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IN THE
APPELLATE COURT OF ILLINOIS
SECOND DISTRICT

<i>In re</i> VINCENT D., a Minor)	Appeal from the Circuit Court
)	of Lake County.
)	
)	No. 12-JA-107
)	
(The People of the State of Illinois, Petitioner-Appellee, v. Deanne D., Respondent-Appellant).)	Honorable
)	Valerie Boettle-Ceckowski,
)	Judge, Presiding.

JUSTICE SPENCE delivered the judgment of the court.
Presiding Justice Burke and Justice Jorgensen concurred in the judgment.

ORDER

¶ 1 *Held:* The trial court properly found that respondent was unfit and that it was in the minor's best interest to terminate her parental rights.

¶ 2 The trial court found respondent, Deanne D., unfit as to Vincent D., and terminated her parental rights. Respondent appeals both findings, arguing that they were against the manifest weight of the evidence. We affirm.

¶ 3 I. BACKGROUND

¶ 4 Vincent D. was born May 4, 2010. The Department of Children and Family Services (DCFS) became involved because respondent continued sleeping with Vincent D. in the hospital bed after

being advised of the risk of suffocation or injury. In addition, respondent required sedation during her delivery because her behaviors were “out of control,” and she accused the hospital staff of switching babies. On May 10, 2010, DCFS took Vincent D. into temporary custody and placed him in a traditional foster home.

¶ 5 The next day, May 11, 2010, the State filed a neglect petition on behalf of the minor that alleged two counts. Count I alleged that Vincent D. was a neglected minor in that respondent suffered from a mental illness and had been diagnosed with Bipolar Disorder and/or Manic Depression which affected her ability to care for him. Count II alleged that Vincent D. was a dependent minor in that respondent had not been taking her medication as prescribed and had been psychiatrically hospitalized. A temporary custody order was entered on May 12, 2010. The order stated that respondent had been diagnosed with Bipolar Disorder and had not taken her prescribed medication. It further stated that respondent had been involuntarily committed at St. Therese Hospital after not following the care provider’s instruction in the hospital when Vincent D. was born.

¶ 6 On September 9, 2010, Vincent D. was adjudicated neglected based on count I of the State’s petition.¹ A dispositional order was entered on September 23, 2010, which provided that respondent was to have supervised visitation with Vincent D., participate in parenting classes and parent/infant play therapy, and complete a mental health evaluation. After respondent received unsatisfactory ratings on several service plans, a permanency order dated June 12, 2012, changed the goal from return home to substitute care pending court determination of parental rights.

¶ 7 On January 31, 2013, the State filed a second amended petition to terminate respondent’s parental rights. The petition alleged five grounds: (1) respondent had been habitually drunk or

¹The minor’s father is not a party to this appeal.

addicted to drugs for at least one year immediately prior to the commencement of the unfitness proceeding (750 ILCS 50/1(k) (West 2010)); (2) respondent failed to make reasonable efforts to correct the conditions that were the basis for the minor's removal (750 ILCS 50/1(m)(i) (West 2010)); (3) respondent failed to make reasonable progress towards the return of the minor within nine months after the neglect adjudication (750 ILCS 50/1(m)(ii) (West 2010)); (4) respondent had failed to make reasonable progress during the nine-month period from July 2011 to April 2012 (750 ILCS 50/1(m)(iii) (West 2010)); and (5) respondent was unable to discharge parental responsibilities due to mental impairment, mental illness, mental retardation or developmental disability, and there was sufficient justification to believe that such inability to discharge parental responsibilities would extend beyond a reasonable time period (750 ILCS 50/1(p) (West 2010)).

¶ 8

A. Fitness Hearing

¶ 9 A fitness hearing was conducted on January 31, 2013. The State introduced four service plans into evidence, which required respondent to participate in mental health services, substance abuse services, parenting classes, visitation, and obtain stable housing and income. Respondent received unsatisfactory ratings on each of the four plans.

¶ 10 Karen Klemchen, a foster care supervisor with Arden Shore Child and Family Services, testified regarding the first two service plans. Klemchen supervised the original caseworker handling respondent's case, Miguel DeJesus, who left the agency in 2011.

¶ 11 The first service plan, dated November 22, 2010, covered the previous five months. The plan stated that respondent had last seen her psychiatrist, Dr. Caban, on August 25, 2010. However, prior to that, Dr. Caban had not seen respondent since January 2010, and she missed her September 1, 2010, appointment. Dr. Caban indicated that respondent needed to be on medication to be stable,

and both Dr. Caban and respondent reported that she was not taking her medication on a regular basis. Respondent completed a mental health assessment in November 2010, which also recommended that she take medication. Counseling could not begin because respondent was unstable and refusing to take the prescribed medication.

¶ 12 In addition, respondent failed to complete a random drug test on July 16, 2010. On October 21, 2010, respondent tested negative on a drug test, but later that evening, respondent was intoxicated and exhibiting “bizarre behavior.” The police were called, and she was hospitalized at Vista Hospital. Respondent failed a drug screen on November 4, 2010, saying she got “lost” on the way to the appointment. On November 18, 2010, respondent completed a substance abuse evaluation.

¶ 13 The service plan further indicated that on July 26, 2010, respondent was referred to parenting classes but did not attend. Respondent also reported that she was being evicted from her apartment and had a history of homelessness.

¶ 14 As for visitation, respondent visited Vincent D. three times a week, during which she displayed appropriate parenting skills by holding, rocking, and playing with him. However, in November 2010, respondent’s visits were reduced to once a week based on her failure to take her medication and comply with services.

¶ 15 The second service plan, dated May 24, 2011, stated that respondent’s ability to participate in services was impacted by her noncompliance with Dr. Caban and treatment. Respondent had been noncompliant with her medication and appointments with Dr. Caban from August 25, 2010, until April 20, 2011. Though respondent was referred for counseling on December 27, 2010, she needed to take her medication prior to participating in individual counseling.

¶ 16 In addition, after reducing respondent's visitation to once a week in November 2010, visitation was suspended from December 10, 2010, until April 11, 2011, due to noncompliance with Dr. Caban and her medication. During the five-month period that visitation was suspended, respondent could not work with a parenting coach. On April 20, 2011, respondent went back to see Dr. Caban and then was referred for a parenting capacity assessment through Thresholds.

¶ 17 The service plan indicated that respondent had completed a substance abuse assessment on December 6, 2010. However, the substance abuse program recommended that respondent address her mental health issues before addressing her substance abuse issues. Respondent tested negative on random drug tests on November 4, 2010,² and May 3, 2011, but she refused to submit to a test on February 16, 2011.

¶ 18 Finally, the service plan stated that respondent had moved to an apartment in Winthrop Harbor. She supported herself financially with social security disability payments and by working odd jobs for her new landlord.

¶ 19 Caseworker Tania Miller was assigned respondent's case in May 2011. She testified regarding the third and fourth service plans. The third service plan, dated November 1, 2011, noted that respondent had been compliant with her medication since June 2011, although Miller observed "very little improvement in regard to her mental health." Respondent was compliant with her medication, counseling, and mental health treatment, yet insisted that she did not have a mental illness and that her problems were related to physical ailments alone. Respondent advised DCFS

²The first service plan listed this date as a "failed" drug screening and this discrepancy is not explained in the record.

that she was complying with mental health treatment because DCFS was “ ‘making her’ ”; otherwise, she would not cooperate.

¶ 20 On May 31, 2011, Miller made a home visit to respondent’s one-bedroom efficiency apartment in Winthrop Harbor. According to Miller, respondent’s living space was “extremely cluttered” with “large amounts of scattered papers covering her bed and only a small pathway for walking through the entire apartment.” There was no place to sleep or cook. Miller visited respondent again on August 15, 2011. Though the bed was free of papers, her entire bedroom was filled with large piles of clothing. Also, there was only a small pathway to walk through the apartment. Miller testified that it was not an appropriate place for Vincent D. to live.

¶ 21 The service plan further stated that respondent was unable to complete a substance abuse assessment due to her refusal to submit to random drug tests from February to October 2011. Respondent did test negative on a random drug test on October 12, 2011.

¶ 22 Respondent completed a parenting capacity assessment through Thresholds on June 3, 2011. The Thresholds report indicated that respondent’s mental illness may result in “ ‘unintentional harm to the child if she were to parent independently.’ ” Supervised visits were recommended until respondent’s mental illness was properly treated.

¶ 23 According to Miller, respondent had weekly visitation but did not incorporate the parenting skills she learned from the parenting capacity assessment. The two main issues were parenting skills and feeding. Respondent had a difficult time filling the two-hour time slot with activities and would insist on long stroller rides. Also, visits were switched to mornings instead of afternoons because Vincent D. did not eat a proper lunch with respondent. She brought food that was inappropriate or opened up cans of uncooked food to feed him. In addition, respondent had to be told to initiate lunch

and allowed only 10 minutes for eating. She became “very frustrated” when Vincent D. threw food on the floor and would end the feeding time altogether. During visits, respondent rubbed Vaseline on Vincent D.’s clothes so that he would breathe better. She also applied diaper cream every time she changed his diaper, even when it was not needed. Overall, respondent’s mental illness inhibited her ability to fully participate, grasp and understand Miller’s suggestions. For this reason, respondent had not been referred for parenting classes or a parenting coach.

¶ 24 The service plan described four specific incidents during visitation. First, on August 23, 2011, Miller terminated the visit early because respondent was cursing and acting aggressively toward her in front of Vincent D. Second, on September 27, 2011, respondent herself ended a visit early because Vincent D. was crabby. Third, respondent became frustrated at a visit on October 4, 2011, when Vincent D. threw toys; she threatened to spank his hands if he did not stop. Last, during an October 18, 2011, visit, Miller had to instruct respondent how to heat a prepared “toddler meal” in the microwave because she attempted to feed it to him cold.

¶ 25 The fourth and final service plan was dated May 4, 2012. The plan stated that respondent continued to participate in individual therapy with Barbara Secor. Secor reported that although respondent had shown a willingness to participate in treatment, her insight and progress remained limited. Respondent resisted her diagnosis of Bipolar Disorder. According to Secor, respondent also had difficulty managing money, arranging transportation, and making scheduled appointments. Respondent had missed six scheduled therapy sessions. She refused to use Dial-A-Ride service with PACE, even though it picked her up at her front door. Respondent often missed scheduled appointments if it involved bus transportation as opposed to someone driving her. Secor discussed the option of respondent entering an assisted living facility to improve her “lack of life skills.”

Respondent did not want to move into assisted living because she did not want to lose her social security disability payments.

¶ 26 Miller testified that despite being compliant with Dr. Caban's psychiatric treatment since June 2011, there was very little improvement in respondent's mental health. Since the case opened, respondent had remained adamant that her health conditions were purely physical rather than associated with mental health concerns.

¶ 27 On January 1, 2012, respondent began attending a parenting support group, and she completed 12 sessions on April 4, 2012. According to the group facilitator, respondent willingly participated in discussion, asked questions, and voiced concerns about Vincent D. during group sessions. On January 10, 2012, respondent also began working with a parenting coach on a bi-weekly basis. However, Miller was often asked to assist the parenting coach during sessions as respondent had difficulty participating in the program due to her lack of "attention" and "cognition." Respondent could not focus long enough during the sessions to retain any information that was being taught. Respondent's "ability to gainfully participate in services [was] impacted by her mental health issues."

¶ 28 The service plan stated that on December 5, 2011, respondent completed a substance abuse assessment. The plan stated that even though the assessment qualified her for substance abuse treatment, her mental health issues and strong denial of a substance abuse problem prevented her from receiving any benefit from the treatment.

¶ 29 Respondent continued to visit Vincent D. once a week. However, on multiple occasions, respondent forgot to bring a lunch or enough diapers for Vincent D. In addition, visits required "close and constant supervision" to keep him safe. Respondent's "slow reaction time" allowed

Vincent D. to climb on and off chairs, jump on furniture, attempt to put his fingers in electrical sockets, and pull book shelves down. Respondent failed to properly discipline him when he threw things or slapped her and “greatly lack[ed]” the parenting skills and adult authority needed to care for a child of his age and development. During visits, respondent also laughed inappropriately, cried, appeared anxious and angry, and wore excessive jewelry.

¶ 30 Miller interviewed respondent in April 2012 and completed an integrated assessment on May 4, 2012. The assessment reiterated the findings reported in the fourth service plan. Respondent had made minimal progress, and the prognosis for reunification was poor. During visitation, respondent needed guidance in both parenting and life skill areas, and she needed constant coaching and supervision when interacting with Vincent D. Respondent displayed aggressive tendencies and was often outwardly frustrated with Vincent D. and Miller. Even after classes, there was no improvement in respondent’s parenting skills, and Vincent D. was not an easy child to supervise due to his developmental delays and sensory processing dysfunction. Miller never recommended unsupervised visitation, and respondent’s continual denial of a mental illness prevented her from making substantial progress toward the return-home goal. Because respondent could not keep Vincent D. safe, Miller no longer recommended the goal of return home.

¶ 31 Barbara White, a licensed clinical social worker for Thresholds Parenting Assessment Team from 1999 to 2011, was qualified as an expert in parenting assessments. White conducted a parenting capacity evaluation for respondent (Thresholds report) at Miller’s request. In particular, White was to evaluate whether respondent was able to parent Vincent D. given her mental illness. For the report, White saw respondent on two occasions, one of which was with Vincent D. Dr.

Kurth, a psychiatrist, and Dr. Hunneke, a psychologist, also saw respondent once. Finally, DCFS records and psychiatric records were reviewed, and respondent completed some questionnaires.

¶ 32 White described respondent as a “poor historian.” Respondent was psychotic and not taking her medication. At respondent’s first visit in April 2011, she had received a Haldol shot from Dr. Caban a few days before, so her symptoms were not “as bad.” Still, she wore numerous rings and bracelets on her arm and bandannas around her ankles. Also, respondent thought that her identity and her purse had been stolen and that people were coming into her home and rearranging things. Respondent thought that people were after her, such as the CIA, and White opined that the delusions were part of her psychosis. In addition, respondent was very labile, meaning that she would have mood swings of laughing to crying during the conversation.

¶ 33 At the second visit in June 2011, respondent’s symptoms were “much more severe.” Her thinking was very disorganized and very tangential, and she needed to be redirected continually. There were times that her psychotic thinking made her incomprehensible. Again, respondent wore excessive jewelry.

¶ 34 The second visit included White’s observation of respondent with Vincent D., who was about 13 months old. Respondent gave Vincent D. a snack but did not give him the sandwich sent by his foster mother. When Miller gave Vincent D. the sandwich, he “hungrily ate it” and was “clearly hungry.” However, respondent had said that Vincent D. did not want the sandwich. Also, respondent had trouble changing Vincent D.’s diaper. He crawled around the floor with no diaper and had a bowel movement. Respondent struggled to put on a new diaper because “it was hard for her to focus on the task.” White testified that respondent loved Vincent D. and was affectionate with him, and there were times that she was appropriate with him. At other times, however, respondent

talked about Vincent D. having bruises and rashes all over him, even though he did not. Also, respondent was very concerned that Vincent D. would be harmed. She repeatedly warned him to be careful, “even though he wasn’t in a situation where he was apt to be hurt.”

¶ 35 White’s concern was that respondent was having a hard time taking care of herself, meaning that she could not also care for a minor child who was so young and dependent on her. For instance, respondent had a hard time with finances. In the past, she had worked as a waitress, hostess, and bank teller, but only for short periods of time. Currently, respondent’s primary source of income was her social security disability payments. She also received alimony from her exhusband,³ and she was concerned how she would manage if he terminated those payments. White noted that respondent talked about how her money was disappearing; how her purses were stolen; and how people were taking money out of her bank account, even though no one was stealing from her. Respondent also had inconsistent housing and a “very limited support system” of mainly her mother.

¶ 36 White’s other concern was that there was no separation between parent and child. For example, if respondent was angry, she would project that anger onto Vincent D. despite no indication that he was angry.

¶ 37 Respondent denied substance abuse issues but admitted receiving “a DUI” the year before (2010). She admitted passing out or not remembering times when she had been drinking, and she admitted to drinking casually to help herself relax. Respondent also admitted to occasionally using cocaine or marijuana to calm down.

³Respondent’s exhusband had custody of their son Nathan. DCFS was involved with Nathan as well, but White could not get access to those records.

¶ 38 Respondent advised White that she was not taking her medications because of the way they made her feel. She denied having a mental illness and claimed that people said this only to make her look incompetent. Respondent admitted that she had been hospitalized before; she had had an “organic breakdown” after her divorce. Prior to her divorce, respondent felt that people were after her, so she stopped eating anything other than seaweed and water. Her weight went down to 60 pounds so that “the people who were looking for her would not be able to find her.” White testified that respondent talked frequently about her health problems, stating that she had had multiple back surgeries due to an accident when she was nine years old. Respondent also had asthma, bronchitis, hypertension, borderline diabetes, and tremors in her head. Respondent told White that the medication she was taking related only to her physical health issues.

¶ 39 White was not able to formulate a “baseline” for respondent, which was how respondent functioned when she was in treatment and taking her medication. This was because respondent was not consistent with her psychiatric appointments or medication during the evaluation period. White’s recommendation was that respondent receive psychiatric help in a structured program, either with inpatient care or an intensive outpatient program. White also recommended a substance abuse evaluation, although respondent was in a “catch 22 position” because the substance abuse organization had evaluated her and could not proceed until her mental health was stabilized. Without treatment, White opined that Vincent D. was not safe in respondent’s care; he was not safe unless respondent stabilized. White also recommended that all visits be supervised.

¶ 40 Ellen Frank, a licensed clinical social worker with Apex Assessments and Counseling, testified next. She was qualified as an expert and completed a parenting capacity assessment (Apex report) on May 23, 2012. Frank was to assess whether respondent could parent Vincent D., who was

two years old. There were concerns about respondent's mental health status and how that affected her parenting. For the Apex report, Frank observed respondent with Vincent D., reviewed case records, and interviewed respondent.

¶ 41 At the interview, respondent wore excessive jewelry. In Frank's experience, people with a Bipolar Disorder diagnosis with manic episodes tended to wear more jewelry than the average person.

¶ 42 During the interview, respondent's thought process was scattered and tangential. She also had "flight of ideas," which were nonsensical, aberrant, and incomprehensible associations. Her thinking was psychotic at moments; it was "disordered to the point of a psychotic process," and there was evidence of paranoia. Respondent exhibited a general belief of victimization, thinking that people were out to get her and deliberately doing things to hurt or damage her. For instance, respondent thought Miller, the caseworker, was out to get her. At times, respondent was agitated, and her speech became more rapid and pressured. Respondent's mood was labile in that it kept changing between tearful, agitated, angry, and calm.

¶ 43 Frank described respondent as a poor historian; details were sketchy, incomplete, fragmented, and vague, although not all of the time. For example, respondent thought she had graduated high school but the record indicated that she had not. In addition, respondent denied having a substance abuse problem but admitted having a DUI. Respondent admitted that she had lost her license.

¶ 44 Frank testified that respondent disagreed with her diagnosis of Bipolar Disorder and stated that she was taking Haldol and Lorazepam for her back pain. However, these were both psychiatric medications. The Apex report indicated that respondent had been compliant with the Haldol injections recently, at the time of the May 2012 Apex report, but not historically. Still, respondent

did not show knowledge or understanding of her own issues; she believed that “this is all from a back injury and from a head trauma” that she believed happened years ago but was never substantiated. Respondent’s ideation, which was her explanation of why something happened and what was required to fix it, was paranoid and in the psychotic range of thinking.

¶ 45 Miller had advised Frank about respondent’s fear that people were stealing from her. Respondent complained that somebody was taking money out of her bank account so frequently that Miller investigated the situation and learned that respondent herself was withdrawing cash from many different cash station locations. Miller did not know if respondent was aware that she was doing this as opposed to someone stealing from her.

¶ 46 Frank explained that when people talked about their life, it was possible to assess their emotional functioning and ability to assess situations accurately. In “all of those areas [respondent] was impaired.” For example, when Frank tried to establish a history of where respondent had lived, “it got so confusing” that Frank could not establish it.

¶ 47 Frank observed respondent’s interaction with Vincent D. Frank thought Vincent D. was “behind” in terms of language skills and his attention span. Vincent D. was “oppositional, defiant, hostile, violent, taking objects and throwing them at [respondent’s] face.” He also threw things at Frank, which was “very unusual.” In about a 75-minute interaction, there was not even five minutes of engaged play between respondent and Vincent D. She wanted him to read, which was not age appropriate or possible with Vincent D.’s problems. Respondent tried to set limits with Vincent D. but was ineffective. Her attempts to discipline him were “timed very late” and inadequate. Vincent D. ran back and forth across the room 30 times in one hour. When he wanted cereal that was on the

table, and she said “ ‘no cereal right now,’ ” he got on her lap and grabbed her face, trying to force his will on her.

¶ 48 In reviewing the case file, Frank learned that respondent’s visits had been reduced from three times per week to once a week due to inappropriate parenting and Vincent D.’s reaction. Vincent D. was very agitated and violent after visits. In addition, respondent was not sensitive to “various directions.” When respondent moved near Vincent D., he would move away from her by going under a table or running to the opposite side of the room. Respondent was attached to Vincent D., but he was not attached to her. “Anytime she approached, he retreated.”

¶ 49 From Frank’s own observation, interview, and the case records she read, respondent “had difficulty taking care of herself adequately.” In Frank’s experience, people who had problems with their “executive functions” often did better in a residential treatment center where some of the burden of taking care of themselves was handled for them, and there was a structure and staff present. Frank recommended that respondent be referred to a residential group home.

¶ 50 Frank testified that Miller had asked her to answer certain questions, such as assessing respondent’s progress in her parenting practices. According to Frank, respondent’s ability to parent had not improved very much. Respondent tried to engage Vincent D. in activities that were age appropriate and some that were not, but she did not know the difference. “That had not changed” over time. For instance, respondent expected Vincent D. to walk at the age of four months and read at the age of two. Also, respondent allowed Vincent D. to physically abuse her, which “was identical to what had been described” one or two years before. Respondent was unable to integrate what she learned from the parenting coach and at parenting classes when interacting with Vincent D.

¶ 51 According to Frank, respondent's mental illness interfered with "her ability to parent very much," even for an average child. Vincent D., however, had special needs and would be hard for anyone to parent, thus requiring an even higher level of consistency, stability, strength, and ability to manage doctors' appointments. A medication regime was needed for both respondent and Vincent D., and Frank did not think respondent would be able to do it. The prognosis of respondent's ability to meet minimum parenting standards was poor, and Frank recommended that Vincent D. not be returned to her. Although respondent had a good heart and really wished to be able to parent Vincent D., it was "not at all likely within a reasonable time frame." Also, Frank noted that respondent's medical condition could not be corrected, only managed. This meant that even when respondent was compliant with her medication and Haldol shots, her mood was still "considerably labile."

¶ 52 Dr. Joanna Caban testified next as follows. Dr. Caban, a doctor specializing in psychiatry, worked for the Lake County Health Department. She first met with respondent in March of 2009 and had known her for 3½ years. Dr. Caban diagnosed respondent with Bipolar 1 Disorder, which was a chronic mental illness characterized by manic episodes. Respondent presented with manic and depressive as well as mixed episodes. Dr. Caban had witnessed manic episodes in which respondent laughed and talked a lot, wore too much jewelry, went from friendly to angry or irritable, and presented with delusions of a persecutory disorder, claiming that people were after her. When respondent was manic, it limited her insight; she saw no reason to take her medication; and she stopped coming to appointments. Dr. Caban had also witnessed depressive episodes in which respondent cried, made poor eye contact, complained about anxiety, and felt overwhelmed.

¶ 53 When respondent was compliant with her medication, she did quite well: she was kind, cooperative, friendly, intelligent, and a very pleasant patient. When she did not take her medication,

however, her symptoms recurred, and her daily life was “very much affected,” such as her impulsivity and choices. When not treated, the Bipolar Disorder impaired her thought process, her emotional process, her judgment and behavior, her perception of reality, and her ability to cope with the ordinary demands of life. Respondent would need to take medication for the rest of her life, and even when taking medication, she still had “vulnerability and some propensity towards mood swings.” There were no medications that guaranteed that there would be “no next episode with a [B]ipolar [D]isorder.” Still, when compliant with her medication, respondent’s mood swings were not so drastic that she was unable to function. When Dr. Caban was asked whether respondent would “be stable enough to possibly parent a child” when taking her medication, she said “yes.”

¶ 54 Dr. Caban testified that since first treating respondent in March 2009, the longest period she had gone without treatment was seven or eight months. After the initial March 2009 appointment, respondent was absent from April to September of 2009. In 2010, she was absent from January until August, when she had her next appointment. At the August 2010 appointment, respondent felt she did not need medication. She was hyperactive, labile, her affect was poorly related, and she had pressured speech. Respondent also presented with persecutory delusions.

¶ 55 After the August 2010 appointment, respondent was absent until April 2011. At the April 2011 appointment, respondent was laughing, hyperactive, and labile. She also exhibited very prolific speech and wore a lot of jewelry, which signaled a manic state. Respondent returned in April 2011 because she wanted to regain custody of Vincent D. After respondent received a Haldol injection, she did not return until June 2011. Respondent was “better” at the June 2011 appointment, in that she was calm, nicely groomed, living by herself, getting along better with her mom, and visiting Vincent D.; she was not manic depressed or psychotic. After the June 2011 appointment, respondent

had been consistent with appointments. Currently, respondent was taking four medications by injection every four weeks.

¶ 56 Dr. Caban had also diagnosed respondent with alcohol and cocaine abuse. Dr. Caban was not aware of respondent engaging in substance abuse for at least two years, although she had not performed a urinalysis.

¶ 57 Sharon Eddington testified first on behalf of respondent as follows. Sharon was respondent's friend and often drove her to counseling and visitation sessions. Sharon observed respondent with Vincent D. about once a week. Respondent was reserved and hesitant to take any action with Vincent D. because respondent thought it was against the rules to direct him in any manner. Respondent would not restrain him physically but would talk assertively.

¶ 58 Julie Nieto, respondent's mother, testified as follows. She had also observed visits between respondent and Vincent D. Vincent D. would hang on respondent, kiss her, and hold her. Respondent was very patient with Vincent D. and disciplined him gently, not aggressively. If Vincent D. was out of control and throwing things, respondent would take the item away and instruct him not to throw things.

¶ 59 Anthony Nieto, who adopted respondent when she was four years old, testified as follows. He was at the hospital when Vincent D. was born. Respondent was holding him when "someone came and yanked [him] away from her." Anthony saw respondent once or twice a month. Other than crying over the loss of Vincent D., respondent's behavior was stable.

¶ 60 Respondent testified as follows. About 10 years ago, she was diagnosed with cocaine and dependent alcohol abuse. For the past 1½ years, respondent received substance abuse treatment at the Independent Center. She did not complete the program, however, because she felt uncomfortable

around the “homeless people.” Miller was supposed to give respondent a referral to go somewhere else, but she never did. During her involvement with DCFS, respondent performed some random drug tests, but on one occasion, she had no transportation, and on another occasion, her back was hurting.

¶ 61 After Vincent D. was born, Dr. Caban “dismissed” respondent and indicated that there were “no more problems” with her, and it was not necessary to return. DeJesus, respondent’s first caseworker from May 2010 to May 2011, suggested that she go back to Dr. Caban because DCFS wanted her to receive more treatment. Respondent started seeing Dr. Caban on a regular basis and was placed on various medications. The medications changed based on her allergic reactions. Respondent had been diagnosed with Bipolar Disorder but did not believe that she suffered from it.

¶ 62 Respondent got along well with DeJesus but not Miller, who was “mean” and did not treat her fairly. Respondent gave the example that Miller drove her to court one day and then dropped her off at the train station, saying that respondent had to get home on her own. Respondent was afraid that she would get lost and end up in another town. In addition, Miller did not assist respondent in completing tasks and services. Respondent had received counseling through a DCFS counselor but DCFS prevented her from continuing those appointments.

¶ 63 Respondent disagreed with Miller that she had a delayed reaction during visitation when Vincent D. was hitting her. Respondent did not delay but rather disciplined him in a way that was patient. Respondent’s method was to try to hold Vincent D.’s hand and tell him to be gentle. Respondent tried to implement the techniques she learned from the parenting coach, although she could not recall any specific example of doing so. During the three years that respondent had visitation with Vincent D., he showed up with bruises on his face five times. Miller explained what

caused the bruising on one occasion but did nothing about the other bruises. In addition, Miller started arguments with her during visitation and did not advise her that Vincent D. had special needs.

¶ 64 Miller came to see where respondent lived. She told respondent to remove things from the bed, straighten things up, and get rid of things, which respondent did. Respondent also cleaned her apartment.

¶ 65 B. Court's Unfitness Decision

¶ 66 On April 4, 2013, the court issued its decision finding respondent unfit. In its detailed ruling, the court stated that in observing respondent's demeanor as a witness, she was a poor historian and often seemed confused and unable to answer direct questions under examination. The court found the State's witnesses to be credible; their observations of respondent were consistent with the court's observation of respondent as she testified.

¶ 67 In particular, the court noted that two clinical social workers, who conducted parental capacity assessments one year apart, opined that respondent was unable to parent. Frank testified that respondent's inability to parent would last beyond a reasonable period of time. While the initial Thresholds report was conducted at a time when respondent was returning to her psychiatric treatment and medication, the second Apex report was conducted after one year of medication and services. However, respondent was "still barely able to care for herself and certainly couldn't care for a child."

¶ 68 The court also made specific findings regarding Dr. Caban's testimony. The court stated:

"And while Dr. Caban stated that if [respondent] remained on her medication, she may be able to parent, Dr. Caban did not see any interaction between [respondent] and her son nor view her parenting skills. Dr. Caban did not provide any counseling, and oftentimes

[respondent] received her medication injections through a nurse at the facility. And while I find Dr. Caban to be credible as to [respondent's] diagnosis of [B]ipolar [D]isorder, her speculation regarding [respondent's] ability to parent does not hold much weight in light of the testimony of the caseworkers and the Parenting Capacity Assessment providers and, of course, in light of [respondent's] continued denial of her mental illness.”

¶ 69 While the court had no doubt that respondent cared deeply for Vincent D. and believed that she was able to parent him appropriately, respondent was unable to recognize her limitations and her mental health issues. Bipolar Disorder was a chronic illness, and based on the severity and length of time of her mental illness, the court found that respondent would be unable to parent within a reasonable amount of time. Vincent D. came into care when he was born in May 2010. Three years later, respondent was no closer to family reunification due to her mental health issues. Even with medication, respondent was unable to parent, and there was no evidence that her condition would change in the future.

¶ 70 The court found respondent unfit on three of the five grounds alleged by the State. Specifically, the court found respondent unfit for failure to make reasonable progress towards the return of the minor within nine months of the neglect adjudication or the other nine-month period alleged by the State, and for her inability to discharge parental responsibilities due to mental illness.

¶ 71 C. Best Interests Hearing

¶ 72 After the court's ruling, the case immediately proceeded to a best interests hearing. Jeanette White, a Court Appointed Special Advocate (CASA), testified as follows. White served as Vincent D.'s CASA when he first came into care in May 2010 and throughout the entire case. At the beginning of the case, White saw Vincent D. during each visitation with respondent. Currently,

White saw Vincent D. on a monthly basis. Because the original foster care family was not interested in permanency, Vincent D. was transferred to another foster family that was interested in a permanent placement. Vincent D., who would turn three years old the next month, had been with the second family for about 1½ years. (since October 2011).

¶ 73 The foster family lived in a two-story, three-bedroom house in Lakemoor. The family had already adopted a daughter, Christy, who was now eight years old, and she and Vincent D. each had their own bedroom. Vincent D. called the foster mother “mom.” When Vincent D. saw his foster mother at the daycare the previous week, he “got this big grin and opened his arms and ran up and said ‘mom’ because he was so surprised to see [her] there.” Both foster parents treated Vincent D. as a member of the family; they were bonded to him; all of his needs were being met; and they were willing to adopt him. The foster family was also involved in church, where Vincent D. interacted with other children.

¶ 74 Vincent D. had a great deal of behavioral issues. He was very aggressive, threw things, and hit people. Vincent D. had been asked to leave several daycare centers and was currently in his fourth placement. The foster mother made a concerted effort to engage Vincent D. in many therapies, such as physical therapy, speech therapy, and behavioral therapy. In addition, the foster mother took him to all of his doctor’s appointments and even to specialists in Chicago. The foster mother was a strong advocate for Vincent D.; she “tried to find out what the problem [was] and how to address it.” She would not take “no for an answer.” For example, if Vincent D. was offered two hours of behavioral therapy, she asked for three.

¶ 75 During White’s observation of visitation between respondent and Vincent D., respondent was “very attentive” to him because it was necessary to watch him “all the time.” Vincent D. called

respondent “mom” but did not run up to her. Respondent would want to hold him all the time, which he did not like, and respondent never “really understood that.” Respondent did not understand Vincent D.’s sensory issues, meaning she was not able to interact with him in a comforting way.

¶ 76 Miller testified next. She handled Vincent D.’s case from May 2011 to November or December 2012. Miller observed respondent’s visitation with Vincent D. over a 20-month period. Vincent D. had behavioral issues such as biting, hitting, scratching, punching, kicking, spitting, and throwing food, and his behaviors had progressed with age. During visitation, respondent did not respond appropriately to Vincent D.’s behavior. When he physically attacked her, she failed to stop him. Respondent let Vincent D. hit her instead of putting him down and disciplining him. In addition, respondent made Vincent sit on her lap, and she would hold him “very tight” even when he did not want to be held. Miller had advised respondent that Vincent D.’s sensory processing issues caused him to not want to be held. He became overstimulated with any type of touch, noise, or activity in his environment and would hit respondent “because of that.” Respondent would also feed him when he was not hungry. When Vincent D. was one year old and transitioning from a bottle to a sippy cup, respondent brought in a jar of unidentifiable food that looked like pasta, meat, and vegetables. When Miller asked what it was, respondent “couldn’t really identify it either,” saying it was food from her house that she packed into a jar.

¶ 77 Miller observed Vincent D. with his foster family. The foster parents were loving and bonded to Vincent D.; they treated him like their own child. Their adopted daughter Christy was also loving and interacted appropriately with Vincent D. The foster parents were willing to adopt Vincent D. and continue therapy for his special needs. Every week, the foster mother ensured that Vincent

D. participated in developmental therapy, speech therapy, and occupational therapy. Also, Vincent D.'s bedroom was appropriate, and Miller had observed his personal effects throughout the house.

¶ 78 Laura Craemer was the final witness to testify. Craemer inherited the case from Miller and had met weekly with Vincent D. and the foster family for the past three months. Christy enjoyed being with Vincent D. and worked at keeping him happy and playing with him. She was very loving towards him even though he sometimes competed with her for the foster parents' attention. The foster family's house was equipped with safety measures such as a gate on the stairs and clips on the drawers. In addition, the living room had an area for Vincent D.'s toys, and the toys were age-appropriate. The foster family lived next to a park and other children. The family would play in the park, take walks, and participate in community activities. Recently, the family went to a water park.

¶ 79 The foster parents took Vincent D. to weekly meetings with a speech therapist and a social worker from early intervention services. In addition, they worked with a developmental therapist twice a week to develop strategies to handle his aggressive behavior and developmental delays. The foster parents were "definitely proactive" and very aware of his delays. On their own, they scheduled Vincent D.'s early education programming to begin that May, and the past November, they had arranged a more comprehensive diagnostic assessment for him. The foster parents were very committed to caring for Vincent D. for the long term and wanted what was best for him.

¶ 80 The trial court determined that it was in Vincent D.'s best interest to terminate respondent's parental rights. Vincent D. had extreme special needs, and the foster family was committed to him both verbally and in their proactive actions of dealing with his special needs. The caseworkers had observed Vincent D. in the foster family's home, and he was very well-cared for and bonded to the family, including Christy. The court changed the goal to adoption.

¶ 81 Respondent timely appealed.

¶ 82 II. ANALYSIS

¶ 83 Termination of parental rights is a two-step process. *In re Julian K.*, 2012 IL App (1st) 112841, ¶ 1. First, the trial court must find, by clear and convincing evidence, that the parent is unfit. *Id.* ¶ 63. Second, the court must determine, by a preponderance of the evidence, whether termination of parental rights is in the minors' best interests. *Id.*

¶ 84 A. Unfitness

¶ 85 Because the termination of parental rights constitutes a complete severance of the relationship between the parent and child, proof of parental unfitness must be clear and convincing. *In re Shauntae P.*, 2012 IL App (1st) 112280, ¶ 88. The trial court is in the best position to assess the credibility of witnesses, and a reviewing court may reverse a trial court's finding of unfitness only where it is against the manifest weight of the evidence. *Id.* ¶ 89. A decision regarding parental unfitness is against the manifest weight of the evidence where the opposite conclusion is clearly the proper result. *In re C.E.*, 406 Ill. App. 3d 97, 108 (2010). Each case concerning parental unfitness is *sui generis*, meaning that factual comparisons to other cases by reviewing courts are of little value. *Id.*

¶ 86 In this case, the trial court found respondent unfit on three of the five grounds alleged by the State. Although section 1(D) of the Adoption Act (750 ILCS 50/1(D) (West 2010)) sets forth several grounds under which a parent may be deemed unfit, any one ground, properly proven, is sufficient to enter a finding of unfitness. *In re Shauntae P.*, 2012 IL App (1st) 112280, ¶ 89. We consider the trial court's finding of unfitness under section 1(D)(p) of the Adoption Act, which defines as unfitness as:

“Inability to discharge parental responsibilities supported by competent evidence from a psychiatrist, licensed clinical social worker, or clinical psychologist of mental impairment, mental illness or mental retardation as defined in Section 1-116 of the Mental Health and Developmental Disabilities Code, or developmental disability as defined in Section 1-106 of that Code, and there is sufficient justification to believe that the inability to discharge parental responsibilities shall extend beyond a reasonable time period.” 750 ILCS 50/1(D)(p) (West 2010).

Accordingly, there are two prongs required to prove unfitness under section 1(D)(p). First, the State must present competent evidence that the parent suffers from a mental impairment, mental illness, or mental retardation sufficient to prevent the discharge of normal parental responsibilities; and second, the State must present sufficient evidence to conclude that the inability will extend beyond a reasonable time period. *In re Cornica J.*, 351 Ill. App. 3d 557, 566 (2004).

¶ 87 In this case, respondent does not dispute that she has been diagnosed with the mental illness of Bipolar Disorder. However, she does dispute that the State presented sufficient evidence that the inability to parent will extend beyond a reasonable time period. In support of her argument, respondent relies on two of the three experts who testified at trial. First, she relies on White, arguing that White never opined that she would never be able to parent Vincent D. Rather, respondent points out that White qualified her opinion by stating that *until* respondent was stabilized, Vincent D. would not be safe in her care. Second, respondent relies on Dr. Caban, who testified that her mental illness was treatable and that when on her medication, respondent was stable enough to parent a child. Respondent concedes that the third expert, Frank, opined that her mental illness impaired her ability to parent and that the impairment would last for an unreasonable period of time. However,

respondent urges this court to place greater weight on Dr. Caban's opinion, given that Dr. Caban was her treating physician for years. We are not persuaded by respondent's argument. A review of the record shows that the State proved by clear and convincing evidence that respondent's inability to discharge parental responsibilities would extend beyond a reasonable time period.

¶ 88 By the time the court ruled on fitness, Vincent D. had been in DCFS care for nearly three years, since his birth in May 2010. The first parenting capacity assessment was performed by White, who saw respondent on two occasions approximately one year into the case (in April and June 2011). Based on her two observations of respondent, White opined that she was psychotic and labile; that she suffered delusions that people were out to get her, rearranging her furniture, and stealing from her; that she exhibited disorganized, tangential, incomprehensible thinking; that she was overly decorated; and that she had a hard time taking care of herself in terms of finances, housing, and a support system. With respect to parenting, respondent had trouble changing Vincent D.'s diaper and feeding him; she imagined bruises and rashes on his body; and she projected her own feelings onto him, meaning she was unable to separate parent from child.

¶ 89 While respondent attempts to create a positive spin by pointing out that White never opined that she would never be able to parent Vincent D., this is because respondent was not receiving treatment or taking her medication at the time White evaluated her. Respondent admitted to White that she was not taking her medications, and she denied having a mental illness. As a result, White was not able to formulate a "baseline" for respondent, which was how she functioned when properly treated and medicated. Yet, White's inability to formulate a baseline does not aid respondent but instead illustrates the severity of her mental illness. White opined that without treatment, Vincent D. was not safe in respondent's care; he was not safe unless respondent stabilized. But that does

mean that the converse is true. In other words, White did not testify that once respondent stabilized, Vincent D. would be safe or respondent would be able to parent. Again, without a baseline, White could not offer such an opinion. Thus, respondent's argument to the contrary lacks merit.

¶ 90 Regardless, any questions remaining after White's assessment were answered in the second parenting capacity assessment, which was conducted by Frank one year later (May 2012). By this time, respondent had been compliant with her medication for nearly one year, since June 2011. Even when taking her medication, Frank observed respondent's thought process to be scattered, tangential, and, at times, psychotic and paranoid; she was labile; and, she had flight of ideas that were nonsensical and incomprehensible. According to Frank, respondent's emotional functioning and ability to assess a situation were impaired: respondent had no understanding of her own issues and believed the medication she took was for physical ailments from unsubstantiated incidents. Because respondent had difficulty taking care of her own needs, Frank, like White, recommended that respondent be referred to a residential group home where there was structure and a staff to help meet the demands of daily life.

¶ 91 Aside from the inability to care for herself, Frank noted that respondent's mental illness interfered with her ability to parent "very much," even for an average child. Respondent was unable to integrate what she learned from the parenting coach and classes. For example, respondent could not distinguish between age-appropriate and age-inappropriate activities, expecting Vincent D. to walk at four months and read at age two. Complicating matters more, Vincent D. had special needs that required an even higher level of consistency, stability, and medical attention. Both Vincent D. and respondent needed a medication regime, and Frank opined that respondent would not be able to manage it. Frank offered direct testimony as to respondent's future ability to parent, saying that

based on what she observed, respondent's ability to parent was "not at all likely within a reasonable time frame." *Cf. In re A.J.*, 269 Ill. App. 3d 824, 828 (1994) (testimony that the parent would not be able to parent her children in the foreseeable future has been accepted as beyond a reasonable time period for purposes of the Adoption Act).

¶ 92 Turning to the expert relied on most by respondent, Dr. Caban, she had treated respondent for a period of about 3½ years. Respondent is correct that Dr. Caban testified that when medicated, respondent was kind, cooperative, friendly, intelligent, and a very pleasant patient. Dr. Caban also said "yes" when asked if respondent, when taking her medication, could "possibly" parent a child. However, Dr. Caban's testimony is not as favorable to respondent as she claims.

¶ 93 Dr. Caban explained that Bipolar Disorder was a chronic mental illness characterized by manic episodes and that respondent would need to take medication for the rest of her life. Yet, Dr. Caban admitted that respondent had a history of not taking her medication, going without it for seven or eight months at a time. When respondent was not taking her medication, Dr. Caban explained that her daily life was "very much affected." The Bipolar Disorder impaired respondent's thought process and emotional process, her judgment and behavior, her perception of reality, and her ability to cope with life's daily demands. Dr. Caban had witnessed respondent's manic episodes in which she was labile and suffering delusions of a persecutory disorder. When respondent was manic, her insight was limited, and she saw no reason to take her medication. Dr. Caban further testified that even when respondent took her medication, she still exhibited a propensity for mood swings; there was no medication guaranteeing that her mental illness would not result in another "episode."

¶ 94 Also, we note that Dr. Caban did not say that respondent, when medicated, was able to parent a child. Rather, she said only that respondent could "possibly" parent a child. Regardless,

the trial court placed little weight on this testimony because Dr. Caban, unlike White and Frank, had never witnessed respondent interact with Vincent D. As stated, Frank observed respondent with Vincent D. at a time when respondent was compliant with her medication and treatment. Yet even when taking her medication, Frank opined that respondent struggled to take care of her own needs, let alone a child with special needs. It is up to the trial court to assess the credibility of the witnesses and accept the testimony of one witness over another, and this court will not reweigh the evidence on review. *In re T.Y.*, 334 Ill. App. 3d 894, 908 (2002).

¶ 95 In addition to the expert testimony, the court also heard other witnesses testify about respondent's capacity to parent. See *In re Daphnie E.*, 368 Ill. App. 3d 1052, 1069 (2006) (in addition to the expert testimony, the court also considered the testimony of nonexperts regarding their opportunity to observe the parent's capacity to parent). For example, Klemchen testified that respondent's visitation and participation in other services was limited by her failure to take her medication.

¶ 96 Miller testified that even after respondent resumed her medication, she observed "very little improvement in regard to her mental health." According to Miller, respondent struggled with basic parenting skills and feeding. Respondent either forgot to bring food, did not bring appropriate food, or tried to feed Vincent D. cold or uncooked food. When working with a parenting coach, respondent's mental illness prevented her from being able to focus or meaningfully participate. Respondent had a difficult time disciplining Vincent D. and needed close and constant supervision to keep him safe. Miller's overall assessment of respondent was that during visitation, she needed constant coaching and supervision, and there was no improvement in her skills. Miller also testified that respondent continued to deny having a mental illness; did not maintain a residence suitable for

a child; had difficulty arranging transportation; struggled to manage her money; and continually imagined that people were stealing from her.

¶ 97 Finally, in observing respondent's demeanor as a witness, the court found her to be a poor historian who often seemed confused and unable to answer direct questions. Respondent had a history of mental illness and hospitalizations and yet continued to deny that she suffered from Bipolar Disorder. While respondent clearly loves Vincent D., the State showed by clear and convincing evidence that her inability to parent will extend beyond a reasonable time period. Therefore, the trial court's finding that respondent is unfit under section 1(D)(p) is not against the manifest weight of the evidence.

¶ 98 Having found that respondent was unfit on this ground, we need not consider respondent's arguments regarding due process and the other two grounds under which she was found unfit.

¶ 99 B. Best Interests Hearing

¶ 100 Respondent next argues that it was not in Vincent D.'s best interest to terminate her parental rights. A reviewing court will not disturb the trial court's decision at a termination hearing unless it is against the manifest weight of the evidence. *In re Julian K.*, 2012 IL App (1st) 112841, ¶ 65. The reason for this deferential standard is that the trial court is in a superior position to assess the witnesses' credibility and weigh the evidence. *Id.* ¶ 66. A trial court's decision is against the manifest weight of the evidence only when the opposite conclusion is clearly apparent. *In re William H.*, 407 Ill. App. 3d 858, 866 (2011).

¶ 101 Under the Juvenile Court Act of 1987 (705 ILCS 405/1-2 *et seq.* (West 2010)), the best interest of the minor is the paramount consideration to which no other takes precedence. *In re I.H.*, 238 Ill. 2d 430, 445 (2010). A child's best interest is not to be balanced against any other interest;

it must remain inviolate and impregnable from all other factors. *In re Austin W.*, 214 Ill. 2d 31, 49 (2005). Even the superior right of a natural parent must yield unless it is in accord with the best interests of the minors involved. *Id.* at 50.

¶ 102 The Juvenile Act sets forth the factors to be considered whenever a best interest determination is required, and they are to be considered in the context of the minors' ages and developmental needs:

“(a) the physical safety and welfare of the child, including, food, shelter, health, and clothing;

(b) the development of the child's identity;

(c) the child's background and ties, including familial, cultural, and religious;

(d) the child's sense of attachments, including:

(i) where the child actually feels love, attachment, and a sense of being valued (as opposed to where adults believe the child should feel such love, attachment, and a sense of being valued);

(ii) the child's sense of security;

(iii) the child's sense of familiarity;

(iv) continuity of affection for the child;

(v) the least disruptive placement alternative for the child;

(e) the child's wishes and long-term goals;

(f) the child's community ties, including church, school, and friends;

(g) the child's need for permanence which includes the child's need for stability and continuity of relationships with parent figures and with siblings and other relatives;

- (h) the uniqueness of every family and child;
- (i) the risks attendant to entering and being in substitute care;
- (j) the preferences of the persons available to care for the child.” 705 ILCS 405/1-3(4.05) (West 2010).

Also relevant in a best interests determination is the nature and length of the minors’ relationships with their present caretaker and the effect that a change in placement would have upon their emotional and psychological well-being. *In re William H.*, 407 Ill. App. 3d at 871.

¶ 103 Respondent argues that she was very attentive to Vincent D. during visitation, and that he called her “mom,” kissed her, and held her. She argues that “since all mental health cases involve parents who dearly love their children, guardianship should be an option.” We have no doubt that respondent loves Vincent D. However, the focus at a best interests hearing is not on respondent but rather what is in the child’s best interest. The evidence shows that it was in Vincent D.’s best interest to terminate respondent’s parental rights.

¶ 104 Vincent D., who was almost three years old at the time of the best interests hearing, had never lived with respondent. According to Frank, he was not attached to respondent but instead would retreat from her during visitation.

¶ 105 Vincent D. had lived with the current foster family for the past 18 months. Three witnesses, White, Miller and Craemer, testified regarding Vincent D.’s bond to the foster family. Vincent D. called his foster mother “mom” and was very bonded to her and Christy. Vincent D. also had his own room, age-appropriate toys, and the house was properly equipped for him with gates and locks. The foster family engaged in activities together, such as going on walks or playing in the park, and

they participated in church and community activities. Vincent D. had friends at church and in the neighborhood.

¶ 106 The foster parents were also committed to addressing Vincent D.'s special needs. They were strong advocates for Vincent D., proactively seeking to get him the most help possible with respect to his medical, educational, and developmental needs. The foster parents made appointments with doctors and specialists for Vincent D. and participated in weekly physical therapy, speech therapy, and behavioral therapy. On their own, they scheduled early education programming and a more comprehensive diagnostic assessment so that they could better address Vincent D.'s needs.

¶ 107 Overall, the foster parents treated Vincent D. like their own child and wanted what was best for him. They were willing to adopt him and provide permanence in his life. Accordingly, the trial court's decision that it was in Vincent D.'s best interest to terminate respondent's parental rights was not against the manifest weight of the evidence.

¶ 108

III. CONCLUSION

¶ 109 For the reasons stated, the judgment of the Lake County circuit court is affirmed.

¶ 110 Affirmed.