Out of Home Placement
Native American Children’s Safety Act, 2016
Native American Children's Safety Act

Amends the Indian Child Protection and Family Violence Prevention Act to prohibit the final approval of any foster care placement or a foster care license from being issued until the tribal social services agency: (1) completes a criminal records check of each covered individual who resides in the household or is employed at the institution in which the foster care placement will be made, and (2) concludes that each of those individuals meets the tribe's standards established pursuant to this Act. Defines a "covered individual" as an adult and any other individual the tribe determines is subject to a criminal records check.

Requires the Tribe's standards to include requirements that each tribal social services agency: (1) perform criminal records checks, including fingerprint-based checks of national crime information databases; (2) check any abuse registries maintained by the Indian tribe; (3) check any child abuse and neglect registry maintained by the state, and any tribal abuse registries maintained in the state, in which the individual resides; (4) request any other state in which the individual resided during the preceding five years to enable the agency to check its registry; and (5) any other additional requirements that the Indian tribe determines is necessary and permissible within its existing authority, such as the creation of voluntary agreements with state entities in order to facilitate the sharing of information related to the performance of criminal records checks.

Prohibits a foster care placement from being ordered if the investigation reveals that a covered individual has been found guilty by a federal, state, or tribal court of a felony involving child abuse or neglect, spousal abuse, a crime against a child, violence, or drugs.

Exempts emergency foster care placements from such requirements.

Requires Indian tribes to establish procedures to recertify homes or institutions in which foster care placements are made.

Directs the Department of the Interior to issue guidance regarding: (1) procedures for a criminal records check of any covered individual who resides in the home or is employed at the institution in which the child is placed after the investigations that preceded that placement occurred, (2) self-reporting requirements for foster care homes or institutions that have knowledge that a covered individual residing on their premises would fail a criminal records check, (3) promising practices used by Indian tribes to address emergency foster care placements, and (4) procedures for certifying compliance with the Indian Child Protection and Family Violence Prevention Act.
Child Abuse Prevention and Treatment Act - Reauthorized 2010
The CAPTA Reauthorization Act of 2010: What Advocates Should Know

By Howard Davidson – January 3, 2011

On December 20, 2010, President Obama signed Public Law 111-320, a five-year reauthorization of the federal Child Abuse Prevention and Treatment Act (CAPTA). CAPTA is an important source of funding for child welfare agencies and a source of funding for some innovative dependency court programs. Last reauthorized in 2003, CAPTA has for 36 years influenced law, policy, and practice changes in state and county child protective services (CPS), particularly through its state grant eligibility requirements. Child welfare system advocates should be aware of several key aspects of the CAPTA Reauthorization Act of 2010.

No Major Changes in Attorney/GAL Requirement

The ABA and several other organizations, notably First Star, the National Association of Counsel for Children, and the National Child Abuse Coalition, unsuccessfully sought four significant changes in CAPTA’s requirement that a court-appointed lawyer, guardian ad litem, or court-appointed special advocate be appointed in court for every child in a child protective (dependency) case. Amendments were sought to enhance child legal representation in these proceedings in several ways. However, none were included in the final act, principally due to bill sponsors’ concerns about state and local costs of implementation.

Those changes, had they been accepted by the bill sponsors, would have required that:

- Every child involved in a court case be appointed an attorney, something CAPTA, since its original 1974 enactment, has never mandated;
- This appointed attorney be designated “legal counsel” for the child, with his or her representation strictly following the Model Rules of Professional Conduct. To clarify this further, we urged removing a 2003 CAPTA amendment about the child’s representative having to “make recommendations concerning the best interests of the child” language—and substituting for it “advocate in court on behalf of the child”;
- The appointed attorney have “adequate time and resources” to properly handle each case, defined as not having an “excessive” caseload and receiving “reasonable and appropriate compensation”; and
- This attorney appointment continue as long as the court maintained its jurisdiction over the case, including all periods of foster care or other residential placement, as well as the process of the child’s transition to adult independence” (in effect, to assure each youth has an attorney until they turn 21, if necessary).

We viewed the last provision as important in light of the 2008 Fostering Connections Act provision of federal financial support for youth ages 18, 19, and 20 that presumes dependency court cases stay open to monitor compliance of child welfare agency responsibilities and to hold periodic timely hearings mandated by federal law; since the inception of CAPTA, it has had an age 18 cutoff for all of its protections.

There was, however, one addition to the act’s provisions on representation of children in court. This added language to the mandate that every child’s court-appointed representatives have “training appropriate to the role” (that language had been inserted into CAPTA during its last reauthorization in 2003). Since then, there had been no formal specification by the
Children’s Bureau of the U.S. Department of Health and Human Services (HHS) as to what comprises “appropriate training.” In the new act, “training in early childhood, child, and adolescent development” is specified for the first time. The act also added this same language in a section on the acceptable areas of caseworker training that is conducted using CAPTA state grant funding.

**Newborns with Fetal Alcohol Spectrum Disorder**

A new CAPTA state grant eligibility requirement modifies earlier CAPTA language that mandates identifying and making “appropriate referrals” by healthcare providers to CPS—and developing service “plans for safe care” of the child—of newborns affected by prenatal drug exposure. Added as a new category of “referral” and “safe care plan” requirements is a population of infants potentially far larger than those suffering from drug exposure: newborns diagnosed with a fetal alcohol spectrum disorder (FASD). The FASD term is newer and connotes a broader group than those encompassed by the older term fetal alcohol syndrome (FAS). Several advocates had urged sponsors of the act to use the term prenatal alcohol exposure (PAE) instead of FASD, as the FASD diagnosis is considered difficult to make upon the birth of a child. But there were concerns that PAE was too expansive and would subject far too many new mothers who had used alcohol during pregnancy to inappropriate interventions, and thus the FASD term was used.

FASD is now used by advocates, educators, federal agencies, and the medical and legal communities as an umbrella term to cover a range of outcomes associated with all levels of a child’s prenatal alcohol exposure. This CAPTA amendment was not meant to cover all situations where a newborn’s mother drinks alcohol during her pregnancy, but rather those where a newborn has facial characteristics, growth restriction, or other abnormalities (birth defects) caused by prenatal alcohol use. FASD children typically struggle in school due to decreased cognitive functioning, developmental delays, and resulting behavioral problems. Sokol, Delaney-Black, and Nordstrom. “Fetal Alcohol Spectrum Disorder.” *Journal of the American Medical Association* 290(22), December 10, 2003, 2996.

It is estimated that FASD is five times more likely among African-American than among white children, and 16 times more likely for American Indian/Alaskan Native children. *Id.*, 2998.

This new CAPTA provision (and the earlier requirement regarding drug-exposed newborns) is not intended to have states make prenatal alcohol or drug exposure a category of child abuse or neglect or to make those children subjects of mandatory reporting laws. Congress carefully chose the word “referral” to avoid that. Rather, the goal is to address the safety and well-being of these children.

Bottom line: Expect to see more newborns referred to CPS for prenatal drug and alcohol exposure. Intervening early through safety plans that promote the health and well-being of these children will be key.

**No Reunification Required for Parents Committing Child Sex Offenses**

States receiving CAPTA state grant funding have long been expected to explicitly not require reunification of a child with a parent when a criminal court finds the parent is responsible for or abetted another child’s death or when a parent’s felony assault caused a serious bodily injury to one of their children. It is unclear why this requirement was originally placed in CAPTA and not Title IV-E. The new act adds two provisions. First, no reunification is required if a parent commits sexual abuse against the child or another child of the parent. Second, no reunification is required if the parent must register with a sex offender registry under the 2006 Adam Walsh Child Protection and Safety Act.

Bottom line: It will now be more likely that states will bypass reunification efforts and proceed to alternative permanency planning when a parent has sexually abused a child.

**Criminal Record and Child Abuse/Neglect Registry Checks**

CAPTA has a separate mandatory “background check” requirement from that found in Title IV-E. The new act cites the IV-E requirement, at 42 USC 671(a)(20), as the criteria for making these mandatory record checks. But CAPTA’s provision remains broader than the IV-E provision in one important way: It mandates criminal record checks for “other adult relatives and non-relatives residing in the household” of prospective foster and adoptive parents. Unlike CAPTA, 671(a)(20) does not require criminal record checks on these other adults in the home, yet it does require checking child abuse/neglect registries on “any other adult living in the home” as well as for criminal record checks on those adults “living in the home of [any prospective] relative guardian” before federal kinship guardian assistance can be provided.

Bottom line: If other adults live in the home of prospective foster or adoptive parents, efforts should be made to ensure criminal record checks are conducted on those adults before a placement is made or federal kinship guardian assistance is provided.
CPS Technology to Better Track Cases
The act now requires that every state have “systems of technology” that support CPS’s ability to “track reports of child abuse and neglect from intake through final disposition.” It is not clear how this new eligibility requirement will be implemented or how it might differ from what most states already do through their federally supported Statewide Automated Child Welfare Information Systems (SACWIS). According to HHS, support for state SACWIS developmental project costs already exceed $2.3 billion (note, in comparison, that CAPTA state grant funding is now only about $26.5 million/year). However, there are states that still do not have a SACWIS or one in development. There is also no language in the act on how this tracking might be integrated with case-tracking technology used by dependency courts and funded partly through the federal Court Improvement Program (42 U.S.C. 629f).

Bottom line: This requirement is likely to play out differently in each state and will require greater clarification on the specific requirements of the technology systems and their integration with other case tracking systems.

Child Welfare Agency Data
Each year, HHS publishes a Child Maltreatment report that includes data collected from states voluntarily using the National Child Abuse and Neglect Data System (NCANDS). Most CAPTA reauthorizations have added elements for states to submit data on “to the maximum extent practicable.” The new act asks states to provide HHS data on the number of CPS personnel responsible for intake, screening, assessment of reports (i.e., as part of differential response), and for investigation of reports, and the average caseloads for each and their state’s caseload or workload maximum limits. States are also asked to provide information on CPS staff qualifications, education, training, and demographic characteristics. Finally, the act asks states to provide the number of children annually referred to CPS due to newborn drug exposure or FASD diagnosis. States must also give the annual number of children substantiated as abused or neglected, under age three, who, pursuant to CAPTA, are eligible for referral and actually referred, for early intervention services under Part C of the Individuals with Disabilities Education Act.

Bottom line: Expect to see enhancements in statewide data collection so that new statistical information is available on CPS staff individual workloads and training, number of referrals to CPS of newborns with drug exposure or FASD, and number of infants/toddlers who, after identification as a child maltreatment victim, receive IDEA Part C services.

Promoting Family Involvement, Collaboration, and Use of Differential Response
The act’s sponsors meant to feature three important themes of CPS reform in these amendments, including encouraging the involvement of family members in a child welfare agency’s decision process; promoting and enhancing CPS collaboration with domestic violence services and substance abuse treatment programs, and increasing the use of “differential response” by states through the use of a noninvestigative/nonaccusatory approach to responding to reports of child maltreatment. Note that these provisions do not mandate these reforms. Rather, the act simply requires states to describe in their reporting to HHS what they are doing in each of the three areas.

Placing these issues in CAPTA does not mean they are new reforms. As of March 2009, 17 states had laws establishing and supporting some variation of family group meetings that involve families in child welfare agencies’ decisions about children’s placements. Active collaboration of CPS and domestic violence programs has been promoted for several decades. A 2008 evaluation of the “Greenbook Initiative” showed the success of such collaborations at six demonstration sites. As of June 2009, 15 state CPS agencies already had active differential response programs, while many others were planning to implement them statewide or conduct pilot projects.

Another new provision further supports involving family members in developing CAPTA state plans. It requires this participation not only of families “affected by child abuse or neglect,” but also from the ranks of community-based child maltreatment prevention agencies. Thus, it appears that from now on, the state plans filed with HHS must show they were developed with these individuals and agencies. The meaning of being “affected by child abuse or neglect” is not clarified, so it might include both family members in households where child abuse or neglect occurred as well as members of other families that may have aided a child who had been abused or neglected.

Bottom line: The act encourages family participation in case planning and placement decisions, collaboration by child welfare agencies and domestic violence programs in cases involving family violence, and use of differential response in child maltreatment cases. While these are not required, HHS wants to hear from states about their efforts in these areas, so they are likely to receive greater attention.
CPS Practices that Promote Homeless Children’s School Attendance

Most of the country’s homeless youth are under age 18. Many have left home due to abuse or neglect, or because their parents abandoned them or pushed them out due to, for example, disapproval of their emerging sexual identity. Some have lived on the streets for some time because they wish to be “on their own.” A new CAPTA provision now requires states to assure or certify to HHS that they have programs and training for CPS personnel that address the “unique needs of unaccompanied homeless youth, including access to (school) enrollment and support.” This provision appears to have been included because of concerns that a homeless youth’s abuse or neglect at home, when reported to CPS, can disrupt the youth’s school attendance and stability. Such disruptions are contrary to the intent of the 2008 Fostering Connections Act and the McKinney-Vento Homeless Assistance Act.

Bottom line: Expect to see improved efforts by states to train and prepare child advocates on the unique needs of homeless youth in the child welfare system, especially strategies to keep or reengage these youth in school.

Participation by Former Child Victims and Homeless Youth Advocates in System Reform

Two new provisions open the door for wider participation by former victims of abuse or neglect, including former foster children, in state groups involved with improving the child protection system. The CAPTA-mandated citizen review panels may now include “adult former victims of child abuse or neglect,” and the state Children’s Justice Act task forces now must include “adult former victims of child abuse or neglect” as well as “individuals experienced in working with homeless children and youth."

Bottom line: Expect to see greater involvement by former foster youth in efforts to reform state child protection systems. These youth offer a valuable perspective, so their input should be encouraged and welcomed. Homeless youth advocates will also be more involved in CPS system reforms.

Knowledge Development and Training

The act’s amendments encourage HHS to support activities that build and share knowledge, or support training, on issues related to:

- CPS inter-agency collaborations (i.e. with health and mental health care, domestic violence, substance abuse, early childhood and special education, and developmental disability programs);
- The use of differential response;
- The improved medical diagnosis of abuse and neglect;
Highlights

Newborns with Fetal Alcohol Spectrum Disorder

- Added as a new category of "referral" and "safe care plan" requirements is a population of infants potentially far larger than those suffering from drug exposure: newborns diagnosed with a fetal alcohol spectrum disorder (FASD).

- This new CAPTA provision (and the earlier requirement regarding drug-exposed newborns) is not intended to have states make prenatal alcohol or drug exposure a category of child abuse or neglect or to make those children subjects of mandatory reporting laws.

- Congress carefully chose the word "referral" to avoid that. Rather, the goal is to address the safety and well-being of these children.

  This means that safety plans be developed for these children in order to promote their health and well-being.
Objectives

- Understand how out of home placement impacts children
- Understand how out of home placement impacts birth and resource families
- Importance of visitation
Out of Home Placement

- Least desired for keeping children safe
- Only used if the child can’t be safe in his/her own home
- Assessment completed; Differential Response ruled out
- Use if only option available to keep children safe
Impact of Placement on Children, Birth Parents and Families
 Surprise, Shock, and Chaos

- Depend on the actions of adults
- More traumatic when sudden and unexpected
- “Stranger” involvement
- Play Ian’s Story on removal
Negative View of Authorities

- Previous experience with authority figures
- Adult comfort vs validation of feelings
- Lack of information
Loss of Control, Powerlessness

- Limited understanding about what’s happening
- Parental involvement with law enforcement
- Separation from parent
- Sense they are being “kidnapped”
- Katie’s Story
Betrayal, Loss of Control

- Fear of what will happen to them
- Lack of trusting person to talk too
- Feeling betrayed by the person they “told”
Confusion and Unpredictability

- Children may not understand why they are being removed
- Previous living situation is important
  - If child is used to chaos, it may result in the child not understanding why there is a problem.

**Mark and Tanya’s Story**
Fear of the Unknown

- They don’t know what will happen now
- They don’t know how to negotiate the unknown
- Strangers are telling them “what to do”
Sense of Guilt or Failure

- May have been warned by the parent as to what would happen if they “told”
- Seeing the family torn apart
- Child who has taken on parenting role in family
- Responsibility for problems in family
Abrupt and Overwhelming Change

- Loss of everything familiar
- Removal from Tribe and community
- Re-traumatizing
- Inability to control the situation
Disruption of Caregiver

- Separation, grief and loss
- Separation from caregiver
- Separation from siblings
Worry about Parents and Siblings

- Overwhelming
- Distress if parents arrested or questioned
- Lack of timely visits
Factors Influencing a Child’s Grief and Loss

The child’s:
- age and stage of development, temperament, past trauma
- attachment to the parent/caregiver
- perception for the reason for the separation
- preparation for the move
- “parting and welcoming messages”
- The post-separation environment
- The environment the child is removed from

The parent’s/caregiver’s:
- bonding to the child
- past experiences with separation and trauma
Birth Parent Grief

“A wife who loses her husband is called a widow; a child who loses her parents is called an orphan. There is no word for a parent who loses a child. That is how awful the loss is.”

(Jay Neugboren)
Understanding Birth Parent Grief

- Birth parents experience grief!
- Birth parent grief often overlooked
- Lack of advocates
- Importance of acceptance of loss and grief
How to Help

- No one is trying to replace them as parents
- Empathy
- Prepared for reactions
- Frustration
How to help

- Understand feelings of inadequacy
- Feelings of jealousy
- Reassurance
  - Child needs them
  - Everyone wants them to succeed
Working with Parents

- Be available
- Assess needs with the parent
- Open, honest and collaborative
- Empathy vs sympathy
- Active motivation
- Community resources (e.g., tribal/spiritual leaders)
Keeping Siblings Together

- Tremendous loss and trauma experienced
- May make healing more difficult
- Significant role of siblings in foster care
Visitation

- Visitation provides opportunities for the child and parent to reconnect and to maintain the parent/child relationship…promoting the chance for a successful reunification
- The more frequent the visitation, the better the chances of an early reunification
- Visitation can be more than just the parents - grandparents, aunties and other family should be considered.
Purpose of Visits

- Primary purpose is to allow children to maintain connections
- Maintain parent/child relationship
  - Reduce sense of abandonment
  - Opportunity to assess parent/child relationship
  - Opportunity for parent to practice parenting skills
  - Opportunity for parents to assess own abilities to parent
- **Visiting should never be used as a reward or punishment**
  (CalSWEC, 2009)
Visitation is a child’s right, not a parent’s privilege

- Use caution in limiting visitation
- Consider the impact on the child
Visitation

Based on age and developmental level

- Frequent and regular
- Written vs verbal
Scheduling Considerations

- Include the family in planning visits
- Understand emotional needs of parent and child
- Realistic expectations
- **Boundaries** (Parents shouldn’t make promises to the children-when they are coming home, etc...)

![Image of children sitting on a porch]
Birth-to-Six Initiative  
Developmentally Appropriate Visitation Activities

<table>
<thead>
<tr>
<th>Stage</th>
<th>Developmental Tasks</th>
<th>Developmentally Related Visitation Activities</th>
</tr>
</thead>
</table>
| **Infancy** | - develop primary attachment  
- develop object permanence  
- basic motor development  
- word recognition  
- beginning exploration and mastery of environment | - meet basic needs (cuddling, feeding, changing)  
- peek-a-boo games  
- help with standing, walking; “come to me” games  
- name objects, repeat name games; reading books  
- taking walks; encourage exploration; playing together with noisy, colorful, moving items |
| **Toddler** (2-4) | - develop impulse control  
- language development  
- imitation, fantasy play  
- large motor development (run, climb, dance, hop)  
- small motor coordination  
- develop sense of time  
- asserting preferences | - making and consistently enforcing rules  
- reading simple stories; playing word games  
- “let’s pretend” games; encourage imitative play by doing things together  
- playing together at the park; assist in learning to ride a bike; dance together to music  
- draw together; string beads  
- discuss events in terms of “after breakfast,” “after lunch,” “before supper”  
- allow choices in foods, activities, clothes worn |
| **Pre school** (5-7) | - gender identification  
- begin development of conscience  
- develop ability to problem solve  
- begin concrete operations (time, space, hierarchy)  
- task completion  
- understanding concept of rules  
- school entry | - be open to discuss boy/girl differences; be open to discussions of sex roles; read books about heroes and heroines together  
- make and enforce consistent rules; discuss consequences of behavior  
- encourage choices in everything  
- point out cause/effect  
- plan activities that have a beginning, middle, and end  
- play simple games such as |
<table>
<thead>
<tr>
<th>School age (8-12)</th>
<th>Skill development (in school, sports, special interests)</th>
<th>Help with homework; practice sports together; show support of special interests; attend school conferences/activities</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• peer group development</td>
<td>• involve peers in visitation activity • attend team activities with child • be able to provide feedback • discuss physical changes expected; answer questions openly</td>
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<td></td>
<td>• team play</td>
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<td></td>
<td>• develop self awareness</td>
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<td></td>
<td>• preparation for puberty</td>
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<tr>
<td>Early adolescence (13-17)</td>
<td>Cope with physical changes</td>
<td>Help with attention to personal appearance (shaving, buying cosmetics); provide information</td>
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<td></td>
<td>• begin abstract thinking</td>
<td>• plan and discuss future; talk about politics, religious ideas • help learn to drive; delegate responsibility</td>
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<tr>
<td></td>
<td>• become independent of parents</td>
<td>• transport to peer activities; include peers in visitation</td>
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<tr>
<td></td>
<td>• changes in peer group associations</td>
<td>• encourage independence by action (help move to apartment, help apply for a job)</td>
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<td></td>
<td>• separation from family</td>
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<tr>
<td>Late adolescence (18-22)</td>
<td>Develop life goals</td>
<td>Be aware of and tolerate independence/dependence conflict</td>
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<tr>
<td></td>
<td>• rework own identity and gender identity</td>
<td>• be open to discuss adolescent’s options, “think through” together</td>
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<tr>
<td></td>
<td>• develop capacity for intimacy</td>
<td>• share own experiences as young adult</td>
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Including the Child

- The location of the visit
- Where everyone will sit during the visit
- What type of physical contact the child wants or does not want
- Are there certain people the child would like or not like at the visit?
- Hand signals the child can use to indicate a need for help from the visit supervisor
- If there are topics the child does not want to talk about
- Child’s feelings towards seeing their parent
Supervised Visitation

- Supervised visits provide opportunities for the worker to assess parents’ progress.
- Supervised visits provide an opportunity for the worker to teach and correct parenting behaviors and see how the parent responds.
Last Words on Visitation

- *Tell me and I’ll forget, Show me and I may remember, Involve me, and I’ll understand.*  Native American Proverb
- Visitation can be a determining factor in the outcome of a case and is best practice in maintaining family connections.
- Family visiting is hard work.
Working with Relative Placements

- Relatives may not be aware of everything that a child has experienced.

- Due to increased use of methamphetamines and other drugs, relatives may need assistance in setting boundaries with birth family.
How to Help

- Be available
- Return phone calls and messages
- Provide resources to family to meet the child’s needs
- Recognize that parenting is more challenging when drugs/alcohol is part of the problem
Questions