ARTICLES

TOO LITTLE, TOO LATE: DESIGNING FAMILY SUPPORT TO SUCCEED

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INTRODUCTION

Removal of children from their families is the dominant response of legislatures and social service agencies when faced with the problem of maltreatment. However, the needs of many children are best served when they are permitted to remain with their families. Implementing safe family preservation requires the provision of services building upon families' strengths to enable families to meet the needs of their children. A pro-family strengths/needs-based system of care cuts across the areas of child welfare, education, health, housing, mental health, substance abuse, and criminal justice. When properly formulated, it simultaneously builds on family strengths, preserves ties between children and families, and attends to needs that, if unmet, put children at risk.

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This strengths/needs approach to services makes possible a genuine partnership between social workers, families, and children. Effective family support requires that services are designed *with* families. Moreover, such services must be sufficiently intensive to address the child's safety and attachment needs, and of a sufficient duration to have a lasting impact. Indeed, unless the family and the older children agree with service providers about their needs, little will change in their lives.

Unfortunately, family preservation has come to mean small, short-term programs emanating out of business-as-usual human services departments. Many families do not get services to assist them in meeting their children's needs; the family support necessary to prevent removal from home or to achieve reunification is simply not in place. In addition, many children do not receive the proper care necessary to recover from maltreatment, which jeopardizes reunification or the success of other permanent placements. Too little service provided too late should not be misconstrued as an indictment of the goal of keeping children with their families.

Families can meet their children's needs if agencies provide the necessary components of family preservation: (1) services must be crafted with the family;[1] (2) standards for minimally adequate homes must guide services;[2] (3) services must be tailored to meet individual needs,[3] particularly those in substance-abusing families;[4] and (4) reunification services must address the risks causing removal and the child's and parent's feelings about separation.[5] This Article describes how services must be designed for family support to succeed.[6]

I.
FAMILY SUPPORT DRIVEN BY NEEDS

A. *Family Preservation as a Statutory Goal: The Adoption Assistance and Child Welfare Act*

Officially, the removal of children as the primary response to neglect and abuse ended in 1980 with the enactment of the Adoption Assistance and Child Welfare Act.[7] The Act requires state child welfare agencies to make "reasonable efforts" to maintain a child with her family or, if removal

1. *See infra* part I.
2. *See infra* part II.
3. *See infra* part III.
4. *See infra* part IV.
5. *See infra* part V.
6. In writing this article, my intention is to help those involved with abusing and neglecting families to step back from day-to-day case demands and think about good practice. The bulk of this article is drawn from my clinical and consulting experience. Others have written about the strengths and needs of children and families. Many of these works are referred to herein, but it is impossible to recognize every influence on this presentation of strengths/needs-based services.
7. Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, 94 Stat. 500 (1980).

is necessary, to return the child safely to the family or arrange another permanent home.[8] But anti-family policies and practices have died slowly.

Prior to the passage of the Act, child welfare agencies in the United States espoused a child rescue philosophy.[9] Although well intentioned, child rescue allowed children to drift in foster care for years and ignored the harm of separating children from their families. In contrast, the Adoption Assistance and Child Welfare Act is based on a family preservation philosophy.[10] "This philosophy has as its starting point the belief that a child's biological family is the placement of first preference and that 'reasonable efforts' must be made to preserve this family as long as the child is safe."[11] Even if reasonable efforts to preserve the family fail and the child must be removed, reasonable efforts must be made to reunify the child with the family.[12]

Even for child welfare workers who believe in family preservation, implementing the philosophy in their day-to-day practice has been difficult. Inadequate services, inflexible agency policies and disjointed funding streams are obstacles to family preservation.[13]

Sixteen years after the passage of the Act, children continue to be subjected unnecessarily to the trauma of lengthy separation from their families. Many neglected or abused children removed from loving but overwhelmed parents could be safely protected in their own homes if agencies provided sufficient services. Children who must be temporarily removed from unsafe homes could be protected if placed with family

8. Practice guidelines concerning the enforcement of the reasonable efforts requirements have been developed for attorneys and national publications have clarified reasonable efforts findings for judges. *See* NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES, JUDICIAL REVIEW OF CHILDREN IN PLACEMENT DESKBOOK (1981) (providing comprehensive guidelines for judges and others involved in child placement case review designed to aid in planning effective placement strategies); MaryLee Allen, Carol Golubock, & Lynn Olson, *A Guide to the Adoption Assistance and Child Welfare Act of 1980*, *in* FOSTER CHILDREN IN THE COURTS 575 (Mark Hardin ed., 1983) (reviewing the history of Public Law 96-272); *see also* James R. Seaberg, *Reasonable Efforts: Toward Implementation in Permanency Planning*, 65 CHILD WELFARE 469, 470-71 (1986) (discussing the history of the "reasonable efforts" requirement); NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES, CHILD WELFARE LEAGUE OF AM. YOUTH LAW CTR., & NATIONAL CTR. FOR YOUTH LAW, MAKING REASONABLE EFFORTS: STEPS FOR KEEPING FAMILIES TOGETHER 11-59 (1985) (offering comprehensive guidelines for attorneys and judges involved in child welfare cases); DEBRA RATTERMAN, G. DIANE DODSON, & MARK A. HARDIN, NATIONAL LEGAL RESOURCE CTR. FOR CHILD ADVOCACY & PROTECTION, REASONABLE EFFORTS TO PREVENT FOSTER PLACEMENT: A GUIDE TO IMPLEMENTATION (2d ed. 1987) (offering general practice guidelines).

9. Alice C. Shotton, *Making Reasonable Efforts in Child Abuse and Neglect Cases: Ten Years Later*, 26 CAL. W. L. REV. 223, 254-55 (1989-1990); *see also* ELIZABETH COLE & JOY DUVA, CHILD WELFARE LEAGUE OF AM., FAMILY PRESERVATION: AN ORIENTATION FOR ADMINISTRATORS AND PRACTITIONERS 11 (1990) (explaining that agencies exercised a "save and rescue" policy for children hurt, neglected, or abused by parents).

10. Shotton, *supra* note 9, at 255.

11. *Id.*

12. *Id.* at 223.

13. *Id.* at 255.

members or friends while the reasons for their maltreatment are addressed rather than placed in unfamiliar foster homes.[14]

Sufficiently intensive services are seldom provided to keep children safely at home. Many states do not consistently adhere to the spirit of the Adoption Assistance and Child Welfare Act. Rather, they define reasonable efforts in terms of those services already available, however inadequate, and plug families into limited, predefined services.

The way in which the Act allocates mandatory and discretionary responsibilities may be largely to blame for agencies' failure to ensure sufficient family support.

> [W]hen a public child welfare agency receives a report of child abuse or neglect, the agency is legally *required* to coercively intervene against the family by investigating the report and, if necessary, removing the child from the home. Yet, if the family needs a particular service to allow the family to remain intact, the agency has *discretion* whether to make any specific service available, even if the agency recognizes that the service is essential to preserve the family.[15]

It is this tension within the Act, coupled with inflexible funding and services that are not individualized, which leads agencies to focus on problems flagged by instances of abuse or neglect rather than meeting children's needs for safety and attachment by building on family strengths. Thus, deficit-driven programs are the norm, despite their ineffectiveness as compared to strengths/needs based services.

B. Defining Reasonable Efforts to Maintain Children Safely with Their Families

1. Ineffectiveness of Deficit-Driven Programs

Emphasizing deficits pushes the family into an enduring defensiveness. For example, case plans will often contain a statement such as "Ms. Lawrence must attend parenting skills class."[16] This is not an assessment of what Ms. Lawrence needs. The service required cannot be determined until the case worker identifies the need that the service will meet. Instead,

14. Conversely, some children are currently at risk because they have been left unsafely at home. For example, the needs of a kindergartner who stops attending school when school officials report him as hungry and dirty and remains in a home with the utilities cut off cannot be met by an impoverished parent. However, agencies consumed with life-and-death health and child safety concerns are likely to ignore this situation.

15. MARK HARDIN, AMERICAN BAR ASS'N, ESTABLISHING A CORE OF SERVICES FOR FAMILIES SUBJECT TO STATE INTERVENTION: A BLUEPRINT FOR STATUTORY AND REGULATORY ACTION at iii (1992) (emphasis added) (explaining the Adoption Assistance and Child Welfare Act of 1980).

16. The cases described in this article are drawn from the author's clinical experience in communities in a number of states. Names, where used, have been invented.

the plan should state, "A strength of Ms. Lawrence is that she shows affection for her children. But when she has to cope with their many demands by herself for long periods, she feels depleted, gets angry, and sometimes loses control of her anger. *Ms. Lawrence needs regular breaks from their demands* so she does not get so worn out." This particular need, once it is specified, would best be matched with a babysitter. If she is referred to a parenting skills class, Ms. Lawrence is likely to feel defensive. If she chooses not to attend the class, she may be accused of not caring about her children.

2. *Designing Strengths/Needs-Based Services*

For family support to succeed, any plan purporting to meet the reasonable efforts requirement of the Adoption Assistance and Child Welfare Act must contain three essential components: (1) services must be based on the family's strengths and needs; (2) children and families must be involved in identifying their strengths and needs and in designing the required services; and (3) services must be regularly adjusted to ensure their effectiveness in meeting the child's and family's needs.

Child and family assessment should generate information to guide services to improve the fit between the child's needs and the family's responsiveness. This should include a description of the strengths of the extended family, attachments, problem solving skills, and community involvement. The process of identifying, with the family, what is required to meet the needs of the children should address, at a minimum, the following:[17]

- What are the family's strengths?
- Who is the child attached to; what relationship(s) does the child have to a parent or other family members absent from home?[18]

17. *See* Lawrence Fisher, *Dimensions of Family Assessment: A Critical Review*, 2 J. MARRIAGE & FAM. COUNSELING 367, 379 (1976) (arguing that cultural and developmental characteristics should be placed at the top of a family assessment hierarchy).

18. When identifying needs and strengths, caseworkers should take note of the children's attachments. Even when children have been maltreated, most still need to have a relationship with their biological families, as well as with other significant caretakers. *See* Matthew B. Johnson *Examining Risks to Children in the Context of Parental Rights Termination Proceedings*, 22 N.Y.U. REV. L. & SOC. CHANGE 397, 408-09 (1996) (noting that children benefit from and need to maintain contact with the family of origin). Agencies often fail to consider seriously this need in designing services for children. *See* Margaret Beyer & Wallace J. Mlyniec, *Lifelines to Biological Parents: Their Effect on Termination of Parental Rights and Permanence*, 20 FAM. L.Q. 233, 254 (1986) (criticizing the current system of permanency planning, particularly its emphasis on termination of family ties rather than reunification, especially given the low adoption rates in child welfare). The harm caused to children by separation from family members outweighs the risk of maltreatment in more cases than presently recognized. *Id.* Moreover, there is little documentation of positive treatment outcomes in addressing the enduring anger, school adjustment difficulties, and identity struggles of children deprived of their families.

- What is the impact of the family's cultural orientation on child rearing?
- How does the family handle conflict between the needs of the child and the needs of the child's primary caretakers?
- How does the family respond to the child's disobedience?
- What environmental, employment, economic, health, and other stressors exist for the family?
- Do family members abuse substances and how specifically does this interfere with meeting the child's needs?
- What is the family's perception of help-seeking and intervention?
- What specifically put the child at risk, and why did the family not attend to those particular safety needs?

Reaching agreement with the family about its needs should start with the very first contact. The caseworker must begin to build a partnership with the family at once. In the author's experience, when the caseworker sees the family's strengths, understands why the child was not protected, and builds a partnership with the family so they can help at the beginning to ensure the child's safety, case outcome improves in comparison to risk assessment techniques that primarily identify parental deficits. Since professionals knowledgeable about child development and families may look at a child's needs differently, reaching agreement can be a time-consuming process. In the author's experience, this process of reaching genuine agreement about the child's needs results in more effective services and earlier, safe case closing.

By recognizing a family's strengths and listening to the family's own assessment of its needs, a caseworker empowers the family. A deficit approach, by contrast, puts family members on the defensive and erodes their trust. Reaching agreement with a family on their needs leads to their active involvement in crafting services and their taking responsibility for change. Instead of sending the family to a program to have something done to it, the message is: You have agreed on what you need. The services you have helped to plan will assist you in getting your needs met.[19]

19. *See* Paul D. Steinhauer, *Issues of Attachment and Separation: Foster Care and Adoption*, *in* PSYCHOLOGICAL PROBLEMS OF THE CHILD IN THE FAMILY 66, 99 (Paul D. Steinhauer & Quentin Rae-Grant eds., 1983) (arguing that decisions regarding foster care and adoption should be undertaken only with the participation of all those involved in the care of the child); *see also* James E. Simmons, Robert L. Ten Eyck, Richard C. McNabb, Barbara S. Coleman, Beverly Birch, & Murtice Parr, *Parent Treatability: What Is It?*, 20 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 792, 800-01 (1981) (finding that when the father is not sufficiently involved in the planning process, the family is likely to terminate treatment early, and that the amount of responsibility delegated to the family is closely related to the family's willingness to cooperate with treatment goals).

Reasonable efforts go beyond providing referrals to services. A family support plan may fail for multiple reasons: the agency may not have properly identified the child's and family's needs; the family may not agree with the caregiver about its needs; the family may not believe the services will meet its needs; and/or the caregivers may be skeptical about the family's capacity to change.[20]

The process of empowering families requires that services be adjusted when a family does not follow through.

> [U]nmet family needs in basic areas such as nutrition, shelter, safety, health care, child care, and so forth negatively affect parents' health and well-being, which, in turn, decreases the probability that parents will carry out professionally prescribed interventions. . . . Thus, a family who [sic] fails to adhere to a professionally prescribed regimen may do so not because its members are resistant, uncooperative, or noncompliant, but because the family's circumstances steer behavior in other directions.[21]

If parents fail to utilize services, they probably do not believe the services will help meet their needs. Labelling the family resistant obscures parents' legitimate reasons for not utilizing services. The family may lack transportation or may require child care. The family may also feel uncomfortable in agencies, in which case the caseworker should arrange for home-based services. Perhaps the family does not fully understand their child's needs or how to meet them. If the family does not become involved in services, the caseworker must ask the family again, "What services will help you to meet your children's needs?"

Many practitioners wonder whether they should bother assessing and reaching agreement with the family about a child's needs if the child's emotional needs cannot be met by existing outpatient services and her educational needs cannot be met by the local school. However, when the caseworker and family reach agreement about the child's educational, emotional, and other needs and specify the help necessary to meet those needs, new services are much more likely to be developed, sometimes in surprising ways. For instance, in the case of Ms. Lawrence, the mother might have been referred to a parenting skills class.[22] However, she really needed a babysitter to go into the home, perhaps daily, to give Ms. Lawrence a regular break so she could make use of her strengths as a parent and not become so depleted that she would lose control of her anger. While perhaps

20. *See generally* ABIGAIL NORMAN, EDNA MCCONNELL CLARK FOUND., KEEPING FAMILIES TOGETHER: THE CASE FOR FAMILY PRESERVATION 2-12 (1985) (describing factors that influence decisions to remove a child from the home and discussing ways in which unnecessary foster placement may be avoided).

21. CARL J. DUNST, CAROL M. TRIVETTE, & ANGELA G. DEAL, ENABLING AND EMPOWERING FAMILIES: PRINCIPLES & GUIDELINES FOR PRACTICE 17 (1988).

22. *See supra* part I.B.1.

not previously included in the local continuum of child welfare services, a variety of informal or contractual arrangements could be used to procure a reliable babysitter in the home, keeping the children safe and leaving their attachment to their mother undisturbed.

A strengths/needs approach to services requires a complex web of working partnerships to protect the child within the family or other placement. Individuals who know the family's and child's strengths and needs must be brought together in the design—not just the delivery—of services. These individuals may include the caseworker, the teacher, the therapist, the nurse, the parent's substance abuse counselor, and a member of the local church. All must work from a shared statement of strengths and needs with which the family agrees and all must be accountable for meeting those needs.

Instead of assuming children will be better off without parents who have maltreated them, practitioners must ask what it will take to keep the child safe and protect the child from the loss of her family. In most cases, families want to meet their children's needs. Abusive and chronically neglectful families are not hopeless. Agencies—with the active participation of families—must design coordinated, strengths/needs-based services to support families in keeping their children safe without disturbing their attachments.

II.

Ensuring Minimally Adequate Homes for Children

Effective support for families in meeting the needs of their children requires an understanding of minimal adequacy. Minimal adequacy should be defined in terms of safety and attachment—not some concept of idealized family life. Differences among families in childrearing require that guidelines for minimally adequate homes be based on universal child development principles. Since cultural differences affect how families define nurturing, caseworkers must focus on whether the child's needs are met and not on how the family cares for the child.

For example, in one case, a pediatrician notified child welfare that a two-year-old was not vocalizing despite normal hearing. The pediatrician suspected the child's speech delay resulted from neglect by the child's deaf parents. The investigative worker found that the parents were teaching the child sign language so she could communicate in their world. The parents resented outside intervention, but the pediatrician persisted because of her belief in a developmental window after which a child cannot easily learn to speak and in the necessity for a hearing child to be prepared to communicate in the hearing world. The caseworker enlisted the assistance of a hearing-impaired social worker from a school for the deaf. The social worker helped the parents recognize as unfounded their fear that the child would

reject them or their deaf culture if she learned to speak by attending preschool with hearing children.

This child's family demonstrates how a culture defines nurturing. Most families repeat the practices they experienced as children[23] and will refuse to implement unfamiliar nurturing approaches that challenge the integrity of the family. If family members believe that adopting new methods will make the child unlike the family, they may feel too threatened to make the recommended changes, even if they have been told the changes are necessary for the child's health or cognitive or social development.

Minimally adequate nurturing guidelines must recognize that most families want the best for their children and that this includes keeping the children within the culture of the family. Applying a reasonable and accountable minimally adequate home standard requires reaching agreement with parents regarding their children's needs as well as how to monitor developmental milestones. Effective support helps families meet their children's needs in ways consistent with their particular culture and nurturing style.

Reaching agreement on universal child development requirements may prove difficult, as illustrated by the following case. The police and media were flooded with complaints about a father living in a van with his small children. As the case worker summarized the situation, the community felt that "child welfare should not allow children to live like that." Essentially, the public felt that all children should be raised in "a nice home." However, no clear-cut standards for normal child-rearing practices exist.

Many children are raised in less than optimal environments for child development. The standard for minimally adequate homes should be determined by the nurturing a child needs. Minimally adequate nurturing must be defined in a developmental context because the conditions that would cause an infant to be physically or developmentally impaired are different than those for an older child.

Practitioners should base judgments regarding the adequacy of a home on whether the child's need for safety (defined as assurance of health and protection from physical danger) and caring (defined as demonstration of love and attention) are met. A family need not adhere to predetermined child-rearing techniques; the family must only provide safety and caring for its children. In many cases, alternate caretakers in the extended family or in-home service providers can be relied upon to meet the child's immediate needs for caring and safety. Thus, an effective intervention involves the following: identifying loving and protective individuals in the household;

23. *See* ROBERT SCOTT, LINDA BAYLESS, DAN CORRIE, LILLIE LOVE, & IRMA VELASCO-NUNEZ, CHILD WELFARE INST., ACHIEVING CULTURAL COMPETENCE IN CROSS-CULTURAL PRACTICE 127-29 (1992) (describing influence of cultural, social, and familial practices).

ensuring that they understand the child's needs for caring and safety; obtaining the agreement of one or more family members, in collaboration with the parents where possible, to take specified steps to meet the child's needs; and checking to ascertain that the child's needs are being met.

The application of a minimally adequate home standard is illustrated by the following cases:

> Sherise[24] is sixteen years old and recently gave birth to Tanya. Sherise was raised by her alcoholic mother and grandmother, both of whom have died within the past two years. Sherise's chronic running away from relatives' homes, residential programs, and shelters have put her and her baby at risk. Sherise's need for love conflicts with her determination to control her own life, and caregivers have been unable to tolerate her independence and lack of trust. Presently, Sherise is coming and going from a relative's home. She does not attend school and is on the street late at night, but the relative is tolerant and nurturing and watches Tanya when her mother is out. Tanya needs:
>
> - to be protected from abuse
> - to be healthy
> - to have an attachment to at least one loving adult
> - to achieve developmental milestones
>
> Caseworkers believed that the best way to ensure safety and caring for Tanya was to provide an alternative caretaker (such as her relative), a stable home, daycare, and a safety plan that built on Sherise's maturity and concern for her baby. Therefore, to achieve a minimally adequate home, the case worker arranged financial support; ensured that Sherise's relative was committed to accepting Sherise when she returned, and obtained Sherise's agreement that she would not take her baby when she left home. Sherise also required continuing efforts to help meet her needs for nurturing and feeling in charge of her life.

> Ms. Johnson[25] is a twenty-four-year-old relapsed crack addict. After her first child was placed for adoption in another state, she completed a chemical dependency program and procured employment. She gave birth to a second child, Germaine, who is now three years old. Ms. Johnson has begun to frequent a crack house, leaving Germaine with a neighbor, Ms. Anderson. Ms. Anderson's two children are in school and she had been planning to return to part-time employment in a nursing home. Ms. Anderson reports that Germaine seems bright, but has delayed

24. *See supra* note 16.
25. *See supra* note 16.

speech, aggressive temper outbursts, is extremely active, and has difficulty concentrating. Although Ms. Anderson is supportive of Ms. Johnson, Ms. Anderson believes that Germaine's behavior problems result from a lack of structure at home. During an unusually lengthy absence by Ms. Johnson, Ms. Anderson took Germaine to her pediatrician for an ear infection and learned that he has significant hearing loss. The pediatrician recommended surgery. Germaine needs:

- to develop age-appropriate language skills
- to have consistent, nonpunitive limits
- to have normal hearing
- to have his attachment to his mother undisturbed
- to be constantly supervised
- to improve his concentration
- to learn how to tolerate frustration

To meet Germaine's needs, the caseworker combined several services. First, the agency hired a trained coach to teach Germaine how to manage his anger, arrange developmental services including speech therapy, and support consistent limits and cognitive stimulation by both Ms. Anderson and Ms. Johnson.[26] In addition, the worker enlisted a recovering person to offer Ms. Johnson sober friendship, reduce her isolation, accompany her to

26. Early intervention with developmentally delayed children has demonstrable long-term benefits. *See* FAY F. RUSSELL, INTERDISCIPLINARY EARLY INTERVENTION FOR DEVELOPMENTALLY DELAYED INFANTS AND YOUTH CHILDREN: A FAMILY-ORIENTED APPROACH (1985) (providing therapeutic responses to child development disorders); Sarale E. Cohen & Leila Beckwith, *Preterm Infant Interactions with the Caregiver in the First Year of Life and Competence at Age Two*, 50 CHILD DEV. 767, 774-75 (1979) (finding that minimal social interaction between caregivers and their preterm infants portends lowered infant competence at age two); *cf.* Nancy K. Young, Valerie R. Wallace, & Teresa Garcia, *Developmental Status of Three to Five Year-Old Children Who Were Prenatally Exposed to Alcohol and Other Drugs*, 16 SCH. SOC. WORK J. 1, 4-15 (1992) (describing a population of high-risk children, ages three to five, who were prenatally exposed to alcohol and other drugs and suggesting the need for individual determination of the capabilities of each child); Susan Jacob, Helen E. Benedict, Jeff Roach, & G. Louise Blackledge, *Cognitive, Perceptual, and Personal-Social Development of Prematurely Born Preschoolers*, 58 PERCEPTUAL & MOTOR SKILLS 551, 559 (1984) (finding that premature three-year-olds do not perform perceptual performance tasks as well as mature three-year-olds). Education of the Handicapped Act Amendments of 1986, Pub. L. No. 99-457, 100 Stat. 1145 (codified as amended at 20 U.S.C. § 1400 (1986)), requires states to set up early intervention programs for children from birth through age two who need special services. An Individualized Family Service Plan (IFSP) must be developed identifying the child's needs, the family's strengths and needs, and the services required. § 677, 100 Stat. at 1150. A case manager is appointed to coordinate speech, hearing, and occupational therapies and other services. *Id.*

Narcotics Anonymous (NA) meetings, and provide in-home instruction about how substance abuse impedes parenting.[27] Ms. Johnson also enrolled in day treatment. Ms. Anderson was paid to provide in-home support and respite as needed. This combination of services avoided placement in a foster home and encouraged Germaine's mother to meet some of his needs. Ms. Anderson received specialized training on insuring safety and consistent follow-through on developmental services while Germaine's mother was recovering.

Ms. Franklin[28] is the forty-two-year-old schizophrenic mother of Cassandra, who is almost three years old and who was placed in a foster home one year ago when Ms. Franklin was hospitalized. Ms. Franklin's older daughters were raised by their grandparents, are now successful college students, and have little contact with their mother. The children's grandparents are deceased. Cassandra is attached to her foster mother and has adjusted well to daycare. Cassandra enjoys seeing her mother on visits. In the past, Ms. Franklin did not take her medication regularly and attended the day treatment program at the mental health center sporadically. She is intelligent and is bored in the program, which is designed for low-functioning chronic mental patients. Ms. Franklin loves Cassandra and has good parenting skills when she takes her medication. Ms. Franklin now lives with her sister. Cassandra needs:

- to feel secure
- to achieve developmental milestones
- to have caretakers respond consistently to her distress and playfulness
- to be protected from abuse
- to be healthy

The mental health center agreed to provide in-home medication maintenance and to assist Ms. Franklin in finding a satisfying part-time activity. The social services agency hired Cassandra's foster mother to work with Ms. Franklin, her sister, and Cassandra during a gradual transition home and on a daily basis after Cassandra's return. The foster mother also provided respite for Ms. Franklin several weekends a month. A cooperative working relationship among the mental health center, the foster mother,

27. In two cities in which child welfare workers and chemical dependency program staff have provided collaborative in-home support—Montgomery, Alabama, and Portland, Oregon—the author has observed that the use of a recovering person to encourage parents to meet their children's needs can be an effective intervention.

28. *See supra* note 16.

> the daycare center, and Ms. Franklin's sister was seen as the best way to ensure caring and safety for Cassandra and to respond immediately to any deterioration in Ms. Franklin's condition.[29]

In defining how to ensure minimally adequate homes in these cases, particular childrearing skills were not a prerequisite and could be developed, provided that the parent embraced the safety and caring needs of the child. Thus, the fact that Sherise did not hold her baby as well as a more mature parent, or that Ms. Franklin would not look directly into her child's eyes as often as would other parents were not, in and of themselves, reasons to remove their children from home. If the child is loved and if workers can establish a safety plan with family members or service providers in the home to ensure that the child's needs are met, nurturing techniques can be strengthened over time.

Using a standard for minimally adequate homes to guide protective services and reunification services represents an important component of family support. To ensure success, the following must be recognized: most families love their children and want them to be safe; family members must be able to state their children's needs; family members must recognize how their own needs interfered with meeting their children's needs; and family members must have confidence that implementing unfamiliar nurturing practices will not make the child unlike the family.

Designing family support to succeed means developing in-home services. These services should be based on the concept of family encouragement to meet the child's needs by doing what comes naturally rather than through imposed techniques. The starting point for ensuring that a home is minimally adequate is appreciating the nurturing approaches handed down from previous generations while also suggesting different approaches with beneficial outcomes for child development that can be integrated into the family.[30] Instead of dictating how the child's needs are to be met, workers should focus on ensuring that they are met.

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29. A number of studies have described the effectiveness of supporting mentally ill parents by preventing rehospitalization and avoiding the deleterious effects of the parent's mental illness on the child's development. Services must be designed specifically to enhance the capacity of mentally ill parents to provide physical care and protection for their children, to maintain an ongoing emotional relationship with their children, and to recognize signs of distress and pleasure in their children. These services must be presented in ways acceptable to mentally ill parents who tend to think in concrete terms and to have difficulty anticipating the future and conceptualizing the consequences of their actions. *See* Judith S. Musick & Bertram J. Cohler, *Psychopathology of Parenthood: Implications for Mental Health of Children*, 4 INFANT MENTAL HEALTH J. 140, 149-57 (1983) (reviewing intervention programs designed to reduce the impact of a mother's psychiatric disorders on her children); *see generally* INTERVENTION AMONG PSYCHIATRICALLY IMPAIRED PARENTS AND THEIR YOUNG CHILDREN (Bertram J. Cohler & Judith S. Musick eds., 1984) (presenting five studies of efforts to help mentally ill patients and their children).

30. *See* Karen I. Wayman, Eleanor W. Lynch, & Marci J. Hanson, *Home-Based Early Childhood Services: Cultural Sensitivity in a Family Systems Approach*, TOPICS IN EARLY CHILDHOOD SPECIAL EDUC., Winter 1991, at 56, 63-68 (emphasizing the need for social

III.
CRAFTING SERVICES TO MEET INDIVIDUAL NEEDS

Just as residential programs of the past became slot-driven, with children placed almost randomly in whatever bed became available, a danger exists that nonresidential services will not be individualized, and that clients will be sent to counseling, parenting class, or in-home programs that do not customize their activities to the culture and character of each child and family. Designing family support to succeed entails collaboration among the family and caregivers in crafting unique services to match the strengths and needs of that child and family—one case at a time. While considerable time is required to craft services case-by-case, once effective strengths/needs-based services start, these cases prove less time-consuming than cases handled through slot-driven referrals.

Individually crafted services must be developed in neighborhoods with the family's natural supports—including church groups, volunteers, and community groups that previously were not considered providers—in addition to public and private human services agencies. To craft services case-by-case, a variety of caregivers may be necessary. For example, a former houseparent in a children's residential program could provide in-home parent skill-building and respite, with family-specific training and clinical supervision. A graduate student could assume the position of in-home parent support caregiver, supervised by a therapist who is offering parent counseling for depression. A neighbor of the family or a community college student working part-time at a child guidance clinic could be trained to provide individual attention services to a child. Service providers may develop a team of full-time generalists who can, with specialized training and supervision, meet the needs of a range of children and families.

Public and private providers in many communities demonstrate flexibility in case-by-case service design, inventing new services, hiring staff specifically for a child and family, and retraining existing staff to meet particular needs. Providers have found that there are fewer logistical difficulties in crafting individualized services than anticipated. For example, a staff person reducing her hours in one home is often able to provide services for another family. A local therapist experienced in incest cases may be paid to provide training and supervision to a behavior coach for a sexually abused child. Aides employed in public school special education classrooms often express interest in earning additional income in exchange for providing individual attention for a child after school and on weekends.

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service professionals to be sensitive to a client family's existing child rearing practices); *cf.* TERRY L. CROSS, BARBARA J. BAZRON, KARL W. DENNIS, & MAREASA R. ISAACS, CASSP TECHNICAL ASSISTANCE CTR., TOWARDS A CULTURALLY COMPETENT SYSTEM OF CARE (1989); Sylvia Sims Gray & Lynn M. Nybell, *Issues in African-American Family Preservation*, 69 CHILD WELFARE 513, 513-23 (1990) (raising welfare service practice issues peculiar to African-Americans).

Collaborative crafting of strengths/needs-based services is necessary to meet unique needs, as the following cases demonstrate:

> Douglas[31] is eleven years old and has a behavior disorder. He has been raised in a small town by his grandfather who is Douglas's only known living relative—Douglas's teenage parents were killed in a car accident and his grandmother died two years later. Douglas does what he wants. Despite his grandfather's efforts, he watches cartoons continuously and refuses to prepare for school. When he comes home from school, Douglas ignores his homework. The school has suspended Douglas numerous times for aggressive behavior. Recently, the police brought Douglas home in the middle of the night. His grandfather reports that Douglas acts bossy and has poor peer relationships. When Douglas's grandfather puts his foot down, Douglas "goes off," so the grandfather does not generally set limits. Douglas has twice spent time at a psychiatric hospital. At first the hospital suggested the grandfather implement a behavior management program at home, but now the treatment team is pushing for residential placement. An in-home worker provided support in the home, but found that Douglas's grandfather failed consistently to follow through with limits. Douglas needs:
>
> - to learn to regulate his behavior so that he has friends, gets sufficient sleep, feels successful, and is not arrested or suspended from school
> - to live with his grandfather
>
> Strengths/needs-based services crafted with Douglas and his grandfather could take various forms. Workers could recruit a foster family whose home contains a small apartment for Douglas's grandfather. The foster parents, depending on their skills, availability, and interest, could receive training on how to teach Douglas to regulate his own behavior. An individual coach could also enter the foster home and school or coparent with Douglas's grandfather in the grandfather's home. To learn to regulate his behavior, Douglas requires individual in-home and in-school instruction and perhaps medication.[32] The instruction may begin as a daily service and include behavior coaching, joint activities,

31. *See supra* note 16.

32. *See* Howard Abikoff, *An Evaluation of Cognitive Behavior Therapy for Hyperactive Children*, *in* 10 ADVANCES IN CLINICAL CHILD PSYCHOLOGY 171, 171-216 (Benjamin B. Lahey & Alan E. Kazdin eds., 1987) (reviewing cognitive training investigations of hyperactive children). *But see* Barbara Henker & Carol K. Whalen, *Hyperactivity and Attention Deficits*, 44 AM. PSYCHOLOGIST 216, 216-23 (1989) (stating that nonpharmacological interventions have not proved as effective in dealing with hyperactivity and attention-deficit disorder as stimulant medication); *cf.* E. Taylor, R. Schachar, G. Thorley, & M. Weiselberg,

feedback, and rewards for improved self-regulation. Douglas's grandfather, other parent figures, and teachers must all participate in promoting and rewarding improved self-regulation. Insuring that Douglas experiences success in school, sports, and other activities is critical.[33]

Ms. Daiz's[34] five children (ages seven to sixteen) have all been in foster placement, some of them for more than five years. This predicament resulted from Ms. Diaz's alcoholism and sexual abuse of the children by a relative. Three of the children no longer have a return home as their permanent goal. Pam, age ten, and David, age five, were abused in one foster home and moved to another foster home nearer their mother. Based on the strong relationship with their mother that had continued through visits, the worker began a reunification process with Pam and David. Ms. Diaz stopped drinking and has been working at one job for more than a year. After the case was transferred to a reunification worker, Ms. Diaz admitted that she does not request the help she needs, and in fact avoids the worker so she does not have to examine her choice to live with a man who abuses alcohol. She recognized that church had once been important in her life, but for years she felt she could not return because she was "living in sin." Ms. Diaz wants her boyfriend to see how his alcoholism interferes with the couple's ability to meet the children's needs. At the time of their abuse in the foster home, David was in therapy for lying, stealing, and urinating in his clothes; Pam was taking an antidepressant; and both were doing poorly in school. David needs:

- to receive basic nurturing: being read to, being cuddled, and being praised

Conduct Disorder and Hyperactivity, 149 BRIT. J. PSYCHIATRY 760, 760-67 (1986) (concluding that inattentiveness in children is distinct from defiant conduct in children with psychiatric disorders).

33. Schools tend to focus on controlling children with emotional and behavioral problems, rather than teaching them how to manage their feelings or ensuring that they develop competence at school. *See* JANE KNITZER, ZINA STEINBERG, & BRAHM FLEISCH, BANK STREET COLLEGE OF EDUC., AT THE SCHOOLHOUSE DOOR: AN EXAMINATION OF PROGRAMS AND POLICIES FOR CHILDREN WITH BEHAVIORAL AND EMOTIONAL PROBLEMS at xii-xiii, 25-30 (1990) (finding that even exemplary educational programs for children with emotional and behavioral problems over-emphasize behavior control and modification, to the detriment of the child's academic and emotional development); *see also* Dante Cicchetti, Sheree L. Toth, & Kevin Hennessy, *Research on the Consequences of Child Maltreatment and its Application to Educational Settings*, TOPICS EARLY CHILDHOOD SPECIAL EDUC., Summer 1989, at 33, 47-49 (recommending support and encouragement for maltreated children's efforts to achieve educational and social competence and professional awareness of risk of excessively controlling such children's behavior).

34. *See supra* note 16.

- to learn how to get attention from his mother (and her boyfriend) without stealing, lying, and wetting
- to improve his concentration and experience success in school
- to have his attachment to Pam undisturbed

Pam needs:

- to feel valued and listened to by her mother (and her mother's boyfriend)
- to be good at something in school
- to overcome the shame, depression, and self-dislilke resulting from sexual abuse
- to have her attachment to David undisturbed

Intensive services are necessary to meet the needs of Pam and David as they return home. An effective service package might include: in-home parent support services, to guide parenting and to assist Ms. Lawrence in making desired personal changes; in-home substance abuse services to help Ms. Lawrence's boyfriend see how his alcohol use interferes with supporting her and nurturing the children;[35] and individual attention services for David and Pam, with a focus on school success and recovery from sexual abuse.[36]

Accessible and flexible services are both necessary and possible. With input of the family, most services can be crafted to meet individual needs. Individual crafting of services should not be limited due to the small size of

35. *See* LESLIE ACOCA & JOAN BARR, EDNA MCCONNELL CLARK FOUND., SUBSTANCE ABUSE: A TRAINING MANUAL FOR WORKING WITH FAMILIES, 27-28 (1989) (photo. reprint 1992) (asserting that the effects of substance abuse ripple outward to affect other family members and advocating a "family disease" approach to treatment).

36. *See generally* Beverly James & Maria Nasjleti, TREATING SEXUALLY ABUSED CHILDREN AND THEIR FAMILIES (1983) (detailing a child sexual abuse intervention system for professionals to use with victims of sexual abuse and victimizers); DIANE H. SCHETKY & ARTHUR H. GREEN, CHILD SEXUAL ABUSE: A HANDBOOK FOR HEALTH CARE AND LEGAL PROFESSIONALS 199-203 (1988) (outlining recommendations for individual and group therapy and other types of treatment for child sexual abuse victims and their families); Linda Damon, Judith Todd, & Kee MacFarlane, *Treatment Issues with Sexually Abused Young Children*, 66 CHILD WELFARE 125, 125-37 (1987) (describing the effectiveness of a California treatment program which placed parents and children in parallel support groups, while providing individual therapy); Henry Giaretto, *A Comprehensive Child Abuse Sexual Treatment Program*, 6 CHILD ABUSE & NEGLECT 263, 263-78 (1982) (discussing the effect of a treatment program for incestuous families); Harriette Grammer & Jeannette Shannon, *Survivor's Group: Clinical Intervention for the Sexually Abused Child in Treatment Foster Care*, 4 COMMUNITY ALTERNATIVES 19, 20-28 (1992) (describing techniques for structuring and conducting a survivors' group for preadolescent girls in treatment foster care and for generalizing skills to the treatment home setting); David P. H. Jones, *Individual Psychotherapy for the Sexually Abused Child*, 10 CHILD ABUSE & NEGLECT 377, 377-85 (1986) (describing one center's experience using psychotherapy to help the sexually abused child).

the provider's staff, nor due to antiquated training and supervision practices. Timing plays a role in how the services are crafted. David and Pam are safe in their foster home. This allows for the creation of an effective provider team. For Douglas and his grandfather, in-home individual attention can begin while a foster home with room for both is arranged.

IV.
SERVICES FOR SUBSTANCE-ABUSING FAMILIES

Many parents who abuse or neglect their children are substance abusers.[37] Substance abuse may lead to an angry assault on children, of which the parent has no memory the next day. Substance abuse may also reduce a person's inhibitions against incest. Although substance abusers may feel guilty about their behavior, they may be unaware of their children's needs. Typically, parents abuse alcohol or drugs in response to stress; they do not realize that they are gratifying their own needs before meeting their children's needs. Moreover, substance abuse becomes the organizer for the entire family; family members cover up and respond to the abuser's dependency.[38]

Addiction is a chronic disease with a slow recovery process. Some individuals are incapable of controlled use and must abstain. Nevertheless, substance-abusing parents can be successfully supported to meet the needs of their children. Substance-abusing parents often require assistance to improve their responsiveness to their children,[39] avoid

37. Little data is available to support this recognized connection. *See* ACOCA & BARR, *supra* note 35, at 1 (referring to consensus of a meeting of family preservation programs that a high percentage of families referred to the programs had substance abuse problems and that the severity and complexity of those problems was increasing); Richard Famularo, Karen Stone, Richard Barnum, & Robert Wharton, *Alcoholism and Severe Child Maltreatment*, 56 AM. J. ORTHOPSYCHIATRY 481, 483 (1986) (reporting study that suggests a statistical association between alcoholism and the maltreatment of children).

38. *See* ACOCA & BARR, *supra* note 35, at 97, 156 (discussing how chemical dependency and child abuse often coexist and reinforce one another).

39. Substance-abusing parents may act inconsistently in their sensitivity to and cooperation with their children. Successful programs increase the sensitivity of parents and their responsiveness to their children by helping parents match their behavior to the child's interests and developmental level. *See* Maria E. Barrera, Kathleen J. Kitching, C.C. Cunningham, D. Doucet, & P.L. Rosenbaum, *A Three-Year Early Home Intervention Follow-up Study with Low Birthweight Infants and Their Parents*, TOPICS EARLY CHILDHOOD SPECIAL EDUC., Winter 1991, at 14, 19, 26 (finding some conservative evidence of the long-term effectiveness of early home intervention program designed to enhance parents' responsiveness and sensitivity to the behavior of their preterm infants); Byron Egeland & L. Alan Sroufe, *Attachment and Early Maltreatment*, 52 CHILD DEV. 44, 51 (1981) (finding that changes in the mother's circumstances, such as the presence of a supportive family member or support services, resulted in a more secure attachment between parent and child); Mary Main & Ruth Goldwyn, *Predicting Rejection of Her Infant From Mother's Representation of Her Own Experience: Implications for the Abused-Abusing Intergenerational Cycle*, 8 CHILD ABUSE & NEGLECT 203, 215 (1984) (arguing that the treatment of cognitive disorders of parents who were abused will make the repetition of abuse less likely); Sharon Silber, *Family Influences on Early Development*, TOPICS IN EARLY CHILDHOOD SPECIAL EDUC., Winter

over-stimulation of their children,[40] and learn proper discipline techniques.[41]

Supporting substance-abusing parents to meet the needs of their children requires an interagency approach that resolves the philosophical differences between family preservation and chemical dependency treatment. Substance-abuse workers might believe a child would be better off away from an abusing family. Substance-abuse counselors have often complained to this author that intervention by child welfare workers enables the parents' addiction and the family's co-dependency. Neighborhood-based interagency efforts can help create sober communities supportive of parenting in cases where the constant pressures of drugs and alcohol previously made family preservation impossible. With the proper services, families are able to recognize the degree to which their use of alcohol or drugs impairs the nurturing of their children.[42]

Services must be sufficiently intensive to ensure that children are safe. One program for crack-using parents significantly reduced safety risks for

1989, at 1, 4, 12, 16-17 (suggesting that child abuse intervention may be most effective when it fosters expression of parental responsiveness, and encourages understanding of proper parental expectations for child competence); Lise M. Youngblade & Jay Belsky, *Child Maltreatment, Infant-Parent Attachment Security, and Dysfunctional Peer Relationships in Toddlerhood*, TOPICS EARLY CHILDHOOD SPECIAL EDUC., Summer 1989, at 1, 1-15 (asserting that poor parent-child attachment resulting from maltreatment affects child-peer relationships); *see also* John W. Fantuzzo, Laura M. DePaola, Leslie Lambert, Tamara Martino, Genevie Anderson, & Sara Sutton, *Effects of Interparental Violence on the Psychological Adjustment and Competencies of Young Children*, 59 J. CONSULTING & CLINICAL PSYCHOL. 258, 264 (1991) (citing studies which suggest that family violence restricts development of empathetic and prosocial competencies in pre-school children); Carol Rodning, Leila Beckwith, & Judy Howard, *Quality of Attachment and Home Environments in Children Prenatally Exposed to PCP and Cocaine*, 3 DEV. & PSYCHOPATHOLOGY 351, 363 (1991) (finding that on-going drug use interferes with the parenting role and compromises a mother's relationship with her children, but that mothers who were able to change their lives formed caring parental relationships with their children).

40. Substance-abusing parents must also learn to provide a mid-range of stimulation. Insufficient stimulation has been linked to reduced cognitive skills in children while excessive stimulation may promote over-activity. Robert H. Bradley & Bettye M. Caldwell, *The Relation of Infants' Home Environment to Achievement Test Performance in First Grade: A Follow-up Study*, 55 CHILD DEV. 803, 807 (1984) (suggesting a correlation between children's exposure to mentally stimulating materials and experiences and their performance on mental and achievement tests).

41. Numerous studies have demonstrated that punitive discipline leads to uncooperative behavior in children; if substance-abusing parents act punitively, their children are more likely to be angry and noncompliant. Substance-abusing parents can be taught to distinguish their children's normal activities from misbehavior and to avoid attributing disobedience to the character of the children. *See* Leila Beckwith, *Adaptive and Maladaptive Parenting—Implications for Intervention*, *in* HANDBOOK OF EARLY CHILDHOOD INTERVENTION 53, 62-68 (Samuel J. Meisels & Jack P. Shonkoff eds., 1990) (citing studies concluding that children maltreated by their parents display aggression, frustration and a tendency to resist or avoid maternal attachment).

42. *See* Elizabeth M. Tracy & Kathleen J. Farkas, *Preparing Practitioners for Child Welfare Practice with Substance-Abusing Families*, 73 CHILD WELFARE 57, 57-58 (1994) (stressing the importance of combining child welfare and abuse treatment systems to ensure the child's well being and the parent's recovery).

children and improved their care by intensive (five to twenty hours weekly) in-home family services: 75% of the parents maintained sobriety for a twelve-month period after treatment.[43] Motivated to keep their children, substance-abusing parents who receive sufficient services to have their children safely at home are more likely to persevere in treatment programs.[44]

Home-based services for substance-abusing parents should include the following key components: in-home parenting support to meet their children's needs; in-home instruction on the consequences substance abuse has for parenting; consistent adult attention for the children, possibly from outside the family; assistance by a recovering person to reduce the abuser's isolation, offer sober friendship, and help her to become involved in community activities; stress management instruction; regular participation in AA and NA meetings; and day treatment, with a focus on parenting.[45] A strong web of services is required to protect children in a substance-abusing family. Two approaches are particularly successful. In one, parents who have lost their children as a result of substance abuse provide in-home and group support with clinical supervision. In the other, social service workers and substance abuse counselors work together to provide services with an in-home team approach.

The following multigenerational story reflects the troubling risks presented by substance abuse:

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43. *See* Mary Jiordano, *Intensive Family Preservation Services to Crack-Using Parents*, PREVENTION REP., Spring 1990, at 4, 4 (describing study and arguing that social workers can successfully treat crack-using parents and their families); Nora S. Gustavvson & Joan R. Rycraft, *The Multiple Service Needs of Drug Dependent Mothers*, 10 CHILD & ADOLESCENT SOC. WORK J. 141, 141-51 (1993) (discussing need for intensive services for drug-using mothers).

44. Jiordano, *supra* note 43, at 4.

45. For a full description of beneficial services, see the following publications: THE NATIONAL RESOURCE CTR. ON FAMILY BASED SERVICES, UNIV. OF IOWA, THE REGIONAL RESEARCH INST. FOR HUMAN SERVICES, FACTORS CONTRIBUTING TO SUCCESS AND FAILURE IN FAMILY-BASED CHILD WELFARE SERVICES (1988) (presenting the results of a two-year study which examined the relationship between services provided and the characteristics of the family to the outcome of the preplacement prevention plans); JUNE C. LLOYD, MARVIN E. BRYCE, & LAVONNE SCHULZE, THE NATIONAL RESOURCE CTR. ON FAMILY BASED SERVICES, UNIV. OF IOWA, PLACEMENT PREVENTION AND FAMILY REUNIFICATION: A HANDBOOK FOR THE FAMILY-CENTERED SERVICE PRACTITIONER (1984) (discussing in-home treatment techniques and providing case examples and information to assist in the formation of in-home plans of care); KRISTINE E. NELSON, MIRIAM J. LANDSMAN, & WENDY DEUTELBAUM, THE NATIONAL RESOURCE CTR. ON FAMILY BASED SERVICES, UNIV. OF IOWA, THREE MODELS OF FAMILY-CENTERED PLACEMENT PREVENTION SERVICES (1989) (presenting results of analysis of eleven family centered placement prevention programs and describing the characteristics of three distinct models which were identified: crisis intervention, home-based, and family treatment); *see also* Miriam Landsman, Kristine Nelson, Ed Saunders, & Margaret Tyler, *New Research: Chronic Neglect in Perspective*, PREVENTION REP., Fall 1990, at 6, 16 (suggesting a list of specific services such as aid in developing parenting skills, and counseling for stress management and issues of grief and loss, but stressing initiatives to ameliorate extreme poverty).

Ms. Brown,[46] age twenty-two, the daughter of an addict with a long history of neglecting her children, is the mother of eighteen-month-old Tyler and infant Rashida. Ms. Brown was living with Ms. Martin when Tyler was born. A health care worker visited Ms. Brown after Rashida tested positive for cocaine at birth.[47] Ms. Martin asked Ms. Brown to leave her home because of her cocaine addiction. Tyler remained and Ms. Martin, who is a nurse's aide, petitioned for and received custody. Ms. Brown recently took Rashida to visit Tyler at Ms. Martin's. Rashida had an infected diaper rash, but Ms. Brown reportedly had taken the baby to all her clinic appointments. Ms. Brown is currently living with her mother at a crack house and does not answer the door when the child welfare worker visits. Rashida needs:

- to be healthy
- to be safe from neglect and abuse
- to be developmentally on target

Ms. Brown has strengths and might be an adequate parent, but if she goes to residential drug treatment, she would be homeless on discharge. If Ms. Martin cares temporarily for Rashida, the baby will have regular contact with her mother and live with her brother. Ms. Brown might be motivated to change her lifestyle if she participates in Tyler's and Rashida's care at Ms. Martin's. However, Ms. Martin requires additional funds since, as a nonrelative, she cannot receive public assistance for Rashida's care. She also needs guidance in assisting Ms. Brown in meeting her children's needs without enabling her substance abuse.

Interagency in-home teams can ensure ongoing assessment of child safety in substance-abusing homes. In cases such as Ms. Brown's, relapses may require periodic intensive protection. It is important in case management to plan for relapses and not to abandon family preservation with the first or second relapse.[48] Visitation and reunification must be carefully planned to support the parent-child relationship and promote safety.

Assiduous safety monitoring, based on appropriate criteria for the child remaining in the home, is particularly important in substance-abusing families. In certain cases, the team may identify extended family members who are not substance abusers and who can ensure that the children's attachment and safety needs are met. However, if intensive intervention

46. *See supra* note 16.

47. For more on the special problems posed by infants born addicted to cocaine and other drugs, see Nora S. Gustavsson, *Chemically Exposed Children: The Child Welfare Response*, 8 CHILD & ADOLESCENT SOC. WORK J. 297, 297-307 (1991) (examining the recent research on consequences of maternal chemical use and suggesting strategies child welfare agencies can use to provide necessary services to these families).

48. Jiordano, *supra* note 44, at 4.

does not reduce the risk to the children, the team may recommend other permanent homes. Deciding when to place children elsewhere because of insuperable safety concerns, failed reunification, or less than minimally adequate care in the home can be a complex balancing act.

Designing family support to succeed means developing nonenabling in-home services for substance-abusing families that help them recognize specifically how drug or alcohol use interferes with meeting their children's needs. Children can be safely kept with and returned to their families if agencies provide strengths/needs-based services, typically for more than a year, with the possibility of increased intensity in order to protect the children in the event that family members relapse.

V.
SUCCESSFUL FAMILY REUNIFICATION

Reunification of children with families requires addressing both the reasons for removal and the angry feelings parents and children experience regarding their separation.[49] Children are often angry and scared after being removed. Parents may have mixed feelings. Although they did not

49. *See* VERA FAHLBERG, MICH. DEPT. OF SOCIAL SERVICES, ATTACHMENT AND SEPARATION 29-57 (1978) (discussing how to recognize and deal with attachment problems in children, and the difficulties children experience with incomplete attachment); DAVID FANSHEL & EUGENE B. SHINN, CHILDREN IN FOSTER CARE: A LONGITUDINAL INVESTIGATION 145-65 (1978) (analyzing implications of circumstances during reunification); Paul Carlo, *Parent Education vs. Parent Involvement: Which Type of Efforts Work Best to Reunify Families?*, 17 J. SOC. SERV. RES. 135, 135-50 (1993) (describing effectiveness of reunification planning); Edith Fein & Ilene Staff, *Last Best Chance: Findings from a Reunification Services Program*, 72 CHILD WELFARE 25, 25-40 (1993) (analyzing the results of a reunification program); Robert George, *The Reunification Process in Substitute Care*, 64 SOC. SERV. REV. 422, 422-57 (1990) (analyzing likelihood of reunification under varying circumstances); Peg McCartt Hess, Gail Falaron, & Ann Buschmann Jefferson, *Effectiveness of Family Reunification Services: An Innovative Evaluative Model*, 37 SOC. WORK 304, 304-11 (1992) (describing relevant factors in the reunification decision); Robert E. Lewis & Scott Callaghan, *The Peer Parent Project: Compensating Foster Parents to Facilitate Reunification of Children with Their Biological Parents*, 5 COMMUNITY ALTERNATIVES 46 (1993) (describing project); Martha Mailick Seltzer & Leonard M. Bloksberg, *Permanency Planning and Its Effects on Foster Children: A Review of the Literature*, 32 SOC. WORK 65, 65-68 (1987) (presenting quantitative evidence of efficacy of reunification and other placement alternatives); Anthony N. Maluccio & Edith Fein, *Growing Up in Foster Care*, 7 CHILDREN & YOUTH SERVICES REV. 123, 123-34 (1985) (reviewing successes in foster care programs); Michael Rutter, *Parent-Child Separation: Psychological Effects on the Children*, 12 J. CHILD PSYCHOL. & PSYCHIATRY 233, 233-60 (1971) (analyzing empirical data on psychological state of children who have been separated from their parents); Merlin A. Taber & Kathleen Proch, *Placement Stability for Adolescents in Foster Care: Findings From a Program Experiment*, 66 CHILD WELFARE 433, 433-45 (1987) (describing positive results of demonstration placement-planning and support from public agencies).

want to be separated from their child, they may dread the difficulties involved in meeting the child's needs.[50] This author has also observed that families who feel unfairly treated by the agency have trouble concentrating on their children's needs. The child's anger and need for nurturing and the parent's ambivalence get in the way of positive experiences during visits or in the early weeks after reunification. The lack of intensive services before, during, and after reunification results in a high rate of return to placement. However, agencies can insure post-reunification safety and stability through the provision of strengths/needs-based services.

Each child and family requires a different mix of services throughout the reunification process:

> First and foremost, workers must address the typically traumatic impact of loss and separation on the placed child as well as the parents and other family members. Second, for some families, contact between children and parents may have to be reestablished before family bonds can be strengthened. Third, the practitioner and family face different challenges in teaching and learning parenting skills when children are out of the home, as there may be fewer opportunities to observe and intervene in parent-child interactions; thus, family visits must be skillfully planned and implemented. Fourth, family reunification does not necessarily involve an immediate crisis, often a motivator for change, as there is when a family is threatened by the imminent removal of a child. In fact, the family may have achieved a certain equilibrium in the child's absence. Fifth, a family whose child has been placed may be perceived by themselves and others as a "failed" family; therefore, fostering hope and a belief in competence and the potential for success presents a greater challenge in work with families who have experienced placement than those who have not. And sixth, during placement a child may have formed a relationship with a caregiver, such as a foster parent, that will need to be recognized and dealt with by parent and child.[51]

50. *See* Peg M. Hess & Gail Folaron, *Ambivalences: A Challenge to Permanency for Children*, 70 CHILD WELFARE 403, 407 (1991) (reporting study that found parental ambivalence concerning reunification based on conflicting feelings about parenting, about a particular child, and/or about a child's return home).

51. Anthony N. Maluccio, Robin Warsh, & Barbara A. Pine, *Rethinking Family Reunification after Foster Care*, 5 COMMUNITY ALTERNATIVES 1, 3 (1993). *See generally* TOGETHER AGAIN: FAMILY REUNIFICATION IN FOSTER CARE (Barbara A. Pine, Robin Warsh, & Anthony N. Maluccio eds., 1993) (covering most aspects of family reunification after foster care).

A. Minimizing the Harms of Separation

1. Timely Provision of Services

Time spent in placement is a critical factor in successful reunification. The success of reunification for an elementary school age child decreases as the child remains in placement longer than six months.[52] A tragic situation that violates the intention of the Adoption Assistance and Child Welfare Act[53] occurs when young children are placed and the agency fails to give the family, child, and foster family adequate support for timely reunification. Even if the family reduces risk factors within a year or two, the child may not be returned home based on her attachment to foster parents, rather than risk of maltreatment.[54] After more than a year with one foster family, it may be impossible to predict which separation will have the more devastating outcome; the child may sustain enduring damage to her sense of self-worth and capacity to form relationships from the loss of both her birth family and foster family. Furthermore, infants who remain in foster care more than a year are at particular risk because of the developmental difficulty of changing homes around age two.[55]

Immediate reunification support is the best way to avoid these consequences. Reunification support should include intensive services to the birth family to reduce risk, visitation supports, and training for the foster parent to prevent disloyalty anxieties in the child[56]. Unfortunately, agencies often fail to begin providing services to the birth family, foster family, or child until months after removal, even where it is apparent at the time of removal which services the parties will require to meet their needs. Such bureaucratic slowness causes reunification to fail. Once removal has begun, the clock is running for the child; family, foster parents, workers, and service providers must move quickly on visitation and services to reduce risk.[57] To get reunification moving, families may require help to recognize

52. NORTH AM. COUNCIL ON ADOPTABLE CHILDREN, THE ADOPTION ASSISTANCE AND CHILD WELFARE ACT OF 1980: THE FIRST TEN YEARS (1990).

53. The Adoption Assistance Act sets certain time limits that were intended to reduce foster care drift by forcing child welfare agencies to decide on a permanent placement in a timely way. These time limits are based on studies that showed a drop-off in reunifications after eighteen months. For a discussion of the Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, 94 stat. 500 (1980), see part I.A., *supra*. *See also* HARDIN, *supra* note 15; NORTH AM. COUNCIL ON ADOPTABLE CHILDREN, *supra* note 53.

54. *See, e.g.*, Johnson, *supra* note 19, at 403-04 (describing courts' application of the psychological parent theory).

55. *See* PAUL D. STEINHAUER, THE LEAST DETRIMENTAL ALTERNATIVE: A SYSTEMATIC GUIDE TO CASE PLANNING AND DECISION MAKING FOR CHILDREN IN CARE 18 (1991) (addressing age as a factor in separation).

56. Maluccio, Warsh, & Pine, *supra* note 51, at 7-14.

57. Timely needs-based decisions about permanency are essential to avoid unnecessarily long stays in foster care. Timely must be defined developmentally: shorter for young children and somewhat longer as children grow older. Family and child must receive the necessary services immediately after placement. If a return home or placement with relatives cannot be made safe, workers must pursue other permanent homes. Children who are

how their child is likely to change in foster care. Although the parent's love for the child may remain unchanged, young children develop new attachments away from home.

The child's need for a stable, nurturing home and the child's need to maintain attachments to her biological family must both be met. The tendency to focus on only one of these needs often results in failed reunification and failed long-term permanence. Agencies must train foster parents to develop a healing relationship with the child without competing with the child's attachment to her family.

2. *The Role of Foster Families*

Foster care represents a support service to the family and not just substitute parenting for the child. Too often, foster parents have been recruited to save a child from bad parents.[58] This has obscured the importance of maintaining the child's ties to her family. Partnerships between birth and foster families through visiting, shared parenting, and informal contacts ensure maintenance of the family-child relationship while the child is in care and during reunification.

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less likely to be reunified should be placed at the time of removal in foster homes that have not ruled out adoption. Preadoptive homes allow children to form ties that do not have to be severed months or years later if adoption occurs. Preadoptive parents are taking a risk and must be supported, not only in forming an attachment to the child, but in participating, based on the needs of the child, in reunification efforts.

Adoption does not signal the end of a child's or adoptive family's needs. The lack of services for children and adoptive parents contributes heavily to the breakdown of adoptive homes. To ensure stability, adoptive placements require the same kinds of intensive services as are needed after reunification. Under the traditional view, adoption signals the end of biological family contact. This is unacceptable for many children who are not returning home, but have significant family relationships. A child's needs for a permanent home *and* for contact with individuals the child is attached to, but not planning to live with, can and should both be met through needs-based approaches to adoption and support for adoptive families.

Only limited information on the ability of older, adopted children to maintain their attachment to their biological families is available. The applicability of divorce literature, which has shown that children fare best with continued attachment to both parents (regardless of the custodial arrangement) to children placed outside of their families after abuse or neglect is unknown. *See* JUDITH S. WALLERSTEIN & JOAN B. KELLY, SURVIVING THE BREAKUP 307-13, 315-18 (1980) (concluding from five year study of children after divorce that contact with both parents helps children adjust); *see also* Rebecca L. Hegar, *Assessing Attachment, Permanence and Kinship in Choosing Permanent Homes*, 72 CHILD WELFARE 367, 368-71, 376-77 (1993) (illustrating the need of children to maintain ties to their siblings and biological parents); John E. Pouylin, *Kin Visiting and the Biological Attachment of Long-Term Foster Children*, 15 J. SOC. SERV. RES. 65, 65 (1992) (describing study noting the importance of the biological family's involvement with its children during and after placement).

58. *See* STEINHAUER, *supra* note 55, at 159 (stating that use of "bad" and "good" labels for the natural and foster parents hinders continued contact between the natural parents and the child, such contact being crucial for the welfare of the child).

Foster parents hold the key to successful reunification.[59] Involving foster parents in reunification planning as soon as the child is placed is essential. Foster parents need training to learn how to help the child cope with post-removal anger, loss, and ambivalence, particularly if the child acts out after visitation.[60]

Foster parents can develop hostility toward the birth parents, blaming the birth parents for abusing and abandoning the child. Often, the more the foster parents care for the child, the angrier they become. Visitation is the time when these feelings are strongest in the foster parents and when the child is most confused; the child needs the most help when the foster parents are least able to provide it. In addition, the child may blame the foster parents for slow progress toward return home. Not infrequently, deterioration in foster placements increases after visits. Foster parents need clinical support to respond to the child's feelings triggered by visits.

3. *The Importance of Visitation*

Visitation constitutes a crucial element of reunification. Arranging immediate and frequent visits for children, beginning in the first weeks after removal, appears to be the best way to ensure successful reunification.[61] Separation from families causes children of all ages to mourn. Foster parents, case workers, and therapists should help children with this mourning to reduce the harm of separation. They must make every effort to enable a child to see her family soon after separation, even if the child is reluctant. In the long run, keeping the child and her parents apart causes greater harm. Avoiding visitation due to worries that it will further traumatize the child encourages the child to avoid the feelings associated with separation and extends mourning and associated behaviors.[62]

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59. *See* Mark D. Simms & Barbara J. Bolden, *The Family Reunification Project: Facilitating Regular Contact Among Foster Children, Biological Families, and Foster Families*, 70 CHILD WELFARE 679, 680 (1991) (noting how foster parents lacking an appreciation of the importance of the biological parents in the child's life may frustrate and discourage visiting by the biological parents).

60. *See id.* at 132, 157 (stressing that foster parents can facilitate ultimate reunification of the child with her natural family by stressing their own temporary roles and by permitting appropriate mourning by the child).

61. *See* Peg McCartt Hess, Garth Mintun, Amy Moelhman, & Gayla Pitts, *The Family Connection Centers: An Innovative Visiting Program*, 71 CHILD WELFARE 77, 77-79 (1992) (reaffirming that frequent, regularly scheduled contact between children and the parents from whom they are separated has consistently been found to enhance the children's well-being).

62. *See* Steinhauer, *supra* note 19, at 69.

> Generally speaking, those children who do best in long-term foster care are those who remain secure in their foster homes but have continuing access to natural parents to whom they remain attached but on whom they cannot depend for the caring, consistency and guidance they need. Visits with the natural family should be used to make it possible for the child to maintain the continuity of important relationships; to remain in touch with—that is, to have stirred up, and therefore available to casework—the feelings and conflicts left unresolved since coming into

The following case illustrates the harm caused by withholding visitation.

> Ms. Chase[63] did not pick up her behavior-disordered seven-year-old son Mark from his special education program. Ms. Chase had feuded with the school for months because the school required her to leave work and pick Mark up when he acted out. Mark had become increasingly assaultive after being sexually abused by a neighbor the year before. Ms. Chase requested counseling for herself and her son and a new school placement. When these were not provided, she felt she could no longer handle Mark's behavior. Ms. Chase has many strengths: she is intelligent and loving and works hard in a low-paying job to provide for Mark. Ms. Chase sought therapy that focused on her anger (she came from an alcoholic family), poor relationships (she saw others as all good or all bad), and self-dislike and depression (she felt constantly victimized, especially by Mark's father who disappeared before his birth).
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> In foster care, Mark improved in a different school, and Ms. Chase wanted to learn how to manage him better at home. However, she was not permitted to have visitation or telephone contact with her son for six months because Mark's therapist believed Mark was too angry to face his mother. Provoked by Ms. Chase's demands to see her son, the angry caseworker communicated mixed signals that precipitated further conflict. As the battle with Ms. Chase escalated, the caseworker, foster parents, and child's therapist gave Mark the message that his mother was dangerous. Consequently, Mark avoided examining his anger at his mother for not protecting him from sexual abuse or abandonment by his father. He continued to be rejection-sensitive, easily frustrated, and belligerent until he and his mother were in counseling together.

Visitation for a frightened or angry child requires skilled clinical assessment of the multiple factors involved in the parent-child relationship and supportive supervision by the child's therapist. If the child does not want to visit, someone close to the child should listen to her reasons, discuss the long-term consequences of no family contact, and offer to have someone the child can trust present during the visit to protect the child

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care; to help the child see directly the reasons for coming into care. By stopping visits the relationship with the parents is not eliminated; this merely encourages the child to idealize and perpetuate in fantasy the absent parents rather than to seek solace in new relationships.

Id. at 98 n.13. *See also* STEINHAUER, *supra* note 55, at 143-57, 173-82 (demonstrating the need for the biological parents' involvement to promote healing).

63. *See supra* note 16.

from what is feared. Risk of recurrent maltreatment may be a reason for limiting visits, but in some of these situations careful supervision, combined with parent education, will make safe visitation possible and mitigate the harm caused by separation.

Visits help children talk about the feelings they have about coming into foster care, which increases the odds that they will make peace with their maltreatment. Workers and foster parents must use acting out that occurs before and after visitation therapeutically. Reducing the child's contact with the family does not stop the acting out; it only encourages the child to bury feelings about separation and to maintain unrealistic hopes. These reactions are the primary contributors to the continuing difficulty in forming trusting relationships seen in many children in foster care.

When foster parents are actively involved in visitation, reunification is more likely to be successful.[64] For instance, child-family contact usually occurs more frequently when caseworkers are not the primary arrangers and transporters for visits and visits take place either in the foster-family or birth-family home. Foster parents who are encouraged to provide support to the child's family can use visits as opportunities to support family members in meeting the child's needs. Nevertheless, the primary purpose of visits is not skill enhancement, but rather a necessary opportunity for the child and family to enjoy natural, uninterrupted time together by playing, eating, and talking.

As the next case demonstrates, children whose parents are incarcerated[65] need contact with their parents as much as children with more accessible families. This need can only be evaluated in the context of a particular child's attachment to her parent, which may require observation of parent and child together.

> Two years ago, Ms. Dalton[66] was sentenced to a jail term of four years for a substance abuse offense. Her nine-year-old daughter Juanita went to live with her father and her seven-year-old son Armand went to live with the children's maternal grandmother. Ms. Dalton's two-year-old son was placed in a foster home where he was joined by a sister born in jail. Six months later, his grandmother died suddenly, and Armand was sent to his own foster home. After a few visits at the jail which the caseworker described as unpleasant and logistically complicated, the goal of the younger three children was changed to adoption. Visits ceased and the siblings seldom saw each other.

64. *See supra* part V.A.2.

65. According to the Center for Children of Incarcerated Parents in Pasadena, California, there are nearly two million such children in the United States.

66. *See supra* note 16.

Armand misses his siblings, especially Juanita. Armand is attached both to his mother and to his foster family. Juanita, likewise, remains attached to her mother. Armand often talks about what it will be like when his mother is released. He imagines she would want her children back. Armand wants to continue to live with his foster mother and to visit his mother. If Ms. Dalton is able to remain drug-free and find a safer place to live, Armand says he would consider who to live with, but that he never wants to be cut off from either his mother or his foster mother. Armand remembers his mother's deterioration: "She was under a lot of stress going to work and raising three kids." In the neighborhood in which they were living, "drugs were just what people did," but Armand is angry at her for the way she treated her children. He says he would like to hear Ms. Dalton say that she is sorry and that she feels responsible and sad for having messed up their lives.

Although the loss of their relationship with their mother may make adoption a reasonable permanency goal for the two younger children, lack of visitation and termination of parental rights should not be imposed on Armand or Juanita, who are attached to their mother. Juanita and Armand must be involved with adults who recognize that their mother continues to be a lifeline whether or not they ever live with her again. Juanita and Armand need to visit regularly with their mother, both because the attachment is so important to them and to make peace with her maltreatment of them. This is a need that is separate from, but equally important to, their need for permanency. At the end of each visit, the children should have time with their therapist to talk about their feelings. Their therapist should keep Juanita's father and Armand's foster mother informed about the likely emotional reactions to the visits, with suggestions for how they could respond without undermining the children's growth or their relationship with their mother.

If a child is attached to an incarcerated parent, visits are essential. The frequency of visits should be determined developmentally, despite the inconvenience of visits in jail or prison. Unfortunately, prison visiting rooms rarely offer toys or privacy for inmates and their children. In order to achieve respect for the attachments of large numbers of children with incarcerated parents, communities will have to orchestrate family preservation discussions between correctional and child welfare staff.[67]

67. Regarding the benefits of visitation to incarcerated parents and the lack of harm to the child from visits behind bars, see DENISE JOHNSTON, *Parent-Child Visitation Rights in the Jail or Prison*, *in* CHILDREN OF INCARCERATED PARENTS 135, 141-42 (Katherine Label & Denise Johnston eds., 1995). In California, the state with the largest prison population in

B. Enabling Reunification to Succeed

Reunification requires respect for the feelings of children. As they develop maturity, children can become partners in decision making about how their needs can best be met. Their views about whom to live with, the circumstances of visitation, and how they feel about contact with abusive parents are matters for sensitive attention. Children may not share the worker's or clinician's larger picture of their needs, but children's views, whatever they may be, must not be ignored. Unexplained decisions ostensibly made on behalf of the child may backfire if the child feels she must protect a parent or be in control of the process herself. Workers must help the child to clarify her needs. They must share adult perspectives, where they differ from the child's view, in ways the child can understand and will find helpful. Specifically, workers must inform the child, in developmentally appropriate ways, about the planned steps and timetable for return home, about reunification expectations, and about any necessary alterations. The foster parents and therapist should give the child the same message. For example, if a child's family does not take necessary steps toward reunification, informing the child without being critical of the family and helping her understand the family's behavior is important.

Practitioners should avoid the common trap of requiring a nicer home and superior parenting skills for reunification than the standards that would have governed safely keeping the child at home to begin with. Therefore, the concept of minimally adequate homes should guide reunification.[68] For a child to return home safely, the family must understand the child's needs and demonstrate how the family can meet those needs. Workers can use extended family and community supports and services to insure the parent's consistency in meeting the child's needs and to address the risks that led to removal.

It is essential that workers offer parents a clear picture about reunification expectations. As a first step, workers must reach agreement with families on their children's needs and what is required to meet those needs. As described in the following examples, families require support services as they adjust to the responsibilities of caring for a child full-time during the first critical weeks after return.

> Titus[69] is thirteen years old and has been in a shelter for four months. His family members are mentally limited and have severe speech impediments; Titus is the only family member without these handicaps. Since his parents separated when he was nine, he has been out of his mother's control. On his thirteenth

the United States, Centerforce, an organization based in San Quentin, operates visiting centers and facilitates visitation of children with incarcerated parents. *Id.* at 139.

68. *See supra* part III.

69. *See supra* note 16.

birthday, marked changes in his behavior were evident. He declared his independence, moved into an abandoned car, and began to work as a lookout for drug dealers. He fought, threatened shelter staff, and ran away. Titus's strengths include: his intelligence, his friendships, and his enjoyment of activities. Titus needs:

- to learn how to handle frustration
- to learn how to respond to pressure without running away from home or school
- to be nurtured by a reliable adult
- to use his intelligence and feel successful

The worker found a therapeutic foster home for Titus. However, in a meeting with his parents to discuss Titus's needs, they said they were willing to get back together, find housing in a different neighborhood, and cooperate if services could be provided to them in their home. More discussion with Titus revealed that workers had overlooked his attachment to his parents. For this reunification to be successful, Titus' parents needed considerable support and instruction in helping Titus manage his behavior.[70] In addition, Titus required a coach to help him learn to regulate his own behavior and to involve him in productive activities. Titus and his parents needed supported opportunities to discuss their readjustment to each other and to learn to enjoy family time together. A provider was hired to meet Titus's and his family's needs through fifteen hours of reunification services weekly, including daily individual coaching, self-regulation instruction, parent support, and home-based family counseling.

70. Subnormal intelligence does not necessarily incapacitate parents, although there is evidence linking the cognitive and emotional deficits of mentally challenged parents with child maltreatment. Research has demonstrated the effectiveness of teaching developmentally disabled parents appropriate parenting responses for common problematic situations. Parenting instruction must be specifically designed for individuals with low intelligence. Preschool enrollment, to ensure that the children receive adequate cognitive stimulation, is often a necessary service in such families. *See* Karen S. Budd & Stephan Greenspan, *Mentally Retarded Mothers, in* BEHAVIOR MODIFICATION WITH WOMEN 477, 482 (Elain A. Blechman ed., 1984) (discussing techniques for improving the parenting skills of mentally challenged mothers and the effects of these techniques on the children); Lucy S. Crain & Georgia K. Millor, *Forgotten Children: Maltreated Children of Mentally Retarded Parents*, 61 PEDIATRICS 130, 130-32 (1978) (providing a case study of child abuse in a family headed by mentally challenged parents and emphasizing the need for services to increase awareness of potential abuse); John W. Fantuzzo, Laura Wray, Robert Hall, Cynthia Goins & Sandra Azar, *Parent and Social-Skills Training for Mentally Retarded Mothers Identified as Child Maltreaters*, 91 AM. J. MENTAL DEFICIENCY 135, 135-40 (1986) (finding that parenting training for mentally challenged mothers improves treatment by these mothers of their children); Lillian H. Robinson, *Parental Attitudes of Retarded Young Mothers*, 8 CHILD PSYCHIATRY & HUM. DEV. 131, 131-44 (1978) (finding that mentally challenged mothers are overly protective of children, but that the mothers can learn proper parenting skills through better programming).

Lucy[71] had colic and, starting at birth, she cried much of every day. Her nineteen-year-old mother and twenty-two-year-old father became increasingly frustrated with their inability to console Lucy. They had no family support and very limited income. The mother called for agency assistance after the father lost his temper. The worker, fearing shaken baby syndrome,[72] removed three-month-old Lucy and set up services. An in-home parenting skills teacher geared her coaching to teach the mother and father about the baby's needs and how to manage their own frustration. Lucy's father participated in a family violence program and learned to walk away before losing his temper. He secured employment and Lucy's mother completed a GED program. Regular visitation increased to weekend visits, with the foster mother providing in-home parenting instruction during the visits. The parents were able to articulate Lucy's needs:

- to be protected from being shaken, hit, or screamed at
- to meet developmental milestones
- to be cuddled and talked to
- to be healthy

The parents learned to recognize the danger of shaking or hitting Lucy and to control their tempers. They also learned about child development stages, Lucy's daily routine, and Lucy's medical needs. The foster mother indicated that Lucy had outgrown her colic but remained an easily frustrated baby. The worker planned a gradual return home, with continued support for the parents after return. The worker arranged payment for as-needed parent support and respite services from the foster mother, who behaved as an extended family member—supportive and available when needed.

Intensive reunification services began soon after Titus and Lucy were placed, which reduced the losses endured by the children and utilized the removal as a crisis for mobilizing the family to protect the children. The most difficult reunification challenges occur when children are in care for long periods, experience depression and anger because of their separation (often aggravated by multiple placements), and develop attachments to their foster families. The birth families do not know what they must do to get their children returned. They often act out their frustrations against

71. *See supra* note 16.

72. *See* Deborah Coody, Mary Brown, Dione Montgomery, Abbie Flynn & Robert Yetman, *Shaken Baby Syndrome: Identification and Prevention for Nurse Practitioners*, J. PEDIATRIC HEALTH CARE, Mar.-Apr. 1994, at 50, 50 (defining shaken baby syndrome as a form of physical child abuse where an infant is held by the extremities or shoulders and vigorously shaken, resulting in intracranial and intraocular bleeding without any outwardly apparent indication of head trauma).

what they perceive as an unresponsive system in counterproductive ways. Observe the following case.

> Niya,[73] six years old, was placed in foster care four years ago after being left alone with her eleven and ten year old siblings in a homeless shelter. Niya's mother was a substance abuser and her father had been incarcerated for burglaries (through which he had supported the family after he was injured in his construction job). For more than two years, the goal for the children was reunification while their mother underwent drug treatment. Their father requested visits with the children at the jail and was denied. Niya had three foster home placements and little contact with her siblings or her mother. When Niya's mother was incarcerated for buying drugs, the court ordered the agency to move toward adoption.
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> Niya's father began visiting her within a few weeks of being released on parole. The oldest child had meanwhile been placed with a cousin and wanted to spend weekends with his father, while the middle child did not want to see her parents and planned to go ahead with adoption by her foster parents. The agency permitted only the monthly supervised visits that Niya and her father enjoyed. Meanwhile, Niya made preplacement visits in another adoptive home that did not work out. The adoptive parents "could not cope with Niya's bond to her birth father and her unwillingness to call her adoptive father 'Daddy.'"[74] Her father and grandmother requested that Niya live with them, but the agency was troubled by the father's long hours as a carpenter. When the agency criticized him for coming to visits smelling of alcohol, he became angry and said he was just a beer drinker and had consistent work performance since he was released from jail.
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> The mother's parental rights were terminated and the father agreed to the middle child's adoption, but after eighteen months of monthly visits with Niya, her father and grandmother wanted unsupervised visits. The court, however, was pushing for permanency, and the agency argued that the father's refusal to get into

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73. *See supra* note 16.

74. According to Dr. Steinhauer,

> Adoptions involving a child who continues to retain a strong emotional tie to members of the birth family or to a foster family are vulnerable to adoption breakdown unless the existing attachment is not merely tolerated but actively protected. . . . [F]orced separation is likely to favor retention and idealization in fantasy of the lost attachment figure, thus interfering with the child's ability to attach successfully to competing adoptive parents.

STEINHAUER, *supra* note 55, at 350; *see also* Victor Groze & Anne Gruenewald, *Partners: A Model Program for Special-Needs Adoptive Families in Stress*, 70 CHILD WELFARE 581, 582-83 (1991) (arguing for lifelong educational support and therapeutic services to improve the capability of adoptive families to succeed with special needs children).

alcohol treatment meant that he had "done nothing to achieve reunification." Niya was being raised as a middle-class child and the worker believed she would experience school failure and have a lower standard of living with her father.

Although angry and difficult with the caseworker, Niya's father possesses many strengths: he is loving and gentle with Niya; reads, plays, and engages with her in conversation at her own level; compliments her intelligence, manners, and appearance; and appreciates her good relationship with her foster mother. He is hardworking and articulate, and obviously pained when Niya asks him at every visit when she can spend the weekend with him and her grandmother. Instead of being forced into an all-or-nothing permanency decision, the agency had to reassess Niya's needs, which were:

- To have her security in her foster home undisturbed
- To have her attachment to her father unthreatened
- To continue her success in school
- To make peace with her father's long absence, her mother's abandonment, and the loss of her siblings

The caseworker gradually increased the time that Niya could spend with her father and grandmother. The agency provided in-home support during these visits, as well as instruction for her foster mother, father, and grandmother on how to respond to Niya's emotional needs. After Niya's father was allowed to work with a new caseworker, he agreed to seeing an alcohol counselor and suggested that he and his mother move into the foster mother's school district to make it possible for Niya to live happily in two families as long as necessary to meet her needs. The agency agreed to pay for in-home reunification services and to set up a special contract with the foster mother to allow her to continue essentially as an extended family member as needed by Niya. Taking these steps required the court, the agency, the foster family, and the biological family to change their fixed positions and design steps to meet Niya's specific needs.

Successful reunification is possible when agencies start services at the time of removal and address both the risks causing removal and the child's and family members' feelings about separation. If case workers recognize the child's multiple attachments and emotional needs resulting from losses and match them with sufficiently intensive services, agencies can help families overcome a history of struggle against the agency and reunification can succeed even after a long placement. Each family will require its own unique combination of needs-based services before, during, and after reunification to ensure safety and stability.

CONCLUSION

Most families can meet their children's safety and attachment needs. Pro-family strengths/needs-based services capitalize on family strengths, preserve the children's attachments to their families, and address needs that, if unmet, put children at risk. Agencies can successfully design family support if they craft services with families, use the concept of minimally adequate homes to guide those implementing services, tailor services to meet individual needs, particularly those of substance-abusing families, and provide reunification services that address the risks causing removal and children's and parents' feelings about separation. While too little assistance provided too late puts children at risk, support services designed to succeed would enable most families to protect and meet the needs of their children.