

Standby Guardianship

DEFINITION OF STANDBY GUARDIANSHIP

The purpose of standby guardianship is to allow parents to make care and custody plans for their children now that will become effective at some future date (Simms, 1996). A standby guardian is chosen by a parent to become the legal guardian of the parent's minor children in the event the parent becomes unable to care for the children. In general, the standby guardian becomes the active caretaker of the children after a "triggering event" such as: (1) the death of the parent; (2) the mental or physical incapacitation of the parent; or (3) the consent of the parent (Child Welfare Information Gateway [CWIG], 2008).

Without standby guardianship, the range of legal options available to parents to plan for the future care and custody of their children is inadequate (Levine, 1995; Mellins, Erhardt, Newman, & Conard, 1996; Waysdorf, 1994). These options include informal arrangements, a will, power of attorney, transfer of guardianship, foster care, and adoption (Andino, 2003; HIV Law Project & Ciatelli Associates, 1994). Informal arrangements, though common, do not provide the new caregiver with a legal bond to the children or the legal authority to serve as their decision-maker (Child Welfare League of America [CWLA], 1997). A signed will designates a guardian to take care and custody of the children only after the death of the parent. Transfer of guardianship, foster care, and adoption require a parent to relinquish care of the children immediately (Families' and Children's AIDS Network: Advisory Task Force, 1995; National Abandoned Infants Assistance Resource Center [NAIARC], 2005).

Standby guardianship, on the other hand, provides a middle ground. This guardianship arrangement enables the parent to retain rights and decision-making responsibilities while still able, and facilitates the transfer of legal custody upon a triggering event (CWIG, 2008; Waysdorf, 1994). Standby guardianship helps to protect the psychological and emotional health of the family by reducing stress and providing stability and support for the child during transition (McAllaster, 2000; Mellins et al., 1996).

HISTORY AND BACKGROUND

Much of the recent discussion about the emotional, social, and legal issues involved in future care and custody planning relates to the HIV epidemic (Willis, Peck, Sells, & Rodabaugh, 2001). This connection developed out of a concern for the growing number of parents infected with HIV and the number of children orphaned by the epidemic. In 1992, researchers from the Centers for Disease Control noted the increasing numbers of women infected with HIV and estimated that, as of December 1991, 19,300 children had been orphaned due to AIDS (Caldwell, Fleming, & Oxtoby, 1992). Updated estimates suggest that between 1980 and 1998, AIDS accounted for 97,376 children who were left motherless (Lee & Fleming, 2003).

To better meet the needs of families affected by HIV, advocates began working to pass standby guardianship legislation (Palmer & Mickelson, 2001). In addition, federal and state dollars were made available for programs to help families affected by HIV/AIDS address the social, emotional, and legal issues involved in making future care and custody plans. Currently, federal funding is provided for voluntary permanency planning projects for families affected by HIV through both the Abandoned Infants Assistance Act (P.L. 100-505, as amended, P.L. 104-235) and Title IV of the Ryan White CARE Act (P.L. 106-345).

THE NEED FOR STANDBY GUARDIANSHIP

The number of AIDS orphans in the United States has declined in recent years, largely reflecting a decrease in the number of AIDS-related deaths (Lee & Fleming, 2003). However, there has been a concomitant increase in the number of women living with HIV/AIDS who have young children. The most recent CDC report states that as of 2005, 95,959 women were living with AIDS in the United States (CDC, 2008). In a nationally representative sample of children of HIV-infected parents, as many as 47% of the children were found to be in the custody of their HIV-infected parent (Cowgill, Beckett, & Corona, 2007b). Such findings present a challenge to current and future caregiving of children, as 76% of women receiving HIV treatment are also mothers (Kaiser Family Foundation, 2007).

Though standby guardianship is often associated with HIV, expansion of the discussion about voluntary permanency planning beyond the HIV service community is clearly warranted. Many situations prevent parents from caring for their children. For example, thousands of children are orphaned every year due to the death of a parent from an illness or another medical condition (Jones, 2004). The Centers for Disease Control's National Center for Injury Prevention and Control (CDC, 2009) reported that in 2005, excluding HIV, over 137,000 people between the ages of 18 and 45 in the United States died from an illness or other medical condition, an accident, or intentional injury.

After unintentional injury, cancer is the second most common cause of death for people of child bearing/rearing age (CDC, 2006; Willis et al., 2001). However, compared to families affected by HIV, there has been considerably less attention paid to permanency plans for families affected by cancer, or other medical conditions, and there are few programs designed to help them cope with the emotional, social, and legal issues involved in future care and custody planning (Willis et al., 2001). For example, in a study of cancer patients, medically related legal needs, including child custody issues, were identified to be important to patients' quality of life (Zevon et al., 2007). Yet, patients mentioned that these medically related legal needs were not met by their current medical or supportive care (Zevon et al., 2007). This and other studies demonstrate the need for interventions and support around child custody and permanency planning.

The increase in single parenthood over the past three decades suggests another reason for the expansion of voluntary permanency planning. Estimates suggest that about 31% of children in the United States, or approximately 23 million children, lived in single parent homes in 2006 (Annie E. Casey Foundation, 2006). This figure represents a considerable increase since 1960, when only 9% of children under 18 years old resided in single parent households (Ellwood & Jencks, 2004; U.S. Department of Health & Human Services, 2001). In addition, the convergence of single parenthood and

medical conditions like HIV and cancer has led to increasing numbers of children orphaned due to illness (Jones, 2004; Willis et al., 2001).

The number of children living in kinship care arrangements also provides a strong case for the need for access to future care and custody planning, as approximately 2.3 million children reside in the primary care of their grandparents (U.S. Census Bureau, 2003). Particularly, older grandparents caring for young grandchildren may need to appoint a future caregiver, with the understanding that advancing age and/or poor health may prevent the grandparents from continuing to provide care to the children (Cook, Boxer, & Burke, 2003).

PROTECTING THE WELFARE OF ORPHANS

In planning for these potential orphans, identifying new, safe, and permanent homes is a priority (Geballe, 2000; Levine 1994). Permanence for children is the central component of child welfare legislation. As explained in *Adoption 2002: The President's Initiative on Adoption and Foster Care Guidelines for Public Policy and State Legislation Governing Permanence for Children* (Duquette, Hardin, & Dean, 1999):

The concept of permanency has assumed a central place in American child welfare law and policy because permanency establishes the foundation for a child's healthy development. The basic needs of children include safety and protection; a sense of identity; validation of themselves as important and valued persons; stability and continuity of caregivers; an opportunity to learn and grow cognitively, physically, and emotionally; and a protected custodial environment that is legally secure. Permanency, as epitomized by a safe, stable relationship with a nurturing caregiver, allows these basic needs to be met. (p. 3)

Adoption 2002 (Duquette et al., 1999) also describes the hierarchy of permanence. For children who cannot remain with their birth parents, adoption and legal guardianship provide the most assurance of safety and stability. In addition, priority should be given to assisting the children to remain within the family's kinship network. Informal arrangements, however, are not preferred, as the caregivers do not have legal standing. Such arrangements may create difficulties for the caregiver and children in obtaining public benefits and in interacting with schools and medical facilities. Finally, foster care is considered a temporary plan; therefore, this option should be used only if alternative permanent placement options are not available.

In this context, standby guardianship provides an alternate method for establishing permanence, and parents can make a specific plan for the future care and custody of their children. Through standby guardianship, parents can maintain custody of their children as long as they are able before transferring care to a designated guardian (Levine, 1995). By offering parents this flexibility in determining the future care of their children, standby guardianship may help to prevent children from entering the child welfare system unnecessarily (Cameron, 2000).

NATIONAL SUPPORT FOR STANDBY GUARDIANSHIP

As a method of providing permanence for children and assisting families affected by terminal illnesses, standby guardianship has garnered wide support. The federal government adopted a strong position in favor of all U.S. states enacting standby guardianship legislation. In fact, the Preamble to the Adoption and Safe Families Act (1997) reads:

It is the sense of Congress that the States should have in effect laws and procedures that permit any parent who is chronically ill or near death, without surrendering parental rights, to designate a standby guardian for the parent's minor children, whose authority would take effect upon: 1) the death of the parent; 2) the mental incapacity of the parent; or 3) the physical debilitation and the consent of the parent. (Sec. 403)

This position was reiterated in *Adoption 2002* (Duquette et al., 1999). In addition to the federal government, the Child Welfare League of America (CWLA) (Beatty & Hershfield, 1995), the American Bar Association (Samerson, 1997), and the American Academy of Pediatrics, Committee on Pediatric AIDS (1999) have all stated their support for standby guardianship legislation. The American Academy of Pediatrics reaffirmed their commitment to this policy position in September 2005 (American Academy of Pediatrics, 2005).

OVERVIEW OF CURRENT LEGISLATION

Currently, standby guardianship legislation has been enacted in the District of Columbia and 19 states: Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Nebraska, New Jersey, New York, North Carolina, Pennsylvania, Virginia, West Virginia, and Wisconsin. Although they do not have specific standby guardianship laws, a few other states (California, Iowa, Ohio, Texas, and Wyoming) have legislation that incorporates important elements of this tool (see State Codes following References).

Although there are differences between the states, most of the standby guardianship laws have several components in common:

1. The statutes allow a parent or a legal guardian to appoint a standby guardian for the minor children.
2. Events that trigger the activation of the standby guardian include the death, the mental incapacity, or the physical debilitation of the parent or legal guardian. However, some states (i.e., Illinois, Maryland, Massachusetts) do not require these triggering conditions and allow the parent to consent to a transfer of guardianship when they feel it is appropriate.
3. The states set forth the procedure for a parent or legal guardian to petition the court for judicial appointment of a standby guardian. A court hearing is then held regarding the petition. Most of the states also allow a parent or legal guardian to designate a standby guardian in writing. After the death or incapacity of the parent or legal guardian, the designated standby guardian must notify the court of the triggering event, file a petition for guardianship, and participate in a court hearing to be appointed legal guardian.

4. The states require that the court be notified about a triggering event within set time limits. If a judge has appointed the standby guardian, few states require an additional court hearing.
5. If a standby guardian becomes active due to parental incapacity, the laws allow for the restoration of parental authority upon the improved health of the parent. The guardian resumes standby status.
6. The statutes allow the parent to revoke the standby guardian agreement at any time.
7. Unless a non-custodial parent's rights have been terminated, all of the statutes require that the non-custodial parent be notified of the standby guardian proceedings, either at the initial court approval, or when the standby guardian provides proof of a triggering event and requests legal guardianship (Larsen, 2000).

Although similar in intent to the other states, future care and custody legislation in California and Connecticut is somewhat different. California allows the appointment of a co-guardian, rather than a standby guardian. This law allows for parents with terminal conditions to:

make arrangements for the joint care, custody, and control of his or her minor children so as to minimize the emotional stress of, and disruption for, the minor children whenever the parent is incapacitated or upon the parent's death, and to avoid the need to provide a temporary guardian or place the minor children in foster care, pending appointment of a guardian, as might otherwise be required (California Probate Code, Sec. 2105).

Joint guardianship in California operates much like standby guardianship arrangements. At the appropriate time when the parent can no longer provide care for the child due to a life threatening condition such as AIDS or cancer, the court appoints the individual nominated as the joint guardian (Public Counsel, 2005). The custody of the child and decision-making responsibilities are shared between the parent and the designated guardian (Public Counsel, 2005).

Connecticut employs both of these arrangements and allows for both standby guardianship and co-guardianship (Connecticut General Statutes Annotated, Sec. 45a-624[a]-[g]).

STANDBY GUARDIANSHIP IN PRACTICE

Limited research has occurred on the implementation and efficacy of standby guardianship. The available research suggests that, although the majority of parents discuss future custody options informally, formal standby guardianship is underutilized.

A study of oncology patients who were single parents found that 50% died without a custody plan for their children (Willis et al., 2001). In addition, a review of four studies completed between 1992 and 2004 found that most, if not all, parents with HIV are concerned about the future care and custody of their children (O'Neal, 1995; Rotheram-Borus, Lee, Lin, & Lester, 2004). However, most parents appear to rely on informal arrangements with family members, and few parents follow through on making a formal, legal care and custody plan for their children. In a nationally representative sample

of HIV-infected parents, only 28% of parents had identified a guardian and prepared legal documentation (Cowgill et al., 2007a). Fifty-three percent of parents in Cowgill et al.'s study said the identified guardian had agreed but no legal documentation had been prepared.

Similarly, in a study of 188 HIV-positive mothers and their children of minor age, only 11% of mothers had prepared a will, health care proxy or possessed some type of insurance for their children (Simoni, Davis, & Drossman, 2000). In contrast, over 40% of the mothers had no custody arrangements for their children. Most of the mothers in that study assumed that relatives would care for their children when they were no longer able. In another study, which examined the residential status of children orphaned by HIV/AIDS, Cook et al. (2003) found that 77% of the children lived with family. However, Cook et al. also found that less than 25% of the child custody arrangements were formalized through legal procedures prior to the mother's death.

More recently, a study of parents with HIV revealed that nearly 43% of parents died without having established a future custody plan for their children (Rotheram-Borus, Lester, Wang, & Shen, 2004). In addition to the lack of arrangements prior to death, parents were also found to frequently change custody plans. Among those parents who did make future plans, over 69% used standby guardianships. Looking specifically at the relationship between child age and permanency planning, younger children were more likely than adolescents over the age of 15 to have established custody plans (Lightfoot & Rotheram-Borus, 2004; Rotheram-Borus, Lester, et al., 2004). Among the younger children, however, children ages 6 to 14 were found to be most likely to have arrangements in place, even though those under 5 years of age may have had the greatest need for permanency planning following the loss of their parent (Rotheram-Borus, Lester, et al., 2004).

OBSTACLES TO THE UTILIZATION OF STANDBY GUARDIANSHIP

Since most states currently do not have standby guardianship legislation, many parents do not have the option to appoint a standby guardian for their children. In the states with standby guardianship, several obstacles contribute to underutilization. These obstacles can largely be grouped into two areas: emotional and systemic.

Physical, emotional, and social stressors often impede completion of custody arrangements. The emotional stress of living with a life-threatening illness has been well documented (Mason & Vazquez, 2004; Lightfoot & Rotheram-Borus, 2004). Among parents living with HIV, those with greater levels of depression and negative coping styles were found to be less likely to form future custody plans for their children (Rotheram-Borus, Lester, et al., 2004). These anxieties may be pressing and require immediate attention preventing the utilization of standby guardianship (Rotheram-Borus, Lester, et al., 2004). The process of designating a guardian is such an emotional challenge that it may hinder parents from nominating a potential caregiver for the child (Cowgill et al., 2007a). The realization that parents may not see their children grow up can be too painful to cope with for some parents (American Academy of Pediatrics, 1999).

Systemically, all states with standby guardianship legislation require that a non-custodial parent be notified about the request to appoint a standby guardian (NAIARC, 2009). Most states assume that the non-custodial parent will take over custody and guardianship of the children, and therefore require extensive efforts by the custodial parent to locate the non-custodial parent. This is true even when the non-custodial parent has had little or no contact with their children, and has not contributed to raising them (Joslin, 2002). A study of 200 mothers with HIV in New York City found that most of the children's fathers had little or no involvement with the children, and few of the mothers wished to involve the children's fathers in future care or custody planning (Casey Family Services, 1999). The study reported that the women feared: "(1) giving the father an opportunity to take the children away from them, (2) re-initiating contact with someone who may have been abusive in the past, or (3) alerting the father to a custody agreement he may not like and therefore increasing the chance he will contest the plan" (p. 121). Consequently, requirements to notify non-custodial parents and the underlying assumptions about their responsibility of care for the children may deter a custodial parent from making a formal permanency plan and appointing a standby guardian.

Other systemic barriers hindering future custody planning can include lack of or misinformation about planning, and complex and insensitive legal and child welfare systems (Cowgill et al., 2007a; Jones, 2004). Parents may not have sufficient knowledge about the range of permanency planning options available, including standby guardianship (O'Neill, Selwyn, & Schietinger, 2003; Cowgill et al., 2007a). They may also not know to whom to turn to get this information or who is available to provide legal services (Cowgill et al., 2007a; Zevon et al., 2007).

The standby guardianship process itself can be complicated and daunting. For example, a problem experienced in some states is that many courts are backlogged with cases, and cases can take a long time to come to hearing (NAIARC, 2005). Some designations are made in the hospital or in an ambulance on the way to a hospital, even as the patient is dying (NAIARC, 2005). Finally, if the petition is filed after the triggering event, the law imposes a limited time (usually between 60 to 90 days) for the standby guardian to submit evidence and complete paperwork, creating additional challenges in the standby guardianship process.

Because of the difficulties involved in going to court and getting a judicial appointment, parents who do make future care and custody plans often prefer to designate the standby guardian in writing rather than through the court (NAIARC, 2005). This puts the onus on the standby guardian to go to court after the death or incapacity of the parent and petition for guardianship based on the written designation. This arrangement means that the parent or legal guardian will not be able to attend a full court hearing and provide testimony to support the appointment of the standby guardian (HIV Law Project, 2009) or influence the decision whether to place the child with the non-custodial parent.

Finally, it is often assumed that after a triggering event, the other parent will care for the children. However, for a variety of reasons, the other parent may be unable or unwilling to become the caretaker for the children, creating additional challenges to standby guardianship utilization (Joslin, 2002). Rather than the other biological parent, the custodial parent may have to look to extended family members to assume responsibility for the care of the children (Rotheram-Borus, Lester, et al., 2004).

Due to these obstacles, many parents either develop no future care and custody plans for their children or rely on informal agreements with relatives and friends (Cowgill et al., 2007a; Cook et al., 2003; Rotheram-Borus, Lester, et al., 2004). As a result, orphans are unfortunately often left in limbo, with no specific or legal plan to provide for their safety and permanence (NAIARC, 2005). Addressing these obstacles and promoting the use of standby guardianship is a key element in establishing permanence by legalizing the relationship between the new caretakers and the children (Geballe, 2000; Family Ties Project, 2006; NAIARC, 2005).

OVERCOMING OBSTACLES TO THE UTILIZATION OF STANDBY GUARDIANSHIP

Because of the emotional and social complexities associated with future care and custody planning, assisting a parent in utilizing standby guardianship, or in making any kind of estate plan or advanced directive, requires a continuum of services. At a minimum, this continuum should include medical, mental health, case management, and legal services (Mason & Vazquez, 2004; Family Ties Project, 2006). Provision of medical services addresses parental illness. Mental health services for parents should address the emotional difficulties of living with a terminal illness, preparing for the possibility of death, and the need for the children to have a safe and permanent home. Children may also need counseling to cope with the loss, or potential loss, of their parents (Jones, 2004). As most parents are simultaneously coping with multiple problems, case management services are needed to provide assistance with concrete needs, including housing, income support, and childcare (Jones, 2004; Family Ties Project, 2006). Legal services should detail the range of permanency options for the family, assist with the completion of the future care and custody plan, and advocate to ensure the activation of the plan (Mason & Vazquez, 2004). Service providers should be knowledgeable about the legal and bio-psycho-social issues involved, and work cooperatively to help provide for the safety and permanence of children whose parents are terminally ill (Fleishman, Retkin, & Brandfield, 2006). Ideally, these care providers would be located together to provide maximum accessibility and continuity of care (Fleishman et al., 2006).

Special considerations should be paid to the needs of single parents with terminal illnesses. For many families, the immediate answer to who will care for the children after the death of one parent is the other parent. Unfortunately, this is not always possible or even desirable. For a variety of reasons, the other parent may be unable or unwilling to become the caretaker for the children (Joslin, 2002). For this reason, increased services should also be made available to members of the relative network (Rotheram-Borus, Lester, et al., 2004).

In deciding with whom the children should live after the parent's death or incapacity, the custodial parent's choice should be recognized as being in the best interests of the children. With this presumption, substantial weight should be given to the custodial parent's choice for standby guardian (Family Ties Project, 2006). Judicial appointment of the custodial parent's choice for standby guardian is not tantamount to terminating the non-custodial parent's rights to the children, because the non-custodial parent does not lose their legal right (NAIARC, 2005).

The presumption that the custodial parent is acting in the best interests of the children should also strongly inform the court processes of appointing and activating a standby guardian. Family court hearings, paperwork, and other administrative details should be streamlined. Furthermore, standby guardianship laws should be designed and implemented such that they parents are encouraged to begin the permanency planning process early (Family Ties Project, 2006).

CONCLUSION

Effectively assisting parents in making future care and custody plans for their children requires the development of flexible permanency planning options, such as standby guardianship. Standby guardianship legislation, in intent and implementation, must recognize the unique situations of parents and acknowledge that in making future care and custody plans the parents are acting in their children's best interests. In practice, providing a continuum of services for the children and parents is key to facilitating the utilization of standby guardianship. At a minimum, these services should include medical treatment, legal assistance, mental health counseling, and case management.

Unfortunately, most states do not allow standby guardianship as an option for future care and custody planning. Even where standby guardianship is available, resources to assist parents seeking guardianship arrangements, as well as programs for the newly appointed guardian, are scarce (Geballe, 2000).

Creating laws and developing multidisciplinary services that promote the safety, well-being and permanency of children are important challenges for legislators and for providers of mental health, medical, legal and social services. As Geballe (2000), in a call to action to meet the needs of children and families affected by terminal illness, explains:

How well we ensure the quality and continuity of parental care for children whose parents are living with HIV and AIDS, or who later die of it, is one of the tests of our generation. If we fail to meet this challenge, we are knowingly placing thousands of children and youth at enormous, predictable, and potentially fatal risk. (p. 407)

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STATE CODES

Arkansas Code of 1987 Annotated, Sec. 28-65-221
California Probate Code, Sec. 2105
Colorado Revised Statutes Annotated, Title 15, Sec. 15-14-201 through 15-14-210
Connecticut General Statutes Annotated; Probate Courts and Procedures, Sec. 45a-624(a)-(g)
Delaware, Title 13, Chapter 23, Subchapter VI
District of Columbia Official Code, Title 16, Sec.2, Chapter 48
Florida Statutes Annotated, Sec. 744.304; 744.3046
Official Code of Georgia Annotated, Title 29, Chapter 4, Sec. 29-4-1
Smith-Hurd Illinois Compiled Statutes Annotated, 5/11-5.3
Hawaii, Parental appointment of guardian, HRS560, 5-202
Iowa Code Annotated, Sec. 633.560; 633.591A
Annotated Code of Maryland, Sec. 13-901 through 13-907
Massachusetts General Laws Annotated, Sec. 201-2B through 201-2G
Minnesota Statutes 2002, Chapter 257B
Nebraska Revised Statutes of 1943, Sec. 30-2601, 30-2613, 30-2614
New Jersey Statutes Annotated, Sec. 3B:12-72 through 3B:12-77
McKinney's Consolidated Laws of New York Annotated, Surrogate's Procedure Act, Sec. 1726
General Statutes of North Carolina, Sec. 35A-1370 through 35A-1382
Ohio Revised Code, Commercial, Sec. 1337.09 (B); Probate, Sec. 2111.02, 211.042, 2111.12, 2111.121, 2111.13
Pennsylvania Consolidated Statutes Annotated, Title 21 Domestic Relations, Chapter 56 Standby Guardian Act, Sec. 23-5602;
23-5611; 23-5612; 23-5613; 23-5614
Texas Probate Code, Section 676
Code of Virginia, Juvenile, Sec. 16.1-349 through 16.1-354
West Virginia Code Annotated, Sec. 44A-5-1 through 44A-5-8
Wisconsin Statutes Annotated, Children's Code, Sec. 48-978
Wyoming Statutes (1985 & Supp. 1995), Probate Sec. 3-2-104; 3-2-108; 3-2-201; 3-3-301 through 3-3-305

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