviewed.

Outline

- I. Children's Needs and Rights
 - a. What does the child want
 - b. Developmental age of child visit recommendations
 - c. Healthy attachments
 - d. Supporting attachments during visits
 - e. Examples of attachment activities
 - f. Establishing Parenting Visit Standards

- g. Attachment activities during visits
- h. Designing visits to meet the child's needs
- i. Child refuses by words or actions to visit a parent
- j. Are all Connection Plans the same?
- II. Parent's Needs and Rights
 - a. Examples of steps to learn new parenting skills
 - b. Teaching and observing parenting skills
 - c. Chronic conditions: addiction and mental illness
- III. Supervision of visits
 - a. Special issues: Domestic violence, siblings, non-offending parents
- IV. Visit research
- V. Best practice standards
- VI. Progressive Visit model
- VII. Conclusions

I. Children's Needs and Rights

Every child in out-of-home care must have a Connection Plan. For most children this will include visits and other forms of contacts with parents, siblings, relatives and other people with whom the child has an emotional connection. The Connection Plan will also address how the child's school continuity will be addressed and how her connections with friends, community and culture are maintained. Removing a child from everything and all the people she knows in order to gain safety today should be considered an unreasonable approach and every effort should be made to minimize disrupting the healthy attachments and daily routines of the child. As visits must first meet the needs of the child a number of questions must be resolved:

- ✓ What does the child want?
- ✓ What is the developmental age of the child?
- ✓ How can adults ensure visits/connections are safe, non-traumatizing and support healthy attachments?

a. What does the child want?

Someone whom the child knows and trusts should talk with the child about his desires. It is critical to have the child's point of view when developing a Connection Plan. Who does the child want to see? What concerns or fears does the child have about any person, location, etc.? Whom does the child NOT want to see? Why does the child not want to see that person? Where does the child feel most comfortable? Where does the child feel safe? Frequency? Activities? Asking these and other questions will help the adults and child plan visits and contacts that will meet the child's needs. The adults then have the responsibility to make earnest efforts to meet the child's request. If the child wants to visit with a parent

or in a location that may have safety issues, the adults should address the safety issues rather than deny the child his request. Making visits comfortable and enjoyable for the child is important as the child most likely is experiencing trauma by the maltreatment and/or placement into care.^{viii} Initially, visits are difficult and uncomfortable for everyone. Helping the child feel comfortable, having some choice or control in what occurs and doing what the child considers fun, will establish positive visits for him. Do not worry about spoiling or giving into the child at this time. Later, when visits are functioning well, the adults can focus on things such as the child learning manners, following rules or behaving in age appropriate ways.

b. Developmental age of the child – visit recommendations

Visits have always been considered an essential activity when children are in out-of-home care but what is known about the frequency that a parent and child have face-to-face contact to meet these purposes? Research has not provided specific answers to this question, in part because the answer is “it depends.” “Empirical research has not examined how much contact is necessary for the development of attachment relationships, our clinical judgment is that visits with infants and toddlers should occur more than once a week, for several hours at a time, and encompass caregiving activities.”^{ix}

The most critical factor that influences the frequency of visits to maintain attachment is the child’s developmental age. And the short answer based on developmental age is that the younger the child, the more frequent the visits should be. A newborn can only understand what is occurring to him right now. He does not understand, “I will see you next week”, so will need visits as frequently as daily. A teenager understands time and may request to see a parent once a week, especially if visits interfere with the teen’s activities such as school, work or friends, so less than daily contact could meet the teen’s developmental need to slowly separate from parental figures.

In most agencies visits begin at once a week, though it would be better to start with even more frequent visits as soon as placement occurs. Children need to be reassured that their whole world has not disappeared or changed, that their parent is OK and stills love them and that they are not in care for doing something wrong. The practice of “waiting until the child settles into his new home” can have disastrous results. For example, a five year old who goes a week with no contact with his family is likely to feel forgotten, lost, worried or have other negative emotions. He will not automatically view the foster family as people he can trust so he is not likely to ask for the comfort and reassurance he needs. He will experience grief and loss and this can lead to emotions such as anger and depression. He is likely to act on these emotions and could harm others, himself or objects. When the first visit does finally occur he is likely to blame his parents (as five years old believe their

parents are all powerful and therefore they are to blame for the lack of contact) and act on his emotions during the visit. In this case there is a higher chance that the first visit will be more than uncomfortable, it may be traumatic for everyone. The birth parent is likely to view the child's new behaviors as being caused by the foster parent and the foster parent to view the behaviors as a result of the child visiting his parents. The worker and others are uncertain how to evaluate the visit and are likely to decrease or stop visits thereby intensifying the child's sense of being forgotten or blamed.

The adults must acknowledge that a child will grieve the loss of his parent and old life even when a child has asked to be removed from his parent's home. Visits, therapy and trained workers, caregivers are needed to actively address the child's loss. "Observing a child's grief and pain over the loss of a loved one is extremely hard for most parents. They may feel that their child has been through "too much" and that the world is no longer a safe place. In response to these perceptions, parents may become lax in their limit setting or overly protective, both of which can create increased insecurity and anxiety in the child. If normal routines are disrupted and children are not permitted to engage in activities consistent with their developmental level (e.g., sleepovers, school activities), they will likely begin to perceive their world as unsafe and unpredictable. This, in turn, will make it harder for children to negotiate the normal grieving process and contribute to persistent symptomatology. It should be noted that parental emotional distress in response to traumatic events and lack of parental support are associated with more severe and persistent PTSD symptoms in some cohorts of traumatized children."^x In assessing a child's behaviors we must consider the possibility that the behaviors are due to grief, loss and separation from his family and daily life and not just a response to the maltreatment, fear of the parent or what occurred on a visit.

Below are guidelines on frequency, length of visits and non-contact activities that should occur based on the child's developmental age. Many children in care have developmental delays so this must be considered when developing the Connection Plan.^{xi} The frequency rate is based on what needs to occur in order to maintain and enhance parent/child attachment. It is also based on the amount of time a child of this age begins to believe something is permanent. Example: How long before a child believes their parent will not come back. This is not the same as a child not having a memory of his parent. Face-to-face contact is the most effective way of maintaining a relationship, especially for infants and young children. Other forms of contact should also occur and can supplement face-to-face contact. These guidelines are the minimum not the maximum that the child needs. The child should have this amount of contact with both parents. If the parents cannot visit together the number of visits per week would be double the frequency rate. Fathers and their family

should be given as many opportunities to visit a child as mothers. Federal data shows that we do not meet this goal even when fathers are known to the professionals.^{xii}

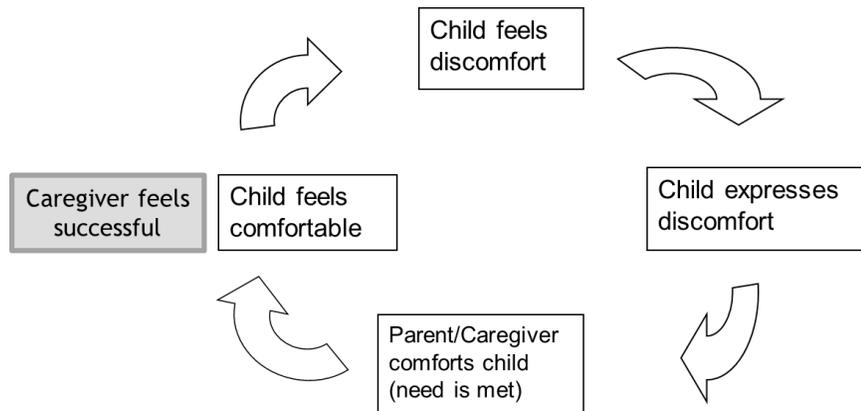
| Developmental Age | Permanency occurs for the child ^{xiii} | Minimum frequency, length of contact and other recommendations ^{xiv} |
|-------------------------------|--|--|
| Infants newborns to 18 months | They slowly learn to understand time and trust that people do come back if they have a healthy attachment to at least one person. Once the child is attached he can experience grief and loss <u>immediately</u> after separation. | <ul style="list-style-type: none"> <input type="checkbox"/> 2 to 5 per week face-to-face with all parents or people who have acted in parenting role is the minimum <input type="checkbox"/> Daily visit is preferable. <input type="checkbox"/> Minimize number of days between visits. <input type="checkbox"/> Consistency in schedule is important. <input type="checkbox"/> Once or more a week with any siblings the infant does not live with <input type="checkbox"/> 60 minutes minimum to begin and lengthen as visits are successful <input type="checkbox"/> Coordination between the caregiver and parent to keep the child on the same eating and sleeping schedule during the visit. <input type="checkbox"/> Supplement contact activities: pictures, parent's voice recorded, video of parent, clothing items from parent with their scent, computer video communication even though the infant may not respond |
| Toddlers 18 months to 3 years | Within a few days the toddler believes that someone who is not there is not coming back. Confusion about the change is likely to begin immediately and grief and loss reactions begin within a few days. | <ul style="list-style-type: none"> <input type="checkbox"/> 2 to 4 per week, face to face with all parents or people who have acted in parenting role is the minimum. <input type="checkbox"/> Daily is preferable. <input type="checkbox"/> Toddlers should not go too many days between visits. <input type="checkbox"/> Consistency in schedule is important. <input type="checkbox"/> Once or more a week with any siblings the toddler does not live with <input type="checkbox"/> Up to 90 minutes minimum and lengthen as visits are successful <input type="checkbox"/> Coordinate between the caregiver and parent to keep the child on the same eating and sleeping schedule during the visit. <input type="checkbox"/> Supplement contact activities: pictures, parent's voice recording, video of parent, clothing item from parent with their scent, toddlers can begin to have phone or computer video conversations even though the call may appear to be one sided, a nightly good-bye call. |
| Preschooler 3 to 5 years | Preschoolers can go a few weeks and still believe the parent will come back and their new situation is not permanent. Grief and loss can begin before this time. | <ul style="list-style-type: none"> <input type="checkbox"/> 2 to 4 per week, face to face with all parents or people who have acted in parenting role is the minimum. <input type="checkbox"/> Daily is preferable. <input type="checkbox"/> Preschoolers should not go too many days between visits. <input type="checkbox"/> Consistency in schedule is important. <input type="checkbox"/> Once or more a week with any siblings the toddler does not live with <input type="checkbox"/> to 90 minutes minimum and lengthen as visits are successful |

| Developmental Age | Permanency occurs for the child ^{xiii} | Minimum frequency, length of contact and other recommendations ^{xiv} |
|-----------------------------|--|--|
| | | <ul style="list-style-type: none"> <input type="checkbox"/> Coordinate between the caregiver and parent to keep the child on the same eating and sleeping schedule during the visit. <input type="checkbox"/> Supplement contact activities: pictures, parent’s voice recorded, video of parent, clothing item from parent with their scent, toddlers can have phone or computer video conversations, daily calls can keep child and parent grounded to what each is doing daily. |
| School Age 6 to 12 years | School age children will believe their new situation is permanent after several months. They may wish that their parent will come back but will have doubts and confusion why the parent has not done so. Grief and loss can occur at any time. | <ul style="list-style-type: none"> <input type="checkbox"/> 2 to 3 per week, face to face with all parents or people who have acted in parenting role is the minimum. <input type="checkbox"/> More frequently if possible. <input type="checkbox"/> Involve the child in visit planning. <input type="checkbox"/> Consistency is good but as child of this age is able to understand time and other issues s/he can tolerate some changes. Use calendars and other methods for the child to understand the schedule. <input type="checkbox"/> Once or more a week with any siblings the child does not live with. <input type="checkbox"/> 60 to 360 minutes minimum and lengthen as visits are successful. <input type="checkbox"/> Supplement contact activities: phone calls, pictures, parent’s voice recorded, video of parent, have child call at night to say good night or talk about the day events, email and other computer based contact such as live video contact. <input type="checkbox"/> Whenever possible do not take a child out of school to have visits. Also consider what after-school activities the child has when scheduling. |
| Teens 13 to 21 years | Teens have an adult understanding of time. They understand the temporary nature of foster care. In fact if the teen has had many placements he may believe nothing or no person is permanent; i.e. willing to stick with him no matter what. Grief and loss can occur at any time. | <ul style="list-style-type: none"> <input type="checkbox"/> 1 to 2 per week, face to face with all parents or people who have acted in parenting role is the minimum. <input type="checkbox"/> More frequently if possible. <input type="checkbox"/> Involve the youth in developing the visit plan. <input type="checkbox"/> Consistency is good but the youth are able to understand time and other issues so he can tolerate changes. Use calendars and other methods for the teen to understand the schedule. <input type="checkbox"/> Once or more a week with any siblings the youth does not live with. <input type="checkbox"/> 60 to 360 minutes minimum and lengthen as visits are successful. <input type="checkbox"/> Supplement contact activities: phone calls, pictures, parent’s voice recorded, video of parent, have child call at night to talk about the day events, email and other computer based contact such as live video contact. <input type="checkbox"/> Whenever possible do not take youth out of school to have visits. Also consider what after school-activities the youth has when scheduling. |

c. Healthy Attachments

“Attachment results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world.”^{xv} A primary method for developing attachment occurs when someone meets a child’s needs for comfort, protection or support. The simple steps in the feeding or bathing, or the infant holding her parent’s finger provide the opportunity for the infant and parent to be in close proximity and to respond to each other’s needs. Attachment activities, when carried out over time, provide consistency and predictability and lead the child to trust and attach.^{xvi} Healthy child development requires an infant to bond and attach to at least one person. Infants who do not have this will develop attachment problems, failure to thrive and can die. When attachments are not healthy or are frequently broken through multiple moves children or extreme inconsistencies, a child may actively resist becoming attached, may not trust adults or can develop an attachment disorder. Attachment is formed through in-person contact and is most likely to occur when there is daily contact where the caregiver provides for the child’s needs such as feeding, clothing, comfort, teaching, sleeping or helping the child handle new or stressful situations. Other attachment activities include sharing joy, repetitive inactions such as smiling at each other, feeling valued and being claimed by each other. Once attachment is developed non-face-to-face contact can help to maintain the attachment though this is not the preferred method. All children need protective, supportive, and emotionally responsive relationships in order to thrive; even adolescents who tell adults they do not need anyone, need healthy attachments to help them successful navigate into adult life.^{xvii} The attachment modeled below highlights the need for a caregiver to respond to a child’s needs.

Diagram 1 – Parent/Child health attachment process



Example: The child feels hungry, child cries or asks for food, caregiver provides food, child feels satisfied and caregiver feels successful. When this cycle is done frequently and with some consistency (perfection is not necessary) the caregiver **and** the child will develop an attachment. Children are capable of and should be encouraged to attach to more than one person through the same process.^{xviii} Most maltreated children have a healthy attachment to at least one person at the time they are placed in care. Connection Plans should assume that the child needs contact with that person as soon as possible, as that person will have the best knowledge on how to comfort the child and help her through the transition into care. Sometimes that person is the child’s sibling and this is one reason siblings should be placed together.

It is critical to keep a child attached to her parents while she is in care if we are to successfully reunite a family. Additionally, a child’s ability to attach is a positive developmental indicator and attachment to substitute caregivers should be encouraged. As Dr. Pavao, an adoption expert says, “You do not teach a child to attach by telling the child to stop being attached to another person.”^{xix} Just as children are stressed and/or traumatized to be placed with caregivers who are stranger, a child is stressed to be returned home to parents with whom the child no longer has a parent/child relationship.^{xx} Lack of attachment will impact the ability of the family to be live together successfully. The professionals need to view attachment through the eyes of the child to develop appropriate Connection Plans. Example: As an infant I do not understand change and believe only what is occurring to me right now. If I only visit with my parent once a week, the visits are short, my parent is not allowed to meet my daily needs or if visits are inconsistent I am not likely to attach (or

remain attached) to that parent. I will be upset when you suddenly (from my point of view if I have not had frequent visits) return me to my parent's home as I am not sure who this adult is and do not trust that this adult will meet my needs. As a teenager my memory is longer, but if I only visit once a week and my parent is not allowed to provide for my need for guidance, supervision and discipline and is not involved in my daily life, I am likely to not value his ability to be a parent and will resist parenting advice/directions once we are reunified.^{xxi} Whether attachment problems are what caused by the maltreatment or by the separation, the child welfare system has the responsibility to address the child's need to have secure, healthy attachments.

When there is not enough contact to maintain a parent/child attachment and the child attaches to the new caregiver some professionals will recommend that that child's best interest is to stay with the new caregiver even if the parent has made substantial progress or the non-custodial parent, who through lack of contact opportunities, has not been allowed to develop that attachment. The child welfare profession has the responsibility to maintain and enhance the child's attachment to his family. When we deny or limit contact we have created the attachment problem. We must remember that children are capable and in fact will be healthier to have multiple caregivers to whom they attach. When the child welfare system denies or limits visits, which leads to lack of attachment, and then using lack of attachment to justify termination of parental rights we are not meeting our legal or ethical responsibilities to provide reasonable efforts to reunify a family whenever possible.^{xxii} The court needs to assess at every review whether parents and children have been afforded frequent and meaningful visits.^{xxiii}

d. Supporting attachment activities during visits

Visit plans must overtly plan for and support attachment activities. Each visit should contain at least one activity or event that supports attachment. Parents who are not allowed to meet the child's needs during a visit will not be able to maintain or strengthen the attachment with their child. Having a crisis or problem such as a child acting out in a visit is not a sign of lack of attachment. As shown in diagram #1, a visit should allow for the normal discomforts to occur so that the parent and child can develop or reinforce their attachment. This is balanced by the guiding rule that if an activity or interaction is traumatizing the child the supervisor of the visit should provide the parent with another action and if this does not work to stop today's visit.

Attachment behavior has been systematically observed in different cultural settings and therefore is believed to be universal, but more research is needed to create attachment assessment tools that are sensitive to culturally and economically diverse families and including plural caregiving systems^{xxiv} The Connection Plan should be developed with the

family members and/or community to ensure that culturally appropriate attachment activities occur during visits and the assessment of parent/child relationship is done by professionals who are knowledgeable of that culture and the in locations that are culturally appropriate.

Dr. Lawler in his article “Toward relationship-based child welfare services” argues that repair and establishment of secure relationship is the key work of the Child Welfare leading to quality attachment between child and parent or surrogate parent. “An extensive research literature has accumulated over the past several decades demonstrating that a child's secure and healthy development depends on having one or more sensitive and responsive “attachment figures” who can correctly read the child's signals for help and respond with assistance and support, ultimately encouraging autonomous emotional regulation and social skills. In contrast, if an attachment figure is not responsive, is often emotionally unavailable, or is outright abusive, a child is likely to develop an insecure pattern of attachment, with corresponding internal working models of relationships, and is likely to have less favorable behavioral, cognitive, and mental health outcomes.”^{xxv}

e. Examples of attachment activities

- Sharing food – type, how it is prepared and how it is eaten
- Clothing and personal care – including things such as hair care, buying clothes together, teaching how to dress, bathing a child and setting boundaries such as a teen’s request for a tattoo
- Teaching skills, traditions, family routines – chores, driving a car, holiday traditions, fixing a broken bike, roles for men, women, girls and boys
- Education – selection of school, interaction with teachers, setting expectations, helping with school work, attending school events
- Religious and moral development – teaching, attending services, rites of passage, moral guidance and consequences for “bad” behaviors
- Playing games and reading – selection done by parent and child, based on their culture
- Development of competencies beyond school – sports, scouting, art, music, community activities – teaching, supporting and attending these events
- Medical – choice of type of medical care, involvement in medical decisions, providing care when a child is ill
- Family history – sharing stories, pictures, scrapbooking (life story books), drawings, developing family tree
- Physical contact – touch, smell, hugging and other forms of contact are specific to a family’s culture, expressing their emotions for each other

The parent and child should be encouraged to select visit activities that mimic what would occur in normal daily life based on their family's culture. The more these activities occur, the stronger the attachment will be and the more likely the parent will be able to practice and demonstrate his strengths.

If there are attachment problems, the parents and child should be provided treatment services to resolve the problems. Attachment problems do not resolve on their own. In these cases visits may include the parent and child attending treatment together. It is recommended that the caregivers of the child also be engaged in this treatment so they can understand the child's behaviors and reactions, and can apply the correct therapeutic response. As 10 to 43 percent of children in care have emotional or behavioral problems and children with these problems are less likely to obtain any type of timely permanency, it is essential that we assess every child who enters care for these problems, provide appropriate services for the child and teach the parents and caregivers how to help the child manage these issues.^{xxvi}

f. Establishing parenting standards

There are not a set of "parenting standards" that can be used by professionals to assess all families involved in the child welfare system. The goal of child welfare is not to establish such standards but to assess when parental capacities and the family support system are strong enough to prevent future maltreatment. We must be careful not to establish standards or individual family requirements that expect parents to demonstrate capacities that are beyond the case facts and the underlining causes of the maltreatment. Visit tools or checklists that expect all families to meet the same standards can lead to unreasonable expectations or allow for cultural bias to influence how we assess parenting skills. Additionally at this time there is not an evidenced based attachment assessment tool that is "sensitive to cultural variations including plural caregiving systems".^{xxvii}

Professionals should not set the standards for parent/child interactions unless it is a part of the substantiated maltreatment, a specific medical or educational need of the child established by qualified experts in that field, or the interaction is causing trauma to the child. The most common example is this type of standard is "the parent will provide a healthy snack during visits". This requirement is not helpful in that the definition of a healthy snack is not universally agreed upon (fruit juice may have more sugar in it than a soda) and the type of food shared between a parent and child is a culturally specific activity. Unless the maltreatment is related to food or there is a current medical condition requiring specific food restrictions the parent should be allowed to provide the food he wants to his child. The agency should talk to the parent about what the child typically eats and use that information to develop the Connection Plan. The chance that a child, as an adult, will

become obese due to the food provided during visits is not the focus of the child welfare intervention and thereby should not be used to set visit standards or be used as a means of assessing the parent's capabilities. It is also not necessary for a child to have absolute consistency in care between the birth and care giving family. Children are capable of handling being a part of two families with very different routines, expectations and household rules. In fact most children do this every day as they go to school, visit grandparents, attend child care or stay with a non-custodial parent.

g. Designing visits to meet child's needs

- Have visits where the child is (the adults do the traveling) to lessen the amount of transportation time. Having visits at school, caregiver's home, nearby community locations and the parent's home will cause less disruption in the child's daily life and problems such as missing school to attend visits and allow for more natural and cultural appropriate interactions. Having visits outside of the agency office has also been shown to decrease the frequency of parents not showing up for visits.^{xxviii}
- Have a consistent set of adults involved in the visits and limit the number of people involved, especially for infants. Think about having a safe family member be the host and/or supervisor of the visit to provide consistency and lessen the work of the social worker. Having a consistent visit supervisor will allow for more accurate assessment as the supervisor can get to know the family, thereby it will be easier to know when progress is being made or interventions must occur. Having too many people handling an infant can be hard on the infant. Example: When a foster parent, transporter, social worker, and supervisor of visit are all involved in one visit there are too many opportunities for information about the child's need not to be communicated between all the adults. Older children need a consistent adult they know and trust to talk about visits.
- Do not always think in 60 minute increments – start at an hour and then move up to 90 minutes – 120 minutes may be too much change at once.
- Have visits outside of agency work hours – evenings and weekends
- Allow children to select the location, time and activities, at least some of the time.
- Have a balance of types of activities. Some visits in which the family just has fun and others where the parents are working on specific skill development or activities like helping with homework.
- Have a safety signal for the child to use to ask for a private conversation with the supervisor of the visit. Allow the child to ask for a break during the visit or end the visit early without the child being blamed or having to justify why he needs this. Teaching the child to trust his instincts, to ask for help and develop ability to self-protect are critical skills for maltreated children.

h. Child refuses by words or actions to visit a parent

Children who refuse to visit or who are traumatized when visiting a parent or sibling should not be forced to continue these visits and should be allowed to have non-face-to-face

contact until the trauma is addressed. If non-face-to-face contact is also traumatizing the child should be in treatment to address his trauma. For these children just discontinuing any contact does not address the child's needs to heal from the trauma.^{xxix} In the treatment the child's relationship with that parent or sibling should be addressed and then this treatment becomes the highest level of safe connection the child can have at that time. If the treatment is successful it is likely the child will slowly begin to have contact with that person with the goal of learning to develop a relationship that is healthy and non-traumatizing. Children do not just forget about the trauma or their relationship with the parent, so it must be addressed. Even infants who have no cognitive memory of the maltreatment are likely to have brain trauma that may require treatment at a later time in her life to address that relationship.^{xxx} It is highly likely that the child will have face-to-face contact with that person as a child or young adult.^{xxxi} The well-being and safety goal is to help the child develop the skills and support system to handle that relationship and to keep herself physically and emotionally safe even if no contact occurs.

i. Are all Connection Plans the same?

Children need different level of contact for the different people in their life. For example, a child may only be having phone contact with one parent and visiting the other parent every day. Or a child is having therapeutically supervised visits with his parents and unsupervised visits with his siblings. Within a week a child may have different types of contacts with a parent: a therapeutic visit, a visit working on specific parenting skills or attachment and then a visit where the parent attends the child's school event. The level of supervision for each of these visits could be different. Siblings may have different Connection Plans; one sibling is having visits with a parent in the family home while his sister is having visits at the agency's visit center. Each child needs a unique Connection Plan.

II. Parent's needs and rights

Visits are a critical reasonable/active effort service provided to the parents, children and their family. The second purpose of visits is to teach and have the parents practice new skills, and then to evaluate the parents' ability to apply the new skills in situations that mimic what will be the family's normal life, if reunification occurs. This issue was addressed by Judge Edwards, who wrote: "Removing children from their parents is not about punishing the child or the parent for abusive or neglectful behaviors. The criminal law is written to address punishment for bad actions. The child protection system is about protecting children, supporting parents' growth, and, if possible, reunifying children with their parents. It is also about serving the best interests of children. In this context, visitation is a critical element, one that is often overlooked by members of the child protection system."^{xxxii} The best practice is for the Connection Plan to support coordination between the parent's services/treatments and what occurs during visits,

e.g. a parent is learning discipline methods in his parenting class and then practicing that method on visits. The Connection Plan should provide the parent explicit opportunities to practice the discipline methods and to be provided feedback on his ability to use the method correctly. Parent skills training programs that are evidenced-based all include hands on practice, demonstration and assessment of the parent by a trained professional.^{xxxiii}

Visits that help a parent improve specific parenting skills, related to the maltreatment, require more than one hour a week of contact. First, it will take more than one hour a week to learn new skills to a level that it becomes the first or “natural” response of the parent, especially in the short time frame required to make permanency decisions. Second, it is possible that a parent is able for one hour a week to parent his child but not be able to safely parent for 24/7. For example, addicts are not always intoxicated and can schedule their drug use to ensure sobriety for short scheduled visits. Parents who only see their child for short periods of time and do not have to handle challenging behaviors of their child can appear to be capable. Children who come to visits at their “best” and only are there for a short time do not provide a realistic opportunity for parents to develop their skills that will be effective during normal daily life. For these reasons it is necessary to slowly progress the visits frequency, length, level of parenting responsibility and other elements of a visit to ensure that the parent and child are observed to be successful under the types of stresses this family is likely to encounter once the child is returned home.

*Elements of a Connection Plan:
Purpose, frequency, length,
location, activities, level of
supervision, who attends, time
of day and day of week, and
responsibilities of all parties.*

a. Example of steps to learn new parenting skills.

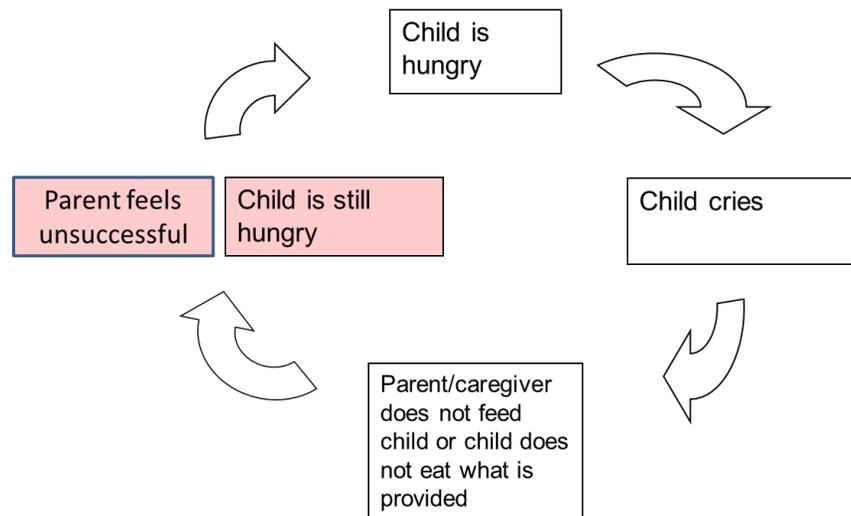
1. The agency completes an assessment to identify the specific parenting capabilities that must be improved (or is provided an assessment by other professionals). The assessment should be based on the skills related to what caused the substantiated maltreatment and not on general parenting skills. The assessment is shared with all the parties.
2. Measurable expectations are established. This measurement is what the parent must consistently demonstrate that would indicate that she is able to keep her child safe from repeat maltreatment. The measurement must be done in positive statements. Not effective as a measurement is: “Do not hit your child.” This is a negative statement and does not indicate what DO we expect the parent to do when a child needs discipline. More effective measurement is: “Parent tells child of her expectations and when the child does not follow expectations she uses non-physical discipline including (Insert method is being taught to the parent.)” This is a positive statement of what is expected and can be observed and measured during visits.

3. Provide evidenced based services to the parent to learn the new skills or methods. (If the parent can demonstrate the skill without participating in the service, this step is not needed.)
4. Provide multiple opportunities to practice the skills/method and be coached by someone capable of applying these skills. Depending on the parenting skills the coaching can be provided by a community professional, agency worker, caregiver, family members or others in the family's support system who has shown they are capable of applying that parenting skills.
5. Parent is provided feedback during and after visits that acknowledges strengths and provides specific suggestions on how to improve.
6. At case planning meetings and court hearings the progress of the parent is regularly reviewed. As progress is made, the Connection Plan is changed to provide more frequent opportunities, for longer periods of time and in more challenging situations in order to support the transition from the agency having parenting responsibilities to the parenting having full time responsibility of the child. If progress is not made, the service/treatment plan and Connection Plan will be changed with the goal of improving or speeding up the progress.

b. Teaching and observing parenting skills

It is not enough to have documentation that a parent has completed services such as parenting classes and addiction treatment or that the parent is currently passing drug tests, to know whether a parent is capable of keeping her child safe from repeat maltreatment. Parenting is a complex task and is impacted by many factors. It is rare in child welfare cases for the professionals to have identified all the possible underlying causes and even if we have done so there are few evidenced-based treatment programs that can guarantee the parent will not relapse into behaviors that will be neglectful or harm the child. Visits need to include demonstration of improved parenting skills for long periods of time, they also need to test the ability of the parent, child and family's support system to respond to protect the child if the parent relapses or needs help. Once this occurs we have more substantial proof that the family is ready for reunification.

Diagram 2 – Parent/Child Unhealthy attachment process



Step in the Cycle of Unhealthy attachment:

1. The child has a need, discomfort or reaction such as being hungry.
2. The child expresses that need through words, body language or actions.
3. The parent tries to meet the child's needs but that does not occur or no caregiver responds to the child.
4. The child is still hungry and the parent feels unsuccessful and both feel frustrated or defeated in this relationship.
5. Attachment is not occurring or is being disrupted.

The reasons for the negative cycle can be many. The assessment as to WHY this occurred and the interrelationship between the parent and child is what needs to be assessed to determine what type of services/treatments are necessary and what the measurements will indicate that reunification is possible.

Case: A 10 month old infant is found to be severely underweight and is placed in care. All agree that the infant was at a normal birth weight and showed normal growth for the first 5 months. The parents say that around that time the infant began to get fussy and refused to drink a bottle or eat any food provided. They thought their child would eventually get hungry enough and then would start to eat. The unhealthy cycle continued many times each day. They report that sometimes the infant would eat and other times she would not; reinforcing their idea that their daughter was choosing when to eat. Positive attachment cycles did occur regarding other needs the infant had such as diapering and playful interactions

Some of the possible underlying causes:

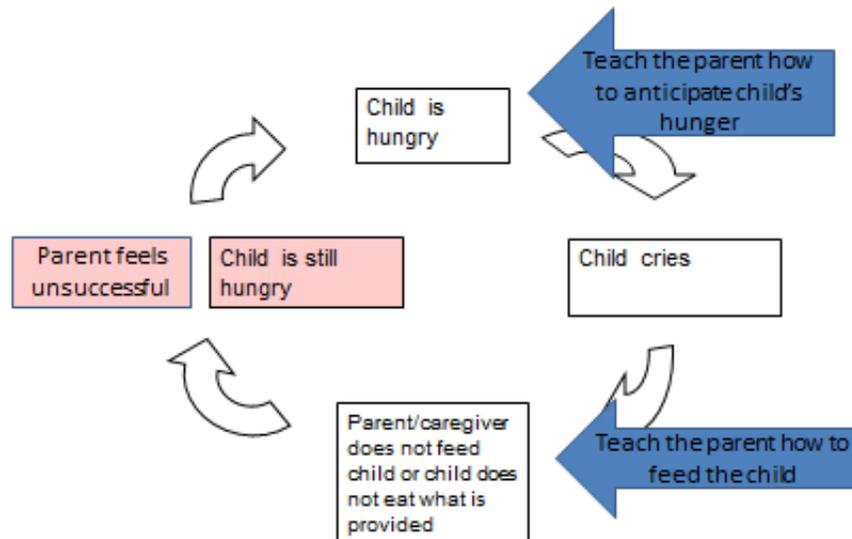
1. The infant has colic.
2. The parents do not have the skills to feed a fussy infant.
3. The infant is communicating her needs in a way the parents do not understand.
4. The parents are not observing the infant consistently enough (child left alone in room, parent intoxicated, parent mental health or other reasons take parent away from infant)
5. There is not enough money to buy the food needed.

All parents and children misattune; that is parents do not always know how to understand their child's messages or know how to respond in a way that will meet the child's needs. "Parents are not perfect, and as long as the lack of attunement is not dominant feature it acts as a constructive aspect that helps the child learn that close relations can develop through attunements..."^{xxxiv} It is critical for the old behavior pattern (misattunement) to be interrupted, stopped and replaced with a healthy pattern. Every time the old pattern is repeated the family becomes more entrenched in feeling unsuccessful in their relationship. As the guiding visit rules state (pages 4-5); it is better to stop a visit early than to repeat the unhealthy patterns. The purpose of the visits is to practice the new behaviors until that become the new norm. When positive attachment cycles do not occur a number of possible outcomes can occur.

1. The infant in this case may die or be severely developmentally impacted due to lack of nutrition at a critical stage of development.
2. The infant will not learn how to interact with the world and brain development and growth is impacted.
3. The infant stops trying to communicate her needs.
4. The parent blames the infant and acts out of frustration and directly harms the infant.
5. This unhealthy pattern and the feelings they generate, transition into other parent/child interactions and what they once did successfully also become dysfunctional.
6. The infant may not learn how to attach to people especially if no one is meeting her needs successfully in areas besides feeding.

Diagram 3 – How Visits can teach and support new parenting skills

Interventions to improve attachments



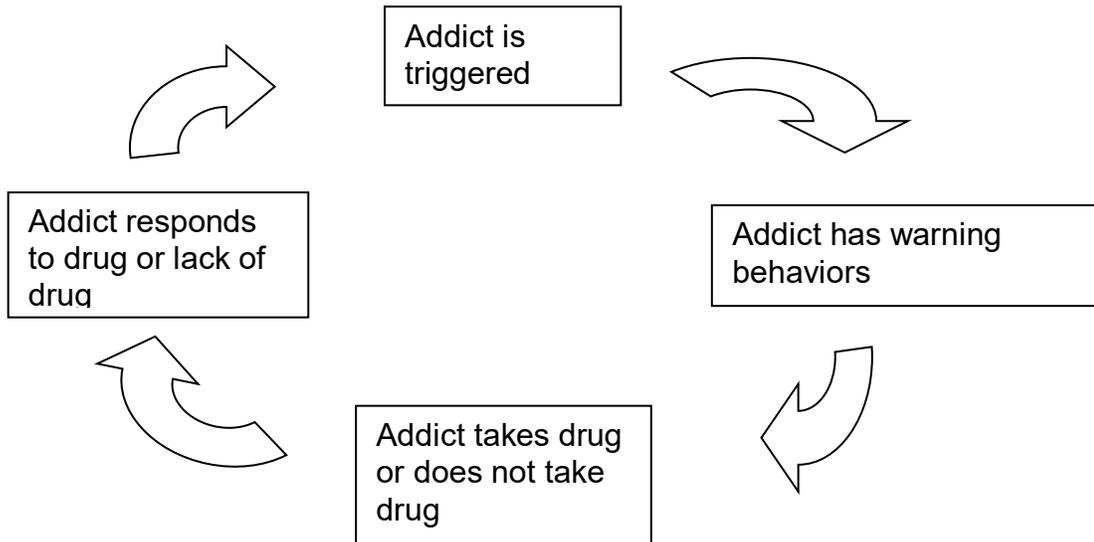
1. During the early parent/child visits observations occurred to determine what are the underlying causes or to eliminate some of the causes. In this case it was observed that the infant has colicky behaviors and would not respond to feeding once she was tired or upset. Then the parents began to blame the infant and would leave her alone rather than face another unsuccessful round of feeding her.
2. The infant was observed with the caregivers and it was determined that child had similar negative feeding cycles with them.
3. The parents and caregivers were provided services to teach them how to watch for and anticipate the infant's needs, and how to use different feeding methods that are known to be effective with colicky infants.
4. The visits are held in the parents or caregiver's home to ensure the child and parents feel comfortable and learn how to handle normal daily distractions.
5. The Connection Plan was developed to start visits before the infant was hungry and then to continue through one eating cycle. The supervisor of the visit was able to coach them on identifying the infant's signs that she needed to be feed. They also practiced the different feeding methods until they found a couple that worked with their daughter. The caregivers and parents used the same feeding methods to ensure consistency that was necessary to help the infant trust that her needs would be met.

6. As visits progressed the supervisor of the visits ensures that when the parents and infant began to interact in the old pattern that an intervention occurs to ensure the child was feed and to minimize the family repeating the negative cycle.
7. Progressively the visits lengthened to allow the parents and infant more time to have successful feeding cycles even when the infant was tired or fussy. It was observed that the parents were able and willing to stay engaged with their daughter even when she did not respond favorably to all of their efforts. They were also able to anticipate when she would need to be feed and begin the process before she became fussy.

c. Chronic Conditions: Addiction and Mental Illness

Progressive visits can help to determine if a parent with a diagnosis of addiction or mental illness is capable of successful reunification even though these are often a lifelong condition. Addiction and some forms of mental illness are parental conditions that usually cannot be cured or resolved within the 12 months in which permanency decisions should be made. In order to pressure the parent to begin services as quickly as possible some professionals use parent/child visits as rewards or punishment. This may be stated as: When you start your drug treatment, visits can begin. Or: When you complete your mental health treatment we will discontinue supervising visits. Though done with the intention of helping the parent it may have the opposite effect of discouraging the parent. When the parent/child attachment is broken and the parent feels it there is no hope of reunification the parent is less likely to visit and may even withdraw more into her addiction. Visits are a necessary parental activity for reunification to occur and should not be linked to participation in other services. The level of supervision is based on the parent's behaviors during visits, not on attendance in treatment services. The progressive visit method coordinates the drug/mental health treatment program with the Connection Plan to ensure safety even if the parent was to relapse. Eventually, many children of parents who have an addiction or mental health diagnosis do go home to that parent.^{xxxv} Developing a Connection Plan that slowly tests the parent's and family support system's capabilities is necessary to determining if reunification can occur. When developing Connection Plans it is useful to understand the relapse cycle.

Diagram 4 – The Relapse Cycle



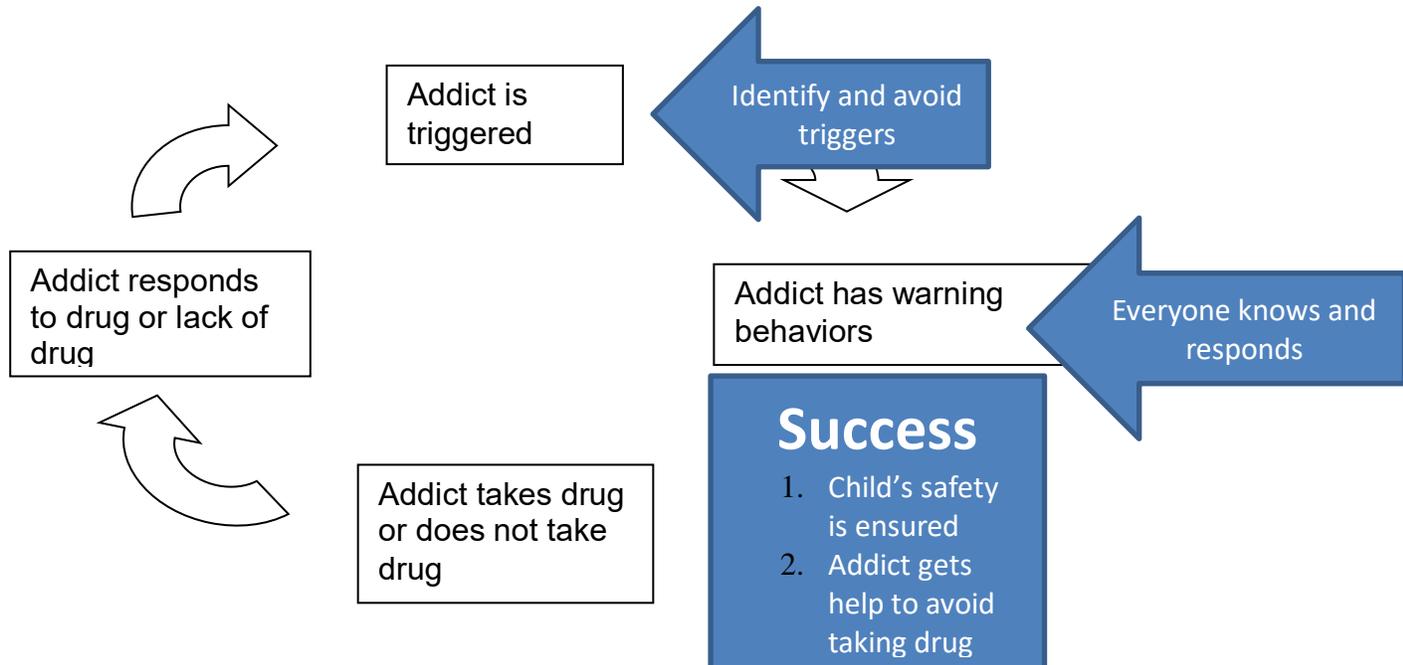
A person with a chronic condition such as addiction or mental illness has physical and mental reactions caused by the condition. Relapse is not just the taking of the drug or having a mental health episode. There is an entire cycle of events that occurs in a relapse cycle.^{xxxvi}

1. Something triggers the addiction/mental illness: time, place, smell, people, etc.
2. The person has warning signs or behaviors. Actions, how their body looks, changes in mood, obtaining the drug, etc.
3. The person makes a decision to take the drug or not, or to ask for help.
4. If the person takes the drug the body/brain has one reaction if the person does not take the drug the body has another reaction.
5. In either case the person went through the relapse cycle.

In some jurisdictions it is the current practice to drug test a parent in the hope that we can then predict if the parent is safe enough to visit with his child. There are two problems with this approach. First, drug tests are not accurate and can be faked, or the parent was sober at the time of the test but took the drug later just before or during the visit. Second, a parent can be sober and if in the midst of a relapse cycle still be unsafe to visit their child. When the parent's body/brain says "I need my drug" or the mental health crisis occurs the parent can lose focus on the child and her needs. Many maltreatment cases demonstrate this in that it is when the sober parenting is seeking their drug that the child is placed in

unsafe situations or with unsafe people. Some parents may be capable of caring for their child while intoxicated such as parents with co-occurring addiction and mental health issues who is more capable while using the drug than when sober as the drug helps her control the mental health crisis. Parents who are acting inappropriately should not have a visit with the child but approaches such as a drug test does not guarantee safety on a visit.

Diagram 5 – Relapse Recovery Plans as part of Connection Plans



Connection Plans for parents with these conditions should coordinate with the relapse plan that is developed by the treatment provider and the parent. The Relapse Plan contains the following information:

- ♦ Triggers are identified--internal or external events (not always observable to others)
- ♦ Triggers are avoided when possible (not all triggers are identifiable or possible to avoid)
- ♦ Warning behaviors are identified--Observable: thoughts, speeches, and behaviors
- ♦ A list of the people who are in position to notice these signs (family, therapist, child, agency worker, supervisor of visit, co-workers)--All of these people should be a part of the relapse plan
- ♦ Aftercare Service plan is developed – What the parent will do to maintain sobriety or mental health after initial treatment. (daily AA, ongoing community treatment program, how to avoid triggers)

- ♦ Communication plan for the agency worker and treatment professionals to give the parent clear consistent messages about her condition, how it impacts her child, the need to place child's needs first, and legal implications if relapse causes the child harm.
- ♦ Identify people in the parent's support system who can do the following:
 - ♦ Be available to help with relapse crisis or provide safety for the child, (Someone who is available after-hours and whom all parties can trust.)
 - ♦ Watch for triggers and report concerns to agency worker and therapist, and
 - ♦ Support the parent in maintaining sobriety and healthy life changes.

Parents who are sober or mentally healthy and have completed treatment but who cannot maintain safe parenting during visits should NOT be allowed to reunify with their child. Demonstrated improved parenting skills and an effective support system are the reasons to progress visits towards reunification.

Parents who have not completed treatment (especially for chronic or lifelong conditions) can be capable of having their child returned home. There may be occasional relapses as that is the normal journey for these conditions.^{xxxvii} The measurement of success is what the parent and the family support system did to keep the child safe and not traumatized by the relapse; that will indicate whether reunification is possible. Progressive visits should continue until 24/7 care occurs to ensure that the family support system will work after the agency closes the case.

III. Supervision of visits

Supervision is a continuum to ensure safety while allowing the most normal family interactions possible.

Factors determining what level of supervision is necessary

- Age of child (ability of the child to self-protect)
- Type of maltreatment the child experienced
- Parent's history of family violence of any type
- Potential for abduction of the child
- Emotional reactions of the child to the parent or visit
- Where the visit will occur
- Who will be at the visit
- Progress parent is making to improve parenting skills
- Parental issues such as addiction and mental illness
- What parenting capacities the parent is working to improve

Each community should have clear definitions of the types of supervision, and the training and skills needed to be a supervisor of visits to ensure clear communication regarding supervision. When an agency or professional believes that ALL visits must be supervised by a professional this leads to limiting visits due to the availability of the professionals. If a person who is trained as a security guard or transporter is considered able to supervise visits their ability to protect the child before an incident is limited. When supervising visits the fear is often that a parent will directly harm the child and supervision is set up to address that possibility. Yet it is the psychological impacts of maltreatment that can be most harmful and are hardest for the supervisor of the visit to observe and stop. What appears to be a normal question, facial gesture or action may be part of the unhealthy parent/child interactions or the relapse cycle therefore traumatizing for the child to observe. Selecting the right level of supervision and a supervisor who has the necessary capabilities is essential. Consider the following definitions of the different levels that occur within the continuum of supervision. The goal is to slowly progress from one level to the next to confirm that a parent and family support system will maintain the child's safety in all situations.

Therapeutic – A professional trained to a specific model or approach of helping parents and children on a specific therapeutic goal such as attachment or parent/child interactions. Supervision based on the therapeutic model. (Not all cases have therapeutic visits.)

Supervised – A trained person within sight and sound distance of the child at all times. This person is able to intervene to protect the child. Has the authority and ability to end a visit early. The supervisor of the visits can be someone such as family or community member. Three different types of supervision can occur. The supervisor will need different training and skills depending on what type of supervision will occur.

1. Supervision to teach a parenting skills
2. Assessment of the identified parenting skills (usually done by agency worker or community professional)
3. Safety supervision – neither of the above is occurring

Monitored or observed – An objective person is observing or the location or event provides enough safety (attending a school event, visit at doctor's office, foster parent occasionally comes into room to check on child). The family support system MUST be used to perform this task at some point in the case as they will be the ongoing monitors after the child is returned home.

Unsupervised – No person is responsible for supervising visit. The parent and child are alone for a period of time that starts at a few minutes and slowly progressing to 24/7 for successful

reunification cases. An ongoing safety plan is in place and is monitored by the family support system so things such as unannounced drop in or phone calls should occur.

The most common form of maltreatment is neglect yet the discussion regarding supervision often starts with the assumption that the parent will become violent or out of control. As we make decisions about the correct level of supervision the “it might happen” discussions can stray far from the realities of the case. The level of supervision is often kept very high even months after a parent is having successful visits. The rationale is stated: We must have the professionals supervise the visit and have it in a secure location such as our agency office because something might happen. “What if the parent tries to hit his child?” – for a parent who has never hit his child. “What if during the visit at the family’s home the parent has a weapon?” – for a parent who has never used a weapon. “What if the parent gets upset and threatens the worker?” – when the parent has never threatened or harmed an adult. In some jurisdictions there a fear or a reality that if any goes wrong during a visit that the agency worker will be held accountable and so the workers are reluctant to decrease the level of supervision. The questions that can better guide the level of supervision are: When the maltreatment occurred did the parent harm the child? In what way? What was the situation or events that led up to the maltreatment? What level of supervision does the child say he needs to be comfortable? The case planning team and the court answering these questions will allow for the level of supervision to be chosen based on realities of the case and should be a shared responsibility for this decision.

Special issues:

Siblings

Siblings have unique and lifelong relationships. The child welfare profession must increase its efforts to maintain and enhance these relationships. First, make efforts early and frequently to help siblings live together. Second, until they can live together arrange for frequent visits and other contacts. Third, most sibling contacts do not need supervision and so the caregivers and family support system can be used from the beginning to help to maintain a high frequency of contact. Here are some questions to review at case planning meetings and court reviews.

- What does the child want?
- What efforts have been made to place the children together? (Do not give up and especially this must be reconsidered whenever a child is moved to a new placement.)
- What has been the visit schedule? If not regular and frequent: why and what efforts are being made to address the issues.
- If placement or visits has been “contrary to the child’s safety and well-being” what efforts have been made to address this? (It is possible to overcome some of these issues.)
- If an older child is asking for placement or visits with an “unsafe” sibling how is that being addressed? Do not assume that the child will just NOT have contact.

- What efforts are being made to help the different caregivers develop a relationship that will ensure sibling contact post final permanency. (This work must start early in the placement not at time of final permanency decision.)
- If caregivers will not support sibling contacts: is this the right placement for the child?

Domestic or intimate partner violence

When there is domestic violence there must be special precautions for the safety of everyone involved in the visit. A misconception is that batterers lose control of their temper and that we can predict when that person will be violent. Instead, batterers use violence to control other people. They can be calm right before the violence. The batterer may try to convince the professionals that there is no reason to worry about his ability to be safe with his child and ask for the level of supervision to be lowered. In reality these types of cases present some of the most likely situations for the child, other parent or supervisor of the visit to be harmed. When domestic violence is known or suspected the agency and court should ask for an expert to help develop the Connection Plan. Some of the advice provided by these experts is:

- The battering parent must have supervised visits and in a secure location initially:
 - Even if the parent has not physically harmed the child.
 - Even when the parent is involved in domestic violence treatment.
 - Even if the child and both parents say it is OK to have unsupervised visits.
- A high level of supervision usually needs to continue for many months even if the abusive parent is not violent or inappropriate with the child.
- The level of supervision can decrease when all of the following occurs:
 - The parent's treatment worker provides information to the agency worker, case planning team, or court that substantial progress is being made. AND
 - The parent admits that his/her behavior has not only harmed the other parent/partner but also harmed the child. AND
 - The parent is able to have visits and demonstrates appropriate behavior and parenting skills with the child. AND
 - The parent does not blame others for causing the abuse. AND
 - The parent puts the child's needs first and does not try to manipulate the child or manipulate the victim parent through the child. AND
 - A safety plan is developed that addresses the parent's pattern of controlling behaviors and entitled attitudes.

Even if all of these have been addressed, be sure to check with the child to see whether or not s/he feels comfortable with the level of supervision being reduced.
- Once the level of supervision is lowered, continue to reassess, with the child and others, whether the child feels safe. Some parents can "act appropriately"

for many visits even though they have not made real changes in their behavior. Once the level of supervision is lowered, the manipulation and verbal threats may occur when the abusive parent believes s/he will not be heard or caught being inappropriate.

- The batterer must arrive at the visit location first and leave last so the child or others cannot be followed.
- The Connection Plan for the other parent or family members are NOT shared with the batterer. The batterer should not know when or where the other parent visits the child or where the child is living, going to school, etc.
- Initially, the batterer and victim parent have separate visits, even if they are still living together, to allow for both parents to work on their relationship with the child.
- There should always be a safety plan for the child even after numerous successful visits.
- The visit should not include other people, except siblings, until substantial progress has been made to improve the parent/child relationship.

Non-Offending parents

The non-offending parent should be allowed to have visits with the child. The level of supervision is based on that parent's abilities. The non-abusive parent does NOT have to have the abusive adult/spouse removed from the home before visits can occur. The agency worker, case planning team, and court must be careful not to "re-victimize" parents in domestic violence cases by asking the parent to choose between his/her spouse or child.

The level of visit supervision for the non-offending parent can usually be at a lower level if the parent has shown the following:

- Voices and acts on the value that the child's safety needs must always take precedence over the needs of the adults.
- A commitment not to allow the abusive person to come to any visit that has not been approved by the agency worker, case planning team, or court.
- Does not verbally or in other ways blame the child for the abuse.
- If appropriate, is attending treatment to address his/her personal issues related to the abuse and his/her ability to protect the children.
- Has a safety plan on how to protect the child if needed.

Until the case planning team is convinced that the non-offending parent can do the above items, the visits should occur in a manner that provides enough supervision to ensure the child's safety and to ensure that visit supervisor has the ability to protect the child if the abusive person were to arrive unexpectedly. The child should have a safety plan that allows for calling for immediate help if the visit is not supervised. The location should be away from the family home or where the abusive parent could participate in the visit until the non-offending parent can demonstrate the ability to protect the child and call for help if needed.

IV. Visit Research

- “More frequent parent-child [visits are] associated with shorter placements in foster care.”^{xxxviii}
- Children who are visited frequently by their parents are more likely to be returned to their parents’ care and have less behavior problems.^{xxxix}
- The American Academy of Pediatrics Committee on Early Childhood, Adoption, and Dependent Care reports: “For young children, weekly or sporadic visits stretch the bounds of a young child’s sense of time and do not allow for a psychologically meaningful relationship with estranged biological parents. For parent-child visits to be beneficial, they should be frequent and long enough to enhance the parent-child relationship.”^{xl}
- “Increased [agency] worker contact with parents of children in care is associated with more frequent parental [visits] and ultimately with a shorter time in placement.”^{xli} Agency workers are responsible for initiating contact with parents and encouraging them to attend visits.
- “When [agency] workers did **not** encourage parents to visit or use visit locations other than the agency office or engage in problem-solving with parents; children tended to remain in foster care 20 months or more.”^{xlii}
- It is **normal for children to react and grieve losses** they have experienced. These reactions are seen before, during and after visits. This is because visits remind the child of his/her loss, and each visit includes both a reunion and another separation. “Children’s reactions to separation have been well documented in divorce research: More than half...were openly tearful, moody, and pervasively sad. One third or more showed a variety of acute depressive symptoms, including sleeplessness, restlessness, difficulties concentrating, deep sighing, feelings of emptiness, play inhibition, compulsive overeating,” and other symptoms. Some children were overwhelmed by their anxiety. Very young children returned to the use of security blankets, using toys they had outgrown, regressed in toilet training, and increased masturbatory activities.^{xliii} **Not having visits does not mean a child does not have any reactions to grief and loss.**
- Parents who are given regularly scheduled visits have a better attendance rate than parents who are told to request visits and thereby visits are not regular.^{xliv}
- Visits can cause a parent to feel pain, anger, guilt, anxiety, humiliation, and ambivalence about the loss of his/her child.^{xlv}
- The psychological well-being and developmental progress of most children who experience separation from a parent is enhanced by frequent contact with both of his/her parents. It is rare that having NO contact of any type with a parent is in the best interest of the child.^{xlvi}
- Frequent contact with parent(s) reassures the child that the parent wants to see him/her and misses the child and this enhances the child’s well-being.^{xlvii}
- Children are attached to their parents and family members and desire to have visits with their parents, their siblings, and other people important in their lives. The majority of people who grow up in foster care have **contact with a member of their families as young adults, and nearly half have contact with their parents.**^{xlviii} If contact with a parent would harm the child/youth, we must help the child/youth prepare to have contact in a safe way.

Assuming the youth will just not have contact can lead to unsupervised contact initiated by the youth without our knowledge or support.

V. Best practice standards

These standards reflect recommendations by parent/child visit experts on what should occur. Not all of these standards are specifically based on law, policy or research.

- Connection plan development needs to include **all** involved parties. Everyone involved in the case must know about the plan even if they did not help to develop the plan. They should be provided with a written copy of the plan.^{xlix}
- Conflict between the parents, between the caregivers and the parents, or among professionals is often expressed by the adults as a desire to protect the child from harm. Do not allow adult conflicts to interfere with a child's right to have a relationship with his/her parent.
- Make visits a normal part of life. Visits should occur WHERE the child would normally be and should include WHAT the child would be doing whenever possible. Visits should allow the family to show love and affection as is normal in that family (unless that has been shown to be abusive).^l
- Whenever possible, visits should occur at a consistent date, time, and place.
- The first visit occurs **within 48 hours of placement**.^{li} The younger the child, the more critical it is that the visit occur soon. Children should be offered an opportunity to call someone the day of placement. This may include parents, attorney, siblings, or someone else who will help the child handle separation issues.
- "The location of the visit should be the **least restrictive, most normal environment**, in the community, that can assure the safety of the child."^{lii}
- Visits should take place, in the following order of preference: 1) in the home of the parent; 2) in the home of a relative or foster parent; 3) in a park or public location; or 4) in an agency setting.^{liii}
- Jails and child welfare agencies are the least normal, most institutionalized settings in which visits can take place. Visits should be held in the agency only if that is the only way the protection of the child can be assured. When visits must occur in these locations, do not expect to see normal parent/child interaction.
- The court's obligation is to make "reasonable efforts" findings will require jurists to decide whether the parent has been afforded frequent and quality visitation.^{liv}
- The agency's plea of insufficient resources should not excuse limiting parent-child visitation. The court and agency should creatively utilize a myriad of community and family resources to supervise visitation when supervision is required. Parental participation in school functions and meetings, religious ceremonies, therapy and medical appointments, and extracurricular activities such as sports and school plays.^{lv}
- Visits should be scheduled more frequently than once a **week**. "Because physical proximity with the caregiver is central to the attachment process for infants and toddlers, an infant should ideally spend time with the parent(s) daily, and a toddler should see the parent(s) at least every two-to-three days."^{lvi}

- “The visit should be of adequate duration to maintain the parent/child relationship. In general, **one to four hours is usually an appropriate time range and then progressing from there.**”^{lvii}
- **Overnight visits** can be considered when it is assured that the child can be protected in the home. “Theoretically, if the child is safe at home for lengthy visits, including frequent overnight visits, he [or she] probably should be moved home with close follow-up supervision and in-home supportive services.”^{lviii}
- Traumatized children are less able to handle separation and therefore more impacted by long separations. There is a need for immediate and ongoing work to keep stability in the child’s life through contacts with family and those with whom the child is attached.^{lix}
- No child should ever be returned home to a parent who has not had successful multiple unsupervised overnight visits in the home of the parent. These visits must include all the people who will be living with the child; i.e. if the mother has a boyfriend who will be living in the home when the child is returned, that person needs to be a part of the visit. The visits should progress to occur during times and situations that may trigger relapse and that mimic the situations that lead to the maltreatment.
- Children must be placed with siblings as a first priority.^{lx} That means actively searching for families who can care for all the siblings. When this does not occur the child should visit regularly with any sibling who lives in another home. This may require having visits with just the siblings to ensure those attachments continue. Visits with other relatives and people with whom the child has emotional attachments should also occur.
- Foster parents/caregivers should be involved and help to support visits. Foster parents must be willing to support the child through the transitions, grief/loss issues, reactions, and emotions related to visits. There must be a working relationship with the birth parents and agency worker to ensure ALL the child’s needs are met, the child’s life is not disrupted by visit schedules that are set up to meet adult needs and the child is not placed in loyalty binds.
- The assigned agency worker (the person writing case plans, court reports, and testifying) must observe at LEAST one face-to-face contact between the parent and child every month. Recommendations to the court must be based on what the worker observed. The supervisor of the visits can provide direct testimony to the court if the agency worker does not observe visits.
- It is seldom necessary to discontinue ALL forms of contact between a child and his/her family in order to protect the child. If safety is an issue, connections may need to start with less than face-to-face contact. Any decision to eliminate all forms of contact with the family must have the approval of the court. Then efforts must be made to find a means of addressing the safety issues to determine if contact may begin at some future date.
- Visits must include interaction between the parent and child to enhance attachment.
- A parent’s incarceration, hospitalization or in residential treatment does not change the frequency need but does make it more difficult to meet the best practice expectations. Children are capable of having visits in these locations if the adults work together. Often the adults are having more negative reactions to the setting than the children. One way to evaluate if a child should have this type of visit: Imagine that the parent instead of being

in jail is serving in the military and will be overseas for many months or is hospitalized for a medical condition in another city. The only contact that can occur would be occasionally through a computer video program, telephone calls or letters. No one is sure if that parent will return home and to be the full time caregiver. Given that child's age and that child's needs, what type of contacts and frequency would you recommend the child and parent have? How will the adults help the child to handle his emotions and concerns about having less than ideal level of contact with his parent or being uncertain of the future? Remember visits are about meeting the child's needs not about whether you believe this parent deserves to visit with his child.

- When frequency of face-to-face visits cannot occur up to best practice standards then other types contacts must increase and should be formalized to help compensate.
- Children will need visits and connections with school, friends, religion, cultural group, community, pets, etc.

VI. Progressive visit model^{lxvi}

Progressive visits start with creating the initial Connection Plan that ensures a safe and successful visit. The plan must meet the child's needs and take place where the child is comfortable. This requires the agency worker to talk to the child, birth parents, caregivers and others. Ask the parents to plan some activity with their child that the child enjoys. Unless the activity is related to the maltreatment, allow the family to choose what they want to do. Ask the parents how they say good night or goodbye when they leave their child with someone else. Help them to be ready to use that routine to say goodbye at the end of visits. Recognize that first visits are often awkward and full of emotions and help the parents and child be prepared to handle their emotions. **Sample first visit:** Parent and child are prepared ahead of time about what occurs on visits, boundaries, guidelines and how to ask for help or directions. The parents should be asked to bring some personal items from their home for the child; pictures, clothes, or favorite comfort items. This item will go with the child back to the caregiver's home. Unless there is a specific safety issue, allow the parent and child to touch each other and express their love for each other. When it is time to end the visit, let the family know ahead of time so they have time for their goodbye routine. Have the parents give the child the comfort item they parent brought, help them talk about the next time they will see each other and what they will do in the until then to stay in touch. Prepare the caregiver to help the child who will probably experience grief and loss after first visits. Find out from the parents what helps to comfort the child and share that with the caregiver. If possible have an icebreaker meeting between the parents and caregivers around the time of the first visit so they can share information about the child.^{lxvii} Start a routine where the parents and caregiver share information about the child to each other either verbally or in writing. Example: When did the child eat and sleep, was there any special event that occurred recently (on visits, at school, at the caregiver's home), is the child having a good day or not, etc.

Once the family has had several successful visits, usually the level of emotions and discomfort will decrease. This is then the foundation Connection Plan. After a few successful visits have occurred, then a progressive step can be taken. The agency worker then changes ONE element at a time such as length or frequency. To maintain a safe, successful visit it is important not to

change too much at once. If the change is successful (there are no new problems or increase in behavior problems and parents successful use new parenting skills), that becomes the new Connection Plan. With baby steps the visit gradually moves towards more normal family interactions: longer, more frequent, in the family home or other community settings, less supervision, etc. This allows for a safe way of teaching and assessing parenting skills.

If, after a change, there are problems, return to the last Connection Plan that was working. It is not necessary to go to the original foundation Connection Plan. Assess what may have caused the problem. After a few visits at the using the last effective Connection Plan make a different type of change, i.e. if you increased frequency, go back to lower frequency. Then try to change another element such as the type of activity the family does during the visit. Progress does not always go in a straight line. A parent can make progress in one element but not another. Alternatively, when a step is being made such as moving from a secure location to a less secure location the level of supervision may need to be increased initially until the parent demonstrates an ability to maintain improved parenting skills in the new location. Progress on visit elements can occur without progress in treatment. The child welfare goal is to have improved parenting skills related to the maltreatment not to completion of treatment programs.

This chart shows the elements of Connection Plans. The written Connection Plan should address each of these elements and how progress will be measured. Each element has a number of possibilities or a continuum. Best practice for Connection Planning is to strive to achieve the maximum whenever possible. For some elements it is not necessary to begin with the minimum level and in fact would be best practice not to do this. Example: Frequency – it would be better to start with multiple contacts a week rather than the tradition of starting with one visit a week.

| Element of Connection Plans | Minimum | Mid way | Maximum |
|------------------------------------|--|---|---|
| Purpose | Meeting child's needs only | Learning parenting skills while meeting child's needs | Meeting both the parent's and child's needs while including the family support system |
| Frequency | Once a week | 2-5 times a week | Every day |
| Length | One hour | 2-12 hours | 24 hours transitioning home |
| Activities | Easiest parenting task the parent knows how to do successfully | Beginning to practice new skills with coaching | Parenting child with new skills during situations and behaviors that occurred during the maltreatment |
| Location | In agency office | Relative's home, parent's home, | Public locations: parks, restaurants, stores where |

| | | | |
|---|--|---|--|
| | or caregiver's home Safety and privacy levels are known | school, doctor – places where safety and privacy can be assessed before the visit | safety cannot be assessed ahead of visit or being in public creates challenging parenting situations as there is no privacy |
| Supervision | Therapeutic | Supervised Observed | Unsupervised |
| Length of time in Care | Initial visits – focus on helping child transition into care and handle grief and loss | Visits to meet Reasonable/Active effort standards | Post Permanency plan developed so child can have contact with ALL families with whom he has an attachment (including birth family post adoption and caregivers post reunification) |
| Planning of visits develop and implemented by | Professionals with input by child and parent | All meet together to plan with professional as facilitator | Parents, caregivers and child lead the planning of the visit and ensuring visits occur as agreed upon |
| Who attends | Child and both parents Separate visits with siblings if needed | Child, parents and siblings together | Entire family including non-related adults who will help to parent the child |

VII. Conclusions

Connection planning is part of reasonable/active efforts requirement. Too often it has been viewed as a supplement service to be provided if there are enough resources. Only seeing your child once a week, for an hour, and in the agency office is not reasonable if we are to meet the goals of our profession to ensure that in a timely manner the family learns how to safely interact, adults can meet the child well-being needs and the child has healthy and stable permanent connections.

Though almost all children will some level of contact with their birth family this report should not be used to provide justification to force a child to have visits or contact with a parent or others when it has been determined that the child would be traumatized by that contact. Children can also be traumatized when we deny them contact with their family. We must acknowledge that visits do cause emotionally reactions by all, including the professionals. We should not be surprised by these reactions and start to address these emotions after a disastrous visit. The profession has the skills and knowledge to proactively help the family, child and caregivers so they can have successful visits. Connection Plans are developed based on a set of elements that have continuums and options. All children must have a Connection Plan but every child will not have visits or contact with a specific parent or person. With these

numerous options available we can develop a safe, non-traumatizing Connection Plan that does allow for frequent face-to-face contact for most children and families.

As each child and family is unique, it is not possible to have standardized Connection Plans or for the plans to remain static for long periods of time. We must use our professional decision making skills to apply the laws, guiding rules, research and best practices and to determine when a case requires an exception to these. As visits cause many conflicts among the adults that too often have the child suffering the consequences all the adults must remember to ask the child what he wants and listen, even if you hear answers that do not match your conclusions. Our job is not to just help the child to be safe today but to help the child learn to make safe decisions throughout his life and to have as healthy of relationship with his family as is possible. Our desire to protect the child today that causes us to limit visits, contacts or connections can lead to a young adult who is now alone with no skills on how to handle his history, trauma, emotions and who may have contact with family members who are unsafe.

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- ⁱ The Geneva Convention of 1947. “The primary need inevitably cited by the families of missing persons is the right to know what happened to their relatives.” *The Missing, The Right to Know*, December 2003, ICRC.
- ⁱⁱ TITLE 42—THE PUBLIC HEALTH AND WELFARE SUBPART 2—PROMOTING SAFE AND STABLE FAMILIES (7) Time-limited family reunification services. <http://www.gpo.gov/fdsys/pkg/USCODE-2011-title42/pdf/USCODE-2011-title42-chap7-subchapIV-partB-subpart2-sec629a.pdf>; U. S. Department of Health and Human Services, Administration for Children & Families. *Children’s Bureau, Children and Family Services Review, Fact Sheet*. 1. http://www.acf.hhs.gov/sites/default/files/cb/cfsr_factsheet_for_courts.pdf
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- ^{iv} *The AFSCAR Report*, July 2012, US Department of Health and Human Services. 52% Returned home and 8% Living with relatives http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report19.pdf
- ^v Festinger, Trudy. *No One Ever Asked Us...A Postscript to Foster Care*. New York: Columbia University Press, 1983. *Of those who aged out, or left foster care upon reaching young adulthood without returning home or being adopted, “...more than eight out of ten (82.9%) of the young adults were in touch with at least one member of their biological families. About one-half, or 48.3%, were in touch with their mothers, fathers, or both. A large majority of these were also in touch with at least one sibling or another relative....All together 22.1% were in touch with their fathers, 35.8% with their mothers, 41.7% with another relative, and more than 3 out of 4 with at least one sibling” (p.172-173). Also, see: Palmer, Sally E. *Maintaining Family Ties: Inclusive Practice in Foster Care*. Washington, DC: Child Welfare League of America, 1995.*
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