Best Practices for Visitation and Family Time

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“Regular, frequent family time increases the likelihood of successful reunification, reduces time in care, promotes healthy attachment, and reduces the negative effects of separation.”

– Susan Dougherty

- The first visit should occur within **48 hours** of placement.
- **Daily** contact for infants and toddlers ages 0-3
- Two to three visits per week for school aged children
- Youth should be involved in the visitation plan with regular contact.
- Consider other forms of contact such as email, phone, texting, Skype, letters
Senate Bill 352

For children 3 and under (TMC, reunification goal)

• Visitation no later than the 3rd day
• File a visitation plan that includes at least 2 visits weekly
• Create visitation plan
  – Outlines steps to allow more visits
• Supervision for health and safety of the child
The System’s Perspective

Families receiving minimum of once a week visits

• Children will be happier, less stressed and better adjusted
• Parents will likely be more cooperative
• Placement will have less problems with children
• Service providers will be able to effectively assess and intervene in areas of need
• Reunification more likely to occur
• Less money spent on long-term foster care placement

Families receiving only one visit per month or less

• More behavior problems in placement
• More dysregulation in child
• More opposition from parents
• Services that may not address real needs of the family
• Case remains open longer
• Child more likely to become ward of the state
The Parent’s Perspective

Parents receiving recommended family time

- Maintain the bond with their children
- Have a sense of hope
- Are more likely to actively engage in services
- Can frequently practice new parenting skills
- Are 10 times more likely to be reunited with their children

Parents receiving infrequent or irregular family time

- Physiological changes in parent result in depression
- Feel hopeless or give up
- Likely to resist services or sabotage visits to protect self from pain
- Relationship with children becomes more strained and ability to parent diminishes through no fault of the parent
The Child’s Perspective

Children receiving recommended family time
- Maintain relationship with parents
- Know parents are okay
- Have less behavioral and emotional symptoms
- Have an easier adjustment to placement
- Are ten times more likely to be reunified with their parents

Children receiving infrequent or irregular family time
- Feel abandoned by parents
- Have increased stress response and cortisol levels
- Have increased depression and behavioral disturbances
- Twice as likely to be in care over a year
Written Visitation Plan

- The content of the collaborative visitation plan includes:
  - Persons who can visit a child or who can be present during visits, such as parents, siblings, grandparents, other relatives/kin
  - Frequency of visitation
  - Arrangements for monitoring or supervision of visits
  - Locations of visits
  - Transportation arrangements
  - Date the plan will be reviewed
  - Consider alternative communication (email, Skype, calls, mail, texts, etc.)
  - Concrete expectations

Source: Minnesota Child and Family Visitation Guide, p. 10-17
Where should visits occur?

• In a familiar environment if possible
• In a home-like environment
• Predictable/consistent location at first
• In an organized but flexible environment
  – Not too over stimulating, Adjustable lighting, Comfortable places to cuddle, Toys that can facilitate healing
• Visits should occur at the CPS office only in cases where safety is a primary concern
Visitation Guidelines

• Where to start?
  – Deciding level of supervision
    • Use risk assessment
  – Moving through the phases of visitation
    • Beginning, Intermediate, Transition

Not used as reward or punishment

Visitation and family contact should never be used as a reward or punishment, but should always be considered a right of families and children. Increased or reduced visitation should be related to an assessment of safety, and not linked to other measurements. (Hess & Prosch, 1988)
Levels of Supervision

**Strict Supervision**: highly structured visit in secure location with stated conditions for the visit, supervisor maintains close watch to ensure safety

**Moderate Supervision**: home or community locations, supervisor works on parent education and coaching and addresses safety concerns

**Relaxed Supervision**: Parent has some time alone with child, continue to work on skills, allows parent to assume caregiving tasks

**Unsupervised**: No safety concerns, parent determines location, leading to overnight visits and reunification

Refer to Minnesota Visitation Guide p. 6 for example assessment
Phases of Visitation

1. Beginning Phase
   • Assess relationship strengths, needs, and safety risks
   • Build rapport among family, placement, caseworker and providers
   • Model appropriate parenting skills
   • Determine appropriate interventions and level of supervision

2. Intermediate Phase
   • Parents learn and practice new skills
   • Continued assessment of parenting skills or safety concerns
   • Enhance the relationship
   • Increase capacity to provide routine care both in and out of the home
Phases of Visitation

3. Transition Phase: Two Paths

Towards Reunification

• Collaboration among caseworker, service providers, parents and placement
• Supports smooth and stable reunification
• Includes other significant figures such as extended family or siblings

Change in Parental Rights

• Plan for ongoing contact or termination of contact (Goodbye visit)
• Use visits to heal past hurts
• Build new positive memories of parent, create family book
• Support child’s transition
• Maintain familial, cultural and community connections
Determining Phases

• Changes to consider as a family goes through the phases:
  – Reduction of safety concerns?
  – Improved Parent/Child Relationship?
  – Increased protective capacity?
  – Service compliance?
    • As it affects level of supervision, not # of visits

• When to limit Family Time
  – After giving the opportunity to make repairs with coaching, therapy, and practice.
  – When concerns that have been addressed are not changing (abusive language, rough physical touch-yanking, grabbing, pulling, etc.)
  – Changes in visitation should be directly related to ongoing safety concerns or if assessment finds that visits would endanger the child’s physical or emotional well-being.
Barriers and Solutions

• #1 & #2 on Survey-Caseload Size and Turnover
  – Reevaluate removal necessity
  – Support Caseworkers
    • Appreciation Day, Training, Enrichment Activities, Stress Management Interventions, Incentives
  – Mental Health Professional Mentors
    • Guide through visit supervision assessment
  – Look to another agency, non-profit, University, Supervision Center, or volunteers for Visit Facilitators
Barriers and Solutions

• #3 Transportation
  – Review Visit Assessment for possible reduced supervision
  – Include all parties in written Visitation Plan
    • Encourage participation
  – Place children closer to parents
  – Allow visits at creative locations
  – Consider weekend visits and weekend transporters
Barriers and Solutions

• #4 & #5 Visitation Policy and Practice
  – Create clear policies that are widely distributed
  – Implement collaborative Written Visitation Plan
  – Step-down supervision based on safety risk
  – Parent Feedback Survey/Continue Parent Collaboration Meetings
  – Flexibility in Childcare Funding (PT vs. FT)
  – Revisit CPS/Felony Background history limits
    • May offer alternative family members or fictive kin options
Barriers and Solutions

- Emotionally Disturbed Children
  - Parent Education/Coaching
    - Parenting Classes not as effective
      - Not standardized, not all evidence based
    - Visit Debriefing
  - Filial Therapy
  - Child/Parent Psychotherapy
  - Child in Play Therapy with parent involved
  - Transportation Creativity
  - Creating Peer Support
  - Family Mentor
  - Use specialist appointments for added visit time and increased parental engagement
Barriers and Solutions

• Training and Continuing Education
  – Implement appropriate training for caseworkers, foster parents, kinship placements, parents, legal professionals and service providers
    • Make resources that can be used universally
      – Videos, workshops, lunch-n-learns, trainings
    • One-on-one consultations
    • Group processing/Support groups
Barriers and Solutions

• Lack of preparation for visits
  – **Parents**: Receive education about feelings and behaviors to expect during a visit and how to address them. Have clear expectations of what they need to do to prepare for visits.
  
  – **Placement**: Provide uniform training across child placement agencies. Placement should be supportive of parent-child relationship, prepare child before and process after visits and know what behaviors to expect and how to address them
  
  – **Children**: Need to know when visits will occur and what will happen. They need to be reminded and have a chance to process afterwards
Considerations for Special Populations

- Incarcerated Parents
- Substance Abusers
- Perpetrators of sexual abuse or severe physical abuse
- Parents with cognitive disabilities
- Extended family and large sibling groups
Incarcerated Parents

• Parent experiences increased depression without child contact

• Child feels increased anger and sense of abandonment without contact
  – Confusion about jail, is parent “bad?”, still love/need them

• Phone calls can increase positive responses from parents and children

• Visitation options should be explored
Substance Abusers

• Visits should NEVER be a reward or punishment for staying clean/relapse/slip or completing services (Cases with positive UA/hair follicle)

• Include conditions of the visit should a parent arrive intoxicated at the time of the visit. This should be discussed at the development of the visitation plan and before each visit when a parent is suspected to be intoxicated.

• Be creative about visits in detox and rehab
Perpetrators of Abuse

(in cases of severe physical or sexual abuse)

• Early and frequent visits are contraindicated
• The victim, perpetrator, and family members should be fully engaged in therapy
• Both victim and perpetrator should show signs of readiness before visitation begins
  – Take responsibility for the abuse, show empathy for victim, identify risk factors and coping skills
  – Resolve PTSD symptoms, articulate thoughts and feelings, desires to see abuser, feels safe
• Visits should initially occur in a structured therapeutic environment
Cognitively Disabled

• Modifications of services will be necessary to account for parents’ limitations
• Workers should empower parents to the extent possible and include parent in planning
• Home visitation and one on one intervention will be required as opposed to group classes
• Consider the role of community services, advocacy groups, government services, family and peer support
Siblings and Extended Family

• Maintain connections to important people such as grandparent and extended family

• Large sibling groups
  – One-on-one time
  – Split visits
  – Overlap mid-visit

• Sibling visits outside of parent visits
  – Consider children not involved in the case
References

American Academy of Pediatrics Committee on Early Childhood, Adoption and Dependent Care, 2000, 1148.


Gottman, J., (1997), Raising an Emotionally Intelligent Child: The Heart of Parenting


Key Considerations for Reunifying Adult Sex Offenders and Their Families, Center for Sex Offender Management, A Project of the U.S. Department of Justice, December 2005


