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The Michigan Child Welfare Law Journal



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Issue Introduction

This issue of the *Michigan Child Welfare Law Journal* is dedicated to the topic of mental health issues in child welfare cases. Parents with mental illness are at risk of child protection involvement, yet the relationship between parents' mental illness and child maltreatment is complex, and professionals struggle to assess and meet the needs of these families. Children with mental health issues may also be at risk of entering the child welfare system. For parents and children with mental illness, the lack of integration between mental health and child welfare systems, and difficulty in accessing high-quality mental health care, presents challenges to obtaining appropriate treatment and avoiding intervention by Children's Protective Services.

In the pages that follow, you will learn about various aspects of mental health issues. Crystal Grant, a staff attorney at Michigan Protection and Advocacy Service, Inc., discusses situations in which parents turn to Children's Protective Services to get their children's mental health needs met, often when mental health services have been insufficient or denied. She describes the difficulties these parents and children face as their quest to obtain mental health services turns into a child protection case, with all of the potential jeopardy such a case entails, and also points to some ways that parents can challenge mental health service reductions and denials.

Katherine Rosenblum and I write about psychological evaluations of parenting capacity. Such evaluations are ubiquitous in child welfare cases, and while they hold great potential to guide treatment and disposition decisions, too many are of low quality and have the potential to mislead the parties and the courts. We discuss professional guidelines regarding psychological evaluations in child protection proceedings and identify broader systemic concerns affecting quality and cost. We also provide detailed questions that attorneys can keep in mind and features they should look for as they deal with these evaluations in their cases.

Kathleen Baltman and Nichole Paradis provide a detailed discussion of what Infant Mental Health (IMH) services have to offer in child protection cases. Usually available through Community Mental Health, these critically important services offer expert assessment and therapy for parents and young children together in order to build parenting skills, heal ruptures in the attachment relationship, and improve developmental

outcomes. Provided in a variety of settings, including in-home or during parenting time, IMH services utilize therapists who have expertise in child development, family systems, attachment, and the effects of trauma and separation. The authors weave an elaborate case example throughout their article, offering not only explicit information about IMH services but implicit lessons in child development, family dynamics, and how to work with young children and their parents.

Frank Vandervort reflects on the role and responsibilities of the Lawyer-Guardian ad Litem in child welfare cases involving mental illness. He emphasizes the need for in-depth, detailed evaluation of the mental health of parents and children to determine their strengths and deficits. He presses for early, comprehensive, and multidisciplinary evaluations. He then urges that these assessments be trauma informed, because complex histories of trauma to both parent and child are rife in child protection matters. If these histories are neglected or misunderstood, it becomes virtually impossible to address the needs of these families adequately. He describes in detail the myriad responsibilities of the LGAL, including how to engage in case planning, effective advocacy for services, and deciding what position to take regarding permanency options.

Also included is a piece written by me about representing parents with severe mental illness in child welfare cases. Navigating some of the same territory as Frank Vandervort, I do so from the perspective of a parent's attorney, describing research findings about the relationship of parental severe mental illness to the risk of child maltreatment. I then discuss gaps in assessment, treatment and reunification services, and I close with a discussion of advocacy strategies.

My hope is that this issue will inform you about several aspects of this complex topic and invite further writing, discussion, and advocacy so that the mental health needs of parents and children can be met more effectively. I want to thank my colleague, Frank Vandervort, for his wonderful assistance in putting together this issue.

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Caught In-between: Parents Who Turn to CPS to Obtain Mental Health Services for Their Children

by Crystal M. Grant, JD

Approximately ten percent of children and adolescents in the United States suffer from serious emotional and mental health disorders. These disabilities impair their day to day functioning at home and in the community¹. The following scenarios are true stories of parents who have been faced with the decision of voluntarily turning to Child Protective Services (CPS) to provide mental health services for their children.

Betty's story

When David² was only two years old, he killed the family hamster. Years later he threatened his sister with a knife. No family members or babysitters wanted to be around him. David's violent and destructive behaviors worsened as he became older. His mother Betty, who is a single parent with limited resources, requested services from her local Community Mental Health (CMH) program in Michigan. David was diagnosed with Bipolar Disorder, Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder (ADHD). He was also deeply affected by the trauma of being abused by a family member when he was younger. While some counseling was provided for David's mental illness, Betty was instructed to take him to the hospital whenever he acted up. The hospital would quickly discharge David stating he was "fine" and had "stabilized" only to have the cycle continue repeatedly. Betty filed a petition for incorrigibility in juvenile court when David was eleven years old. Additional services were provided for a short amount of time but ended when the case was dismissed. Child Protective Services (CPS) also became involved with the family but explained that a neglect pe-

tion would have to be filed in order to provide payment for the necessary services, which included residential treatment. Betty felt that this was the best way to help David. Betty lost her job with a social service agency when the neglect petition was authorized by the Court. Nonetheless, she knew her son was receiving treatment and that was all that mattered. Betty loved her son but questioned whether family reunification was truly in David's best interests.

Sam's story

Some parents turn to CPS when they make too much to qualify for CMH services but cannot afford to pay for services out of pocket. Seven year old Tyler has severe autism and his destructive behavior is difficult to manage. His father Sam applied for services through CMH but was denied because his income is too high and he did not qualify for Medicaid. Unable to find any caregivers for Tyler, his father turned to a day treatment program which provides services for children with various disabilities and would be equipped to handle his son's needs. Sam's private insurance refused to pay for the program and he simply could not afford to pay out of pocket at a cost of almost \$2000 per month. Sadly, Sam has considered relinquishing his parental rights so that the state can effectively address Tyler's needs through Medicaid programs available to children who are wards of the state.

Stories like Betty's and Sam's are all too common among parents whose children have behavioral challenges as a result of a disability. Many children simply do not have adequate coverage for mental health care

leaving their parents with very limited choices. Parents who have private insurance are often faced with restrictions on their mental health benefits.³ Most private insurance companies do not cover the array of intensive, community based rehabilitative services that are needed to address severe mental or emotional disorders.⁴ Many middle class parents find that their income exceeds the requirement for publicly funded mental health services, and they are unable to cover the costs of services excluded by their private insurance.

Parents who qualify for publicly funded programs through Medicaid may not be offered the multitude of services available. These unenforced entitlements are another cause behind the relinquishment dilemma. One example of a mandate too often unenforced is Early Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT provides that Medicaid eligible children are entitled to all medically necessary services to treat or ameliorate a health condition, including mental disorders. EPSDT has also been referred to as “well child” visits. The services are required regardless of whether or not such services are otherwise covered under the state Medicaid plan for adults ages 21 and older.⁵ Parents are usually unaware of this requirement and unable to sufficiently advocate for their children when services are not offered or denied.

Some states rely heavily on voluntary custody arrangements where parents temporarily give custody of their children to the state for the purpose of placing their children in out-of-home treatment settings. These parents retain their parental rights and do not face the stigma of being placed on the court’s abuse and neglect docket. In other states, the parents must claim that their children are out of their control or at risk of abuse in order to gain access to costly treatment and specialized residential services.⁶ The true extent of this phenomenon is difficult to measure, as most child protection agencies do not differentiate between “mental health only” and other abuse and neglect cases.⁷

The “Katie Beckett” Waiver

Medicaid services are often out of reach for families who have been turned down by their private insurance, because they do not meet the income eligibility requirements for Medicaid. When children live at home, their parents’ income and resources are deemed available for medical expenses and therefore count against their eligibility for Medicaid services.⁸ Federal law has provided states with the option of

covering children with physical and mental disabilities in the community if the child would be eligible for institutional services but can be cared for at home. This option was provided within the Tax Equity and Financial Responsibility Act of 1982 (TEFRA) and is considered a waiver.⁹

The waiver is often referred to as the Katie Beckett “waiver” or “option.” In Michigan it is called the Children’s Home and Community-Based Services Waiver or, more commonly, the Children’s Waiver Program (CWP). Katie Beckett was a child with viral encephalitis who used a ventilator for most of the day. When her family’s private insurance ran out, Medicaid covered Katie’s healthcare costs, but only as long as she lived in the pediatric intensive care unit at the hospital. When President Ronald Reagan heard about Katie’s plight, he became upset and referred to the situation as an example of a cold bureaucracy and prompted changes in the law.¹⁰ Like Katie Beckett, many children with serious mental health issues are admitted to psychiatric hospitals and other residential facilities. These children can often be treated in the community with appropriate services and supports. Utilizing the Katie Beckett Waiver or TEFRA will allow for a greater number of children with disabilities to remain at home and receive services regardless of their parents’ income.

Advocating for Medicaid Recipients

One method of advocacy for parents whose children are Medicaid eligible is challenging the denial, termination or reduction of mandated services through Medicaid Fair Hearings. These hearings are held by the State Office of Administrative Hearings and Rules (SOAHR) within the Department of Energy, Labor, and Economic Growth. These proceedings are governed by the Administrative Procedures Act (APA).¹¹ The hearings are held in front of an administrative law judge (ALJ) designated by SOAHR to conduct the hearing in an impartial and unbiased manner. Once the ALJ has issued an opinion, the agency or appellant may file a written request for a rehearing or reconsideration with SOAHR.

After the administrative process has been exhausted, the appellant may proceed to circuit court.¹² In one case, the parents of a 14 year old Medicaid beneficiary appealed the Michigan Department of Community Health’s decision to terminate their son’s eligibility in the Children’s Waiver Program. A circuit

court judge found that the child, who had a primary diagnosis of Autism Spectrum Disorder consistent with Pervasive Developmental Disorder, met the requirements outlined in the Department's Medicaid Provider Manual and the Code of Federal Regulations.¹³ The judge's ruling allowed the 14 year old to receive services under the Children's Waiver Program, which includes services such as family and non-family training, community living supports, transportation, respite care, environmental accessibility adaptations, specialty medical equipment and other specialty services.¹⁴ Unfortunately, few families take advantage of the Medicaid appeal process. Advocates should educate families on their appeal rights and provide technical assistance when appropriate.

Legislative Solutions

Medicaid agencies have been under intense pressure to hold down costs due to the program's size and growth.¹⁵ Recent legislation incorporated in the Deficit Reduction Act (DRA) and the Affordable Care Act (ACA) will affect both eligibility for children's mental health services and the benefits available. If a state chooses the option created, families of children with disabilities may buy into the Medicaid program. Medicaid coverage would be purchased by parents with family incomes of up to 300% of the federal poverty level for children under age 10 whose disabilities meet Supplemental Security Income (SSI) criteria.¹⁶

Conclusion

While mental health agencies have come a long way in developing programs that address children's mental health needs, we must remove the barriers that prevent access to necessary services and tear families apart. For families already qualifying for Medicaid, CMH must inform them of the services available, enforce the entitlements and educate them on their right to appeal denials. The expansion of coverage options for families whose children have disabilities would be a significant step toward providing needed services. We cannot continue to ignore the "cold bureaucracy" that President Reagan referred to in 1981 – the cost is simply too high. ©

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Endnotes

- 1 *Mental Health: A Report of the Surgeon General*, 1999. <http://www.surgeongeneral.gov/library/mentalhealth/home.html>.
- 2 Client names have been changed to protect confidentiality.
- 3 *Avoiding Cruel Choices: A guide for policymakers and family organizations on Medicaid's role in preventing custody relinquishment*. Koyanagi, Chris. Bazelon Center for Mental Health Law. (2002). <http://www.bazelon.org/LinkClick.aspx?fileticket=-g7QVr0wWF8%3D&tabid=104>.
- 4 *Id.*
- 5 § 1905(r)(5) of the Social Security Act; 42 U.S.C. § 1396d(r)(5).
- 6 Research in the Service of Policy Change: The "Custody Problem", Friesen, Barbra, Giliberti, Mary, Katz-Leavy, Judy, Osher, Trina, and Pullmann, Michael. *Journal of Emotional and Behavioral Disorders* 11 (1), 39-47 (2003).
- 7 *Id.*
- 8 *Understanding Medicaid Home and Community Services: A Primer*. U.S. Dept. of Health and Human Services. (October 2000). <http://aspe.hhs.gov/daltcp/reports/primer.htm>.
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- 10 Katie Beckett: Patient Turned Home-Care Advocate. National Public Radio (NPR). Shapiro, Joseph. (2000). <http://www.npr.org/templates/story/story.php?storyId=131145687>.
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- 12 *Demystifying the Administrative Law-Medicaid Fair Hearings Process*. Michigan Bar Journal. Gigliotti, Lisa. (December 2010). <http://www.michbar.org/journal/pdf/pdf4article1781.pdf>.
- 13 In re B.D., a minor with a developmental disability through his mother S.D., 08-1302-AA, Washtenaw County Circuit Court (2010) (citing 42 CFR § 440.150).
- 14 Children's Waiver Program. http://www.michigan.gov/mdch/0,4612,7-132-2941_4868_7145-14669--,00.html.
- 15 *The Role of Medicaid in State Budgets*. Policy Brief. Washington, DC: Kaiser Commission on Medicaid and the Uninsured (2001). <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14001>.
- 16 Affordable Care Act (Health Reform, P.L. 111-148) 2010; Deficit Reduction Act (DRA, P.L. 109-171) 2006.

Psychological Evaluation of Parenting Capacity in Child Welfare Proceedings

by Katherine L. Rosenblum, PhD and Joshua B. Kay, PhD, JD

In the child welfare context, courts, attorneys, and child protection agencies often turn to psychologists to evaluate parenting capacity. As evaluators in child protection cases, psychologists may be asked to evaluate different parties for different purposes, acting as agents of the court, the child protection agency, or directly retained by the parents or the lawyer guardian ad litem. In this article we focus specifically on psychological evaluations addressing issues pertaining to parenting capacity (in contrast to, for example, assessments that focus solely on child psychological well-being or developmental status). These types of assessments may help to inform dispositional decisions, including placement, visitation, reunification services to be provided, or termination of parental rights. We aim to (1) clarify the uses, and limitations, of such assessments in child protective proceedings, (2) provide an overview of professional guidelines regarding psychological evaluations in child protection matters, along with criteria for evaluating whether the assessment meets these guidelines, and (3) briefly identify broader systems issues surrounding psychological evaluations.

Psychological Evaluations in Child Protective Proceedings

What purpose can, or should, assessments serve in child protective proceedings?

Within the context of child protective proceedings, psychologists are frequently asked to address questions related to parenting capacity that may include, for example: (1) *Is the parent currently able to provide adequate safety and care for the child?* (2) *Is it likely that the parent can be successfully treated to prevent future harm? If so, how, and if not, why not?* (3) *What therapeutic interventions would be recommended to assist the parent?* Evaluations may also be useful in identifying parent characteristics that are relevant for assessing the capacity of the parent to recognize and/or address

specific child needs and/or family or environmental conditions. A number of parent characteristics (e.g., psychiatric illness, cognitive delays, substance abuse, capacity for insight) may be relevant with regards to the ability to recognize or address child needs (e.g., medical frailty, unexplained injuries, nonorganic failure to thrive), or address family or environmental conditions (e.g., domestic violence, isolation, homelessness). Although each of these risk factors often exists in the absence of abuse, neglect, or poor parenting, they may indicate areas of potential concerns and indicate a need for further clinical assessment.

The primary purpose of the evaluation is to generate relevant, professionally sound results and/or opinions that address appropriate questions. These evaluations assist in the determination of the child's risk for harm, identification of appropriate rehabilitative services, and the determination of whether or to what extent such services have resulted in a reduction of the risk of harm for the child. Indeed, many psychologists have specialized training and skills relevant to the assessment and evaluation of parenting capacity, including, for example, expertise in the administration and interpretation of standardized assessments; the conduct of a sensitive clinical interview; diagnostic assessment; treatment and familiarity with evidence-based psychotherapy options; and specialized skill in observational assessments of parent-child interaction. By providing an informed, objective perspective, a psychological evaluation can contribute valuable information that can inform the court team and ultimately serve to enhance the fairness of decisions.

More specifically, parenting assessments can address a number of critical aspects of parenting capacity that may help in making more informed legal decisions. For example, Budd (2005) suggests that a parenting assessment can (a) describe the characteristics and patterns of parental functioning, (b) identify and explain possible reasons for problematic behavior

and the potential for change, (c) identify both person-based and environmental conditions that are likely to promote or interfere with adequate parental behavior, (d) describe the child’s functioning, needs and vulnerabilities in relation to the parents’ own strengths and deficits, and ultimately, (e) provide guidance regarding intervention. A strong evaluation should include clear, concise descriptions and conclusions based on the data collected and provide detailed recommendations to help the situation improve. In other words, a solid evaluation will not only discover problems, but also identify strengths and potential solutions.

However, it is equally important to note that there are also a number of things that a parenting assessment *cannot do*, and Budd (2005) notes that these include (a) comparing an individual’s parenting capacity to a [nonexistent] universal standard of parenting fitness, (b) predict parenting capacity based on psychiatric diagnosis, (c) rule out the effects of situational characteristics (e.g., current stressors, demand characteristics) on the assessment process, (d) predict future behavior with certainty, or (e) answer questions that are not asked by the referral source.

The absence of a universal standard of parenting fitness is a key limitation impacting all parenting capacity assessments. Despite decades of research on parent-child relationships that has established associations between qualities of parenting and child outcomes, absolute or culturally-transcendent standards of parenting have not been established. There is remarkable variability in definitions of “good enough” parenting, and the field has not, and is unlikely to, define a consistent standard reflecting this quality. Nonetheless, the evaluator may guard against arbitrary or personal biases by articulating the specific findings that serve as a basis for their opinions about parenting adequacy, and should focus instead on a *minimal* parenting standard, that is, the minimal level of acceptable functioning that is sufficient to protect the safety and wellbeing of the child.

Ethical Standards and Guidelines for Psychological Evaluations in Child Protection Matters

All psychological services, including evaluations in child protection cases, must conform to the ethical standards promulgated in the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2002). Conduct that vio-

lates the Ethics Code may be the basis for a licensing complaint or provide support for a malpractice action. Several sections of the ethical standards apply readily to the evaluation context, and Section 9 particularly addresses assessment. Table 1 lists key requirements from Section 9 of the Ethics Code. Legal practitioners should keep in mind that all psychologists must be trained in and comply with the ethical standards, and the standards thus may be used as a learned treatise to impeach a psychologist during cross-examination (MRE 707). It is a simple matter to do basic research about the intended use, reliability, and validity of published psychological measures on the websites of test publishers and by accessing articles about these tests on websites such as Google Scholar.

Psychological evaluations in the context of child protection matters differ from evaluations that may occur as a part of clinical service (e.g., during psychotherapy), because there is a high likelihood that the evaluation will be used in legal proceedings. Most clinicians are not trained in forensic assessment and therefore may fail to follow established guidelines regarding appropriate forensic practice (Committee on Ethical Guidelines for Forensic Psychologists, 1991). These aspirational guidelines include such things as requirements for informing the client of the limits to confidentiality, the need to independently corroborate information obtained from a third party, and a higher standard of data documentation.

The American Psychological Association also has developed specific guidelines for psychological

Table 1. Key requirements of the APA (2002) Ethical Principles and Code of Conduct.

<ul style="list-style-type: none"> • Opinions based on adequate examination of individual and information and techniques sufficient to substantiate findings (9.01)
<ul style="list-style-type: none"> • Evidence-based, valid, reliable techniques and tests (9.02)
<ul style="list-style-type: none"> • Interpretation of assessment results accounts for purpose of assessment and any relevant contextual factors (9.06)
<ul style="list-style-type: none"> • Assessment based on up-to-date tests and test results (9.08)

evaluations in child protection matters (1998). These guidelines do not establish an absolute standard of practice, but rather reflect aspirational guidelines that are intended to facilitate and help ensure a high level of appropriate professional practice by psychologists. In other words, these guidelines are informative of what are considered best practices for conducting these psychological evaluations. lists key features of these aspirational guidelines for child protection-related psychological evaluations and may be a useful summary for assessing the adequacy of a given evaluation.

Based on APA guidelines (1998) and current work on defining a protocol for appropriate parenting evaluations, there are a number of core elements to an adequate parenting capacity assessment (Budd, 2001; Grisso, 2003; Otto, 2003). These core features include a *focus on the parent's capabilities and deficits as a parent* and on the parent-child relationship. Although a range of adult qualities and characteristics may become evident through interview and assessment, the evaluator needs to identify how these are related to specific aspects of parental fitness, demonstrating how they function as a risk or protective factor for the child, or how they may facilitate or hinder the parent in benefiting from rehabilitative services. A second feature is a *focus on functional competence*, which means that the evaluator has assessed parenting skills in relation to the needs of that parent's children. Rather than simply evaluating and reporting on adult trait-like qualities or diagnostic assessments, a functional assessment examines what a parent knows, does, understands, believes, and is capable of doing *in relation to parenting*. Finally, a third feature is the *use of a minimal parenting standard*. This is, in essence, evaluating a parent not to identify whether parenting meets a universal standard of 'good' quality (which may reflect cultural biases or beliefs that are non-universal), but rather, to determine whether caregiving meets a standard of minimal competency required to provide sufficient safety and care necessary for child wellbeing.

With regards to obtaining an appropriate evaluation, it is critically important that the referral source first specify appropriate questions [e.g., "What factors might place this parent at risk for failing to adequately protect her child?" but not "Will this parent neglect her child again?"], and should specify the desired information so that the evaluator can use these questions to guide the assessment process.

Once referral questions have been clarified, the evaluation can begin. As noted in Table 2, the evaluation should involve an interview with the parent; several hours, which may be divided across several sessions, are usually needed in order to complete the clinical interview and collect needed information. The clinician should make clear the purposes of the interview and limits to confidentiality and check for parent understanding. The interview should cover a range of content areas, including but not limited to the parent's own circumstances, background, and understanding of the current situation; the parent's perspective on the child and on the parent-child relationship; and the parent's own hopes or expectations regarding the current allegations and situation.

Typically, an assessment should include multiple methods of data gathering. In addition to seeking collateral information (including phone and in-person interviews as well review of prior reports and records), this may include administration of relevant psychological tests or measures. An important caveat, however, is that most extant psychological measures have not been developed to assess parenting capability in the context of child welfare per se and have not been rigorously evaluated in this context. Thus it is critical that the evaluator make efforts to select measures that are appropriate for the client and the referral questions and interpret test results conservatively. Whenever possible, the evaluator should look to corroborate test results using other data sources.¹

In addition, an assessment should typically aim to include direct observation of parent-child interaction. The APA guidelines for psychological evaluations in child protection matters (1998) appropriately specify that these observations should be done in as natural and ecologically valid a setting as possible. While this may not always be possible (e.g., in instances where parental contact with the child has been limited or prohibited by the court), whenever contact is permitted efforts should be taken to observe parent-child interaction and to seek to do these observations in as natural a setting as possible. Finally, reports should respond to the referral question(s), and should clearly delineate how the data described were used to form the examiner's opinion. The report should thus provide an adequate review of the data with a clear description of how the data and findings have informed interpretations and conclusions. The report should include a

Table 2. What to look for in a parenting capacity assessment.

Does it follow APA (1998) Guidelines for Evaluations in Child Protection Cases?

- Determine scope of the evaluation based on the nature of the referral question
- Inform participants about the limits of confidentiality
- Use multiple methods of data gathering (e.g., records, questionnaires, interviews, observations, collateral sources).
- Make efforts to observe child together with parent, preferably in natural settings
- Neither overinterpret nor inappropriately interpret assessment data
- Provide an opinion only after conducting an evaluation adequate to support conclusions

Do the methods and content directly address parenting?

- Focus evaluation on parenting characteristics and the parent-child relationship rather than general adult cognitive or personality functioning
- Use a functional approach, emphasizing behavior and skills in everyday performance (e.g., what the parent understands, believes, knows, does, and is able to do with regard to parenting) (Grisso, 1986)
- Look for evidence of minimal parenting adequacy rather than comparing parent to an optimal standard
- Describe parent's current strengths, rather than only weaknesses, as they relate to the parent-child relationship and meeting children's needs
- Identify contextual conditions (environmental, social, or historical variables) likely to positive or negatively influence parenting adequacy
- Describe the prognosis for remediation of problems and potential interventions to address the problems

Does it list and answer specific referral questions?

- Clarify what issues or questions are to be addressed regarding parental functioning, the problems or events that have given rise to the concerns, and the outcomes or options that will be affected by findings
- Answer each referral question, by summarizing the data and linking the findings to interpretations

Is the report thorough, clear, and understandable?

- Provide a chronology of assessment activities, including full names and dates of instruments administered, persons interviewed, and records reviewed
- If diagnostic terms are used, explain what they mean in lay terms, the basis for the diagnosis, how the diagnostic condition is likely to impact parenting, and optimal interventions for the condition
- Fully disclose the limitations of the assessment and offer alternative explanations for data; in particular, consider the reliability and validity of findings when based on normative comparison groups that differ from the parent being evaluated
- Avoid making casual interpretations (e.g., "the parent is unable to love because of her own history of deprivation") or predictions about the future (e.g., "this parent will abuse again") that cannot be substantiated
- Avoid making specific recommendations about legal questions that are the domain of the court; instead, offer behavioral descriptions, possible explanations, directions for intervention, and future issues to assess in regard to parenting adequacy
- Provide the full name, professional title, degree, discipline, and licensure status of all participating evaluators

Note. Table reprinted from Children and Youth Services Review, Vol 27 (2005), Karen S. Budd, Assessing parenting capacity in a child welfare context, 429-444, Copyright 2004, with permission from Elsevier.

clinical summary and recommendations, which should stem from the assessment and be linked to the specific risk factors or deficits described in the report (e.g., intervention, advocacy services, resources).

Systemic Concerns Regarding the Use and Conduct of Psychological Evaluations

While we have outlined important guidelines and considerations regarding the assessment of parenting capacity in the child welfare context, it is important to note that many of the parenting capacity evaluations one is likely to see in child welfare proceedings will not meet these criteria. There are likely many factors affecting the availability and reliability of solid, thorough psychological evaluations in child welfare proceedings, and we detail a few of these issues below, along with some suggestions regarding systems changes that may help to reduce the impact of these concerns.

1. *Costs associated with parenting capacity evaluations.* Perhaps not surprisingly, the costs associated with a high-quality parenting evaluation are not insignificant. Given the need for a multi-method (e.g., interview, standardized tests, observations), comprehensive approach, these evaluations are time-intensive, and the expertise and skill required to conduct these evaluations are not insubstantial. Thus, the “market rate” for this type of evaluation is likely to be high and currently is often outside the range offered for reimbursement by the courts or Department of Human Services.
2. *Low-quality parenting evaluations.* When courts or agencies cannot pay close to market rates for evaluations, it gives rise to legitimate concerns that the evaluations they are able to get are more likely to be substandard. Although some talented psychologists are willing to do these evaluations with a high degree of care and competence, it is common sense that purchasing evaluations at below-market rates is more likely to result in evaluations that fail to meet a minimum standard of practice.
3. *Overuse of parenting evaluations.* In some jurisdictions it is fairly standard to request a psychological evaluation, and relevant agencies and/or the courts may not question whether

such evaluations are truly needed in order to address relevant questions for the specific case.

Clearly, these three factors are not unrelated. The overuse of psychological evaluations may lead to high costs for the agency or courts, leaving insufficient funds to pay market rate for quality, time-intensive assessment. The consequences of substandard evaluations are severe. Such evaluations not only fail to help clarify questions or provide proper guidance in cases, but they may inadvertently mislead parents, attorneys, agencies, and the courts, diminishing the prospects for good case management, reunification service planning, and legal decision-making. Given that MRE 702 notes that expert testimony is supposed to “assist the trier of fact to understand the evidence or to determine a fact at issue,” and that the testimony must be “based on sufficient facts or data” and be “the product of reliable principles and methods” that have been “applied reliably to the facts of the case,” substandard evaluations should not be tolerated by the courts or the parties.

The dangers of substandard evaluations present a critical systems issue, and courts and parties must ask whether the questions relevant to a given case require a psychological evaluation or might instead be reasonably answered by other sources. For example, could the question of progress in treatment be addressed through careful discussion with the parent’s therapist? If psychological evaluations are employed more conservatively, a reallocation of funds may permit assignment of the evaluation to the most qualified clinician, who may be more willing to conduct the required comprehensive evaluation if compensation is appropriate to the request and task demands.

Conclusion

Psychological evaluation of parenting capacity in child welfare cases may be useful to aid in determining whether a parent currently is able to keep a child safe, the likelihood that treatment could be or has been successful to improve the parent’s ability to keep the child safe in the future, and what treatment is indicated. Referrals for such evaluations should contain specific questions, and the evaluations should be limited to answering those questions. Evaluations should focus not only on problems but on strengths and potential solutions. It is important to note, however,

that evaluations cannot predict behavior or treatment prognosis with certainty. There is also no universal standard of parental fitness, and a good evaluation will instead focus on a minimal acceptable parenting standard sufficient to protect the safety and wellbeing of the child. All findings should be specifically tied to parenting abilities; that is, there must be an empirical basis for conclusions about parenting capacity.

All psychological evaluations must comply with the ethical standards for psychological practice. Ideally, they will also meet aspirational, best-practice guidelines as well. Unfortunately, high-quality evaluations are time-consuming and costly. When an agency is unwilling to pay the market rate for such evaluations, quality may suffer, which can have severe consequences for the quality and validity of evaluations. A sub-standard evaluation not only fails to be truly useful, it may actually mislead the court and parties, diminishing the prospects for a successful and just resolution of a child welfare case. Therefore, we urge that psychological evaluations be used only when necessary so as to free up funds to pay for high-quality evaluations and that courts and parties be mindful that other sources of information, such as a parent's therapist, may answer many relevant questions. ©

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Endnotes

- 1 It is worth noting that MRE 703 requires that the "facts or data in the particular case upon which an expert bases an opinion or inference shall be in evidence."

Infant Mental Health: What Judges and Lawyers Should Know About Relationship-Based Assessment and Intervention

by Kathleen Baltman, M.A. & Nichole Paradis, M.S.W., L.M.S.W.

Introduction

The field of infant mental health (IMH) is based on theoretical foundations that include infant development & behavior; family relationships & dynamics; attachment, separation, trauma, & loss; disorders of infancy & early childhood; and cultural competence. These knowledge areas are applied to relationship-based direct services to improve developmental outcomes for infants and toddlers. In other words, IMH therapists understand the importance of infants' and toddlers' earliest relationships and their influence on all later development. The formation of effective collaborative relationships between IMH therapists and child welfare and legal professionals can enable utilization of expertise in the relationship needs of infants and toddlers to better determine the best interests of the very young child. Child welfare workers and/or legal professionals may not know about infant mental health in general and may not be aware that IMH services are available in the community.¹ The goals of this article are to better inform legal and child welfare professionals about basic IMH principles and practices, and how IMH therapists can serve as a resource providing assessments, recommendations, and intervention, including support during visitation, for infants/toddlers in foster care and their families. Throughout this article, we use a composite case example to illustrate IMH principles and practices.

Initial referral to infant mental health

Annette Granston, LMSW, is a state licensed social worker and professionally endorsed Infant Mental Health (IMH) Specialist with a Community Mental Health

agency's Infant/Toddler and Family program. Annette received the referral information phoned and faxed to her by Ms. April North, the foster care worker (FCW) on a new case. Before deciding on first action steps, Annette sat at her desk and considered what she knew so far about her new case:

Children:

- *Guy Richmond, 18 ½ months*
- *Dolly Davis, 3 months*

Mother:

- *Kristy Davis, 19 ½ years*

Fathers:

- *Joe Richmond, 30-year-old father of Guy, abandoned family just after Guy's birth. Signed Parent-Agency Agreement to plan for Guy, but kept only the first and third of six scheduled visitations.*
- *Steve Makowski, father of Dolly, died at 20 years old, after an apparent drug overdose just before Dolly's birth.*

Others with roles in this FC case:

- *Guy's (licensed) foster parents, Mrs. Grace Rogers and Mr. James Rogers*
- *Dolly's paternal grandmother and relative foster care provider, Mrs. Rhonda Makowski (widowed)*
- *Ms. Violet Hillings, neighbor who first took Kristy and Guy in to stay with her when Joe Richmond abandoned them and then later offered them a permanent home with her when Steve died and Kristy could no longer hold her restaurant job.*

Reason for and outcome of Children's Protective Services (CPS) referral (made six weeks ago):

- Investigated and substantiated charge of child neglect following Dolly's hospitalization due to pneumonia and weight loss when Dolly was 6 weeks old.
- Mother and children were living with Ms. Hillings – reported on referral as “an older woman” Kristy met when she shared an apartment with Joe in the same complex. Kristy and Guy stayed briefly with Ms. Hillings when Joe abandoned them and then officially moved in with Ms. Hillings after Steve died.
- Upon CPS investigation, Kristy was not at home, with whereabouts unknown by Ms. Hillings. Ms. Hillings was cooperative and expressed concern, but Guy was found to be dirty, with soiled diaper and runny nose. Sleeping arrangements were judged inadequate (no cribs). Kitchen was very dirty and had insufficient food.
- Ms. Hillings had foster care history – parental rights terminated on two children when they were preschool age.
- Court ordered immediate removal of Guy and Dolly from Kristy's care.
- Guy was placed with licensed foster parents, Mr. and Mrs. Rogers.
- Dolly was released from the hospital after three days with diagnosis of non-organic failure to thrive (NOFTT) and placed with her paternal grandmother (PGM), Rhonda Makowski. A referral for Early On (Part C) services was made by the hospital social worker.

Current housing and visitation status:

- Kristy continues to live with Ms. Hillings, who drives her to weekly (one hour) supervised visits at the FC agency. Guy is transported to and from the visits by his foster mother. Dolly is transported to and from the visits by her PGM.

Reason for infant mental health services request:

- Since the children's removal, there have been four successful visitation sessions following two weeks of unsuccessful visit attempts (when Kristy failed to come to the agency).

- The FCW has expressed increasing concern about mom and children's behavior during visits. Mom just sits and holds Dolly while intermittently rocking back and forth on the couch. Guy spends most of the hour sitting next to her on the couch and sucking his thumb. Sometimes, Kristy whispers to him. He cries when the visit is over and doesn't want to go with Mrs. Rogers.
- Mrs. Rogers reports that she is finding Guy increasingly difficult to handle. He is “wild” before and after the visits. After the last visit, it took three nights for him to be able to sleep without waking up screaming every few hours. She thinks the visits are hurtful to him.

Annette first called Ms. North and learned that in order to speak to Kristy to arrange a home visit she needed to call Ms. Hillings' cell phone. Ms. North said that she had told Kristy that she should expect a call from a therapist who would work with her to “get her children back.” Ms. North also reported that the hospital social worker had said the IMH therapist could provide Early On services,² too. Annette replied that she would see what was needed, and what was possible, and get back to Ms. North.

Annette called the number and spoke to Kristy. Kristy's voice was soft and without expression when she agreed to let Annette come to the apartment at 10:00 the next morning. Annette thanked her and said that she really appreciated Kristy's being able to meet with her on such short notice. Kristy said, “Yeah,” and hung up the phone.

What is an infant mental health therapist?

Infant mental health (IMH) therapists are master's degree or higher-prepared professionals with specialized education, training, experience and, where possible, a Level II, III or IV endorsement from the Michigan Association for Infant Mental Health (MI-AIMH) or another IMH affiliate³ in culturally sensitive, relationship-focused practice toward improving developmental and mental health outcomes for infants/toddlers and their families. “Central to an infant mental health perspective is the belief that all children benefit from a sustained primary relationship that is nurturing, supportive and protective.” (MI-AIMH, 2000, pg. 3).

What does an IMH therapist do? What does a “relationship-focused IMH intervention” include?

As described in *Case Studies in Infant Mental Health* (2002, pg. 4-5), the skills and strategies often employed by IMH therapists include:

- Building a relationship with parent(s) and using the relationship as an instrument of change
- Meeting with the infant/toddler and parent together throughout the period of intervention
- Sharing in the observation of the infant/toddler’s growth and development
- Offering anticipatory guidance to the parent that is specific to the infant/toddler
- Alerting the parent to the infant/toddler’s individual accomplishments and needs
- Helping the parent to find pleasure in the relationship with the infant/toddler
- Creating opportunities for interaction and exchange between parent(s) and infant/toddler and therapist
- Allowing the parent to take the lead in interacting with the infant/toddler or determining the “agenda”
- Identifying and enhancing the capacities that each parent brings to the care of their infant/toddler
- Reflecting the parent’s thoughts and feelings related to the presence and care of the infant/toddler and the changing responsibilities of parenthood
- Reflecting the infant/toddler’s feelings in interaction with and relationship to the caregiving parent
- Listening for the past as it is expressed in the present
- Allowing conflicts and emotions that are related to the infant/toddler to be expressed by the parent – holding, containing, and talking about them as the parent is able
- Attending and responding to parental histories of abandonment, separation, and unresolved loss as they affect the care of the infant/tod-

der, the infant/toddler’s development, the parents’ emotional health, and the early developing relationship

- Attending and responding to the infant/toddler’s history of early care within the developing parent-infant relationship
- Identifying and treating disorders, delays and disabilities of infancy and early childhood, parental mental illness, and family dysfunction
- Remaining open, curious and reflective

Initial home visit with Kristy

Annette drove to meet with Kristy at Ms. Hillings’ apartment. The complex, located in an industrial suburb of a large urban center, was pretty bleak looking. There were several two-story buildings; none of them adorned in any way with grass or shrubbery or flowers. The main door of Ms. Hillings’ building was open, and Annette climbed the stairs to find the right apartment. The stairway was dimly lit and a couple of the apartments had children’s bikes outside their doors.

When the door was opened after several firm knocks, Annette smiled and introduced herself to Ms. Hillings. Ms. Hillings asked Annette to come in and said that Kristy was asleep on the couch. “She isn’t sleeping too well at night,” she whispered.

Kristy stirred in response to Ms. Hillings telling her to sit up – that “the new worker” had come to see her. Ms. Hillings then sat down in a worn upholstered chair across the room and directed Annette to sit wherever she wished. Noting another upholstered chair, closer to the couch, Annette sat down facing Kristy. Kristy eyed her for a minute and said, “So. You gonna help me get my kids back?” Annette smiled a little and said, “Kristy, I certainly want to do what I can to help you. We’ll need to talk, and as much as I wish we didn’t, we’ll need to do what will feel like a lot of paperwork, and I want to be able to meet with you, and with you and your children together, so that I can learn more about how I might best help all of you.”

Kristy listened, then looked away and shrugged her shoulders. After a minute, she looked back at Annette and, in a very flat tone of voice, said, “Whaddya wanna know?”

Kristy appeared to be almost without hope, yet her questions suggested that hope hadn’t totally died. Annette settled back in her chair and said, “What would you like

me to know first, Kristy? Why don't we start with that and then, if I need to ask questions for the paper work, we'll do that before I leave."

Kristy looked at Ms. Hillings and then at Annette and said, "Can she stay?"

"If you'd like her to be here while we talk, that's okay, Kristy." Annette knew that this wasn't the right moment to discuss confidentiality, but made a mental note to talk with her (and Kristy's FCW) about it soon. She knew that it would be important for everyone to be clear about what aspects of their work together could remain confidential and what would need to be shared with the FCW and the courts.

Kristy looked at Ms. Hillings, who nodded and said, "I'm right here, honey." Continuing in her mostly expressionless voice, Kristy talked a bit about her history. She spoke almost telegraphically and without any sequence that Annette could easily follow. Annette didn't want to push too much during this first visit, but she found herself needing to ask a number of prompting questions in order to begin to put together a cohesive picture. Kristy responded to all of the questions, but only with minimal detail. Nonetheless, by the end of the hour, Kristy had actually shared quite a bit of her history and background. She thanked Kristy for meeting with her and asked if she could come to the agency on Thursday when the children were going to be there. Kristy agreed. She also agreed to stay after the visitation so that the two of them could talk some more. Annette said good-bye to Kristy who hugged her knees and sat looking at the floor while Ms. Hillings opened the door for Annette and said good-bye. Ms. Hillings had not moved or said a word during the hour.

What are the principles of confidentiality that guide an IMH therapist's work?

IMH services are typically delivered in the home or in public settings like a park, foster care agency visitation room, shelter, etc. Therefore, the IMH therapist must be sensitive about questions she asks, statements she makes, or disclosures that are offered by the parent(s) when others are nearby. Whenever possible, the IMH therapist will find a moment when she can speak to the parent(s) privately to determine who each parent feels comfortable hearing and knowing private information that might be discussed. The IMH therapist will obtain written releases that give permission to discuss the case with other professionals involved in the case such as the foster care worker, representatives from the legal system, child care providers, teachers, physicians, etc.

Reflections on first home visit

Annette immediately typed up her visit notes. She now knew that Kristy had been born in a small town in East Texas. Her parents moved around a lot because they were always being evicted for one reason or another. Kristy said that sometimes her parents left her with her grandmother – her mother's mother – for days at a time. She didn't seem to want to say much about her parents, but when asked where they were now, she said that her mother doesn't do much other than get stoned and that she thinks her father is in jail. When asked about her grandmother, Kristy looked down for a while and then said, in almost a whisper, that she had died suddenly when Kristy was sixteen.

When asked how she got to Michigan, Kristy said that a high school friend had moved here and had given her his address. Kristy shrugged and said that she ran away, hitchhiked to Michigan and tried to find him, but couldn't. While she was looking for him she met some other people, including Joe, Guy's father. She stayed at different friends' places, but when she got pregnant, she moved in with Joe. Things were okay for a while, but they started fighting before the baby was born and he left them when Guy was a few months old. Kristy then moved in with Ms. Hillings.

Kristy got a job at a fast food restaurant and Ms. Hillings took care of Guy. When she said that Ms. Hillings took really good care of Guy, her voice was slightly animated and she looked at Ms. Hillings. Then she looked down again and was silent. When prompted, Kristy said that she met Steve at the restaurant, but things started not going too well for her. She said that she got pregnant around the same time she discovered Steve used drugs. Then she said, with no change of tone, "He's dead now. Dolly never had no daddy."

IMH therapist's role in a foster care-involved family

"Infant mental health principles are based on research and clinical experience that support infants' emotional development within the context of their caregiving relationships. Helping caregivers to understand and manage their infant's emotional behavior can assist them in responding more effectively to the infants and can enhance interactions between infants and caregivers.

For infants in foster care, the guidance and support provided through relationship-focused intervention with infants and parents can mean the difference between a stable placement and placement disruption and also can strengthen families for reunification or adoption.” (Dicker & Gordon, 2004).

Conducting a thorough assessment and providing relationship-focused interventions become much more complicated when the infant/toddler and his/her siblings have been placed outside the home. The IMH therapist will need to see the infant/toddler in the context of her relationships with her birth parent(s) and her foster parents and ideally with any other caregivers, such as a child care provider. Therefore, the IMH therapist will arrange for observations of the infant/toddler with her multiple caregivers at times of day that will enable her to see each caregiver participating in daily routines such as feeding, changing, and playing. All such visits need to be scheduled around the infant/toddler’s nap schedule and around each caregiver’s other responsibilities (e.g., employment, care of other children, substance abuse treatment, etc.) (MI-AIMH, 2005).

When an IMH therapist begins work with a court-involved family, she may need to work particularly hard to gain the trust and confidence of family members. Birth parents often feel a sense of betrayal toward “helping” professionals. IMH therapists may find that a focus on non-judgmental emotional support, location of appropriate resources and provision of some concrete needs will help to earn the parents’ trust. For example, the IMH therapist may be able to use her knowledge of community resources to locate diapers and formula or emergency food for the parents, and that may help the family to understand that she is, in fact, there to help.

Once a relationship has been established with the birth parent(s), the IMH therapist will work with him/her/them to better understand how the infant/toddler has been affected by 1) the circumstances that led to the court involvement, 2) any removal and subsequent separation, and 3) time, i.e., developmental progress that has occurred since the removal.

Visitation at foster care agency

(Seventh week of children in care, first week with IMH services; first opportunity for IMH therapist to observe infant-parent interactions)

Annette made sure that she was at the agency a few minutes before the scheduled visitation time. She wanted the opportunity to observe initial greetings between Kristy and the children, which would tell her so much about the current status of the attachment relationship between each of them – as felt and unconsciously understood by each of them – infant, toddler and mother.

Annette couldn’t help but be encouraged when she saw that Kristy and Ms. Hillings were already seated in the agency’s waiting area. She also had a fleeting sense that both were glad to see her arrive. The foster care worker was there, too, and said that they could go on into the visitation room; that she would wait for the others to arrive and bring them into the room. They all went into a carpeted room, pleasantly appointed with toys and books quite visibly placed on low open shelves. There was a large comfy-looking sofa and a matching chair in the room. Off to one side, there was a rectangular child-sized table with six chairs around it.

Annette decided to sit on the rug, where she could more easily get a sense of how Dolly and Guy might experience entering the room and seeing their mother. Kristy sat on the couch, and Ms. Hillings went to a corner of the room and sat cross-legged on the floor.

Mrs. Makowski and Dolly were first to arrive. As Kristy stretched her arms out toward Dolly and said her name, Annette saw Mrs. Makowski’s mouth go straight and tense as she handed a rather sleepy looking baby over to Kristy. Without looking at Kristy, she said, “I’ll wait outside.” She turned and left, but Kristy was already totally engrossed in the baby who had been placed in her arms. As her arms tightened around Dolly and she began to sway from side to side, Dolly’s eyes opened. As they focused on her mother’s face, her body seemed to stiffen. She stared at Kristy for a bit and then, gradually, her body grew less tense. She closed her eyes as her mother began to rock her.

Moments later, Guy burst into the room, saw Kristy and froze. He stood just inside the door, stuck his clenched fist into his mouth and sucked on his knuckles, watching his mother as she rocked Dolly. As Annette watched closely, she saw something that really spoke to her: for just about a minute, as Guy watched his mother, his body moved in

rhythm with his mother's. Then he abruptly turned away and went to the toy cupboard. Without seeming to pause, he began to pick up the contents of the cupboard and, one at a time, threw each of them out into the center of the room, wielding each one more swiftly than the last. Kristy watched him for a minute and then said, "Stop that, Guy. Come over here. Right now." He continued and she repeated her statement twice before he abruptly stopped and walked to her. He climbed up next to her and sat, leaning into her as he again put his fist into his mouth and sucked on it. Kristy stopped rocking Dolly, but did not speak. Dolly's eyes remained closed. After a couple of minutes, Guy's body softened as he leaned into his mother's body. As Annette watched quietly, the three of them seemed to almost mold into each other and become motionless together. Annette knew that this was a very important time for each of them, but she also knew that it was a time that was full of anxiety. She sat very still for about five minutes while she watched for signs of readiness for change from any of them.

As she anticipated, Guy began to grow restless and Annette decided that it was time to attempt an interpretation: "Kristy, it seems that Dolly and Guy really want to be close to you. Do you think that you could try coming down here on the rug with me and see if you could help them explore some of the playthings in this room? I think they might like some of the toys, but only if you are the one who shows them what's here."

Kristy seemed to need to think about this. Finally, after what seemed like forever, she slid down off of the couch and sat opposite Annette. For the rest of the visit, Kristy held Dolly in one arm while attempting to "read" to Guy as he, very excitedly, brought her one book after another. Sometimes he flipped one page at a time; sometimes he just briefly held the book in front of her and then whisked it away. He was clearly giddy with the attention she was able to give to him. Dolly had gradually opened her eyes and appeared to watch Guy quite closely as he engaged his mother.

Predictably, Guy was quite distraught to see the FCW come into the room and announce the end of the visit. Slowly and silently, Kristy went back to the couch, sat down, put Dolly down next her, closed her eyes, wrapped her arms around herself and began rocking. Guy ran to his mother, locked his arms around her knees and began to wail. Dolly's body became quite still and tense; her eyes remained open.

Annette began to speak for Guy: "Mommy, I don't want our play time to stop! Please help me say good-

bye to you." She said, "Kristy, can you come out to the waiting room with Guy and Dolly?" Ms. Hillings stood up and said, "Come on, Kristy." Kristy picked Dolly up, but didn't move. Ms. Hillings then took Kristy's arm and steered them all out, Kristy holding Dolly and Guy hanging on to his mother's legs. Kristy's facial expression looked dark and tense, but she was silent as she removed Guy's arms from her legs. Guy's foster mother picked him up and he kicked and screamed all the way out of the building. Dolly began to cry loudly when Kristy placed her into her grandmother's waiting arms. Neither Mrs. Makowski nor Kristy spoke to each other or to Dolly during this transition.

After the children left, Annette could clearly sense everyone's emotional overload. She knew that it would not be easy for Kristy to meet with her, but she also felt that it was important to hold to the agreement they had made.

She asked Kristy to go with her into a small room off of the waiting room. Kristy took hold of Ms. Hilling's arm and fairly dragged her into the room with her. They all sat down. After a seemingly long silence, Annette said, "That was a very hard visit for all of you. Even though you may have felt like not being there, or not staying, you did. You helped your children to know that you love them. I think that, if you can agree to keep meeting with me, I may be able to help. I don't really know how yet, because you and I don't know each other yet, but would you be willing to try?" (Silence) "I don't think that we need to try to talk today; I'm sure you don't feel much like talking now. But maybe I could come out to see you early next week and we could talk some more and think about making a plan about how we might work together – all of us."

After another long silence, Kristy said, quietly, "Okay." Annette said, "Thank you, Kristy. Thanks for trying to take another chance." She said good-bye to them and left.

Observations: making meaning of behaviors and interactions

Because infants and toddlers do not yet have much expressive language, careful observation of their behavior and reactions provide the best clues to what they are thinking and how they are feeling. IMH therapists are trained to use formal and informal observation methods, paying close attention to the ways that infants/toddlers signal to parents/caregivers and how the parent/caregiver responds to those signals. IMH therapists must rely heavily on a theoretical founda-

tion of infant/toddler development to understand how an infant/toddler of a particular age would typically behave to make better sense of any anomalies in observed behavior.

Cultural differences will influence the ability to accurately assess the caregiving environment and capacities. For example, IMH therapists are trained to recognize picking up a crying infant as a sensitive response. However, in some families, parents are discouraged from picking up a crying baby for fear of spoiling the child. Culturally competent IMH practice suggests that the IMH therapist will ask about a parent's caregiving behavior and explore how and why the parent responds the way that he/she does. Doing so helps the IMH therapist to better understand the cultural context of parenting practices and establishes trust with the parent(s).

Post-session reflection, assessment and planning time

As Annette reflected on the visit, most immediately compelling was her recall of the reunion behaviors of both Dolly and Guy. Although Annette had observed many such reunions, each one of them was a powerful reminder of how traumatic it can be for infants and toddlers when there is a disruption in the attachment relationship. Annette knew that all children have ways of letting their parents know how they've felt about a separation: for example, some children hold back a bit before they grin and rush headlong into an embrace; others don't hold back, but hang on extra tightly when they've achieved the physical contact they've missed. Individual differences and cultural norms also play an important role in how reunions are completed.

Annette knew from experience that if she and Kristy could work together toward a schedule for the visits, and that if the visits could happen frequently enough to be held in the children's minds from one time to the next, the good-byes should gradually become less traumatic for everyone involved. She left a voice mail message for the FCW to please call her in the morning so that they could discuss the possibilities and benefits of a more frequent visitation schedule.

Frequency of visitation

The publication entitled *Supporting Relationships for Infants and Toddlers With Two Homes* (MI-AIMH,

2010) was compiled as a guide for decision-making in foster care and divorce custody arrangements. It includes recommendations for visitation based on the developmental capacities of infants and toddlers and is very useful when determining the best visitation arrangement for an infant/toddler in foster care. Below is an adapted excerpt regarding infants/toddlers of 7-18 months who have experienced abuse/neglect:

“For most infants/toddlers of this age, frequent short contacts are the best way to build relationships without overwhelming the child. Overnights and contacts longer than 8 hours should be avoided. For infants/toddlers and parents who have had little previous contact, up to half-day visits are recommended to build up familiarity in routines. In general, the parent's other court-ordered commitments and the willingness of the foster parent [or IMH therapist] to supervise visits will determine whether extended contacts are possible. When the infant/toddler has a good relationship with the parent, longer and more frequent contacts may be appropriate, provided the infant/toddler's behavior and special needs are not made worse by parenting time and the foster parent [or IMH therapist] is willing to supervise additional visits. The parent may be authorized to take a toddler on short trips outside the foster home.” (MI-AIMH, 2010).

Supported vs. supervised visitation

There are important advantages to having the IMH therapist present during visits, as she can observe and support the parent's interaction with the infant/toddler and communicate the needs of the infant/toddler to the parents. This intervention can make a critical difference in maintaining and/or repairing the attachment relationship between the infant/toddler and the birth parent(s).

Models like the Supported Visitation protocol first developed at the WSU-PACT Program⁴ can optimize opportunities to support the birth parent(s) in finding new and developmentally appropriate ways to respond to the infant/toddler, practice new parenting skills, and repair some of the negative results from the maltreatment and subsequent removal and separation.

The PACT Supported Visitation model begins by transforming the role of the “visit supervisor” to that of “family coach.” Often, the IMH therapist will assume the responsibilities of the family coach.

The IMH therapist/family coach will:

- Advocate for more frequent visitation between parent(s) and infant/toddler
- Make a contract with the family that grants permission to provide intervention during visits
- Help the parents plan a developmentally appropriate activity and a general routine to be followed at each visit
- Understand and support the feelings and behaviors for both parents and infants/toddlers during separations and reunions
- Provide a nurturing environment to encourage appropriate family play/interaction
- Encourage parents to focus on the present
- Label and acknowledge the affective responses of parents and infants/toddlers
- Provide developmental guidance
- Remain strengths-focused
- Meet with the parent(s) after each visit in order to evaluate how the visit went and to revise the plan, if necessary, for the next visit
- Facilitate communication with the foster parent(s)

The objectives for birth parents involved in supported visitation are to:

- Consistently participate
- Focus on the present
- Facilitate planned activity and attend to the routine
- Be emotionally available so that they might identify and express their feelings, identify infant/toddlers signals and respond in a developmentally appropriate manner
- Demonstrate empathy for the infant/toddler's experience

The outcomes that are hoped for/anticipated for the infant/toddler are to:

- Interact with the parent(s) in ways that maintain and strengthen the attachment relationship

- Increase capacity to signal wants and needs more clearly
- Improve ability to expect and feel a sense of control over visitation events

Second visitation at foster care agency

(Eighth week of children in care, second week with IMH services; first visit using Supported Visitation protocol)

Annette felt understandably anxious and hopeful as she sat in the foster care agency lobby and waited for everyone to arrive for visitation. "Eight weeks they've been separated," she thought, "and still only one session a week." She knew that the foster care worker, who had been amenable to Annette using a Supported Visitation protocol, was still trying to increase the frequency of the visits. One of the problems was Mrs. Rogers' strong disapproval of the idea, since Guy had such a hard time after the visits. She said that she just couldn't change her schedule to get him to more than one visit per week. Annette really wished that she could meet with Mr. and Mrs. Rogers. Usually, she was able to arrange to visit the foster parents' homes as early in the intervention as possible so that she could observe the child's interactions and relationships in a different caregiving environment. It was always very helpful to her and she really regretted not being able to do so in this case. She was also feeling frustrated about not being able to see Dolly at her grandmother's home so that she could begin the Early On services that had been ordered. Annette's impressions from last week's initial observations were that Dolly was no longer failing to thrive, but she couldn't be certain without further assessment. She also had quite a bit of Early On paperwork to complete and was feeling anxious about meeting her reporting deadlines.

She was at least glad that Kristy had agreed to try the new plan. At the beginning of the home visit following the previous visitation session, Kristy had been quite withdrawn. Gradually, as Annette first acknowledged how difficult parts of that visit must have been for Kristy, and then quietly recounted some of her observations of Dolly and Guy's clear indications of their attachment to their mother, Kristy began to pay closer attention, even smiling once as Annette talked. As before, Kristy kept looking over to where the ever-silent Ms. Hillings sat. Kristy didn't seem to want to talk much, but when Annette began to explain the Supported Visitation protocol, she appeared to be listening very closely. She began to par-

icipate in the planning. Annette was quite encouraged to see signs of hopefulness in Kristy.

Kristy and Ms. Hillings arrived at the visit carrying a small bottle of apple juice, a small plastic glass and a package of graham crackers, as previously planned with Annette. Kristy showed Annette the small rattle that she had gotten at the dollar store. Annette showed them the foam rubber ball she'd agreed to bring and the paper and crayons that Kristy had thought Guy might like to try.

Kristy was clearly both excited and nervous. Her anticipation appeared to help her when the children arrived; instead of withdrawing when Guy and Dolly initially appeared reluctant to be close to her, she actually used words of welcome, taking Dolly in her arms and grabbing hold of Guy's hand and saying, "I have things to show you." Understandably, even though the plan had been to have some playtime first and then the snack, Guy reached for the crackers and wanted to take them to the couch. Kristy appeared flustered and called his name in a rather gruff voice. Annette immediately said, as she went over to Guy, "Are you telling mommy how happy you are that she brought you such good food?" She took his hand and led him back to the table, saying, "Mommy, thank you so much! I want to have snack right now!" Guy looked at Annette with surprise, as did Kristy. Annette said, "Mom, can Guy and I help you get snack ready?"

After that quick exchange, Guy sat fairly quietly and watched Kristy feed Dolly the bottle of formula that Mrs. Makowski had brought at the request from the foster care worker. Guy drank his juice and made a strong grunting sound while thrusting his glass toward Kristy. Kristy said, "You've had enough now." Guy immediately threw himself on the floor and began to cry, "No, no, no!" Again, Annette spoke for him, saying, "Are you wishing you could have lots and lots of juice?" Guy stopped moving, looked at Kristy and pointed to Dolly. "More!" Kristy said, "She's a baby." Annette then said, "Mommy? Do you have other things for Guy?"

While Kristy pulled the paper and crayons out of the carrying bag, Annette said, "Now I'll put the juice away so that you and Mommy can play together." Guy was immediately distracted by the new objects. He picked up a crayon and scribbled vigorously on the paper. When Dolly's bottle was empty, she turned and nestled into Kristy, watching intently while Guy continued to scribble with each of the crayons. Kristy took another sheet of paper and imitated Guy's scribbling. This made Guy laugh very hard. Again and again, he would scribble back and forth on his paper and then hand his mother the crayon

for her to scribble on her paper. After a little time had passed, Annette wondered aloud, "I wonder when Dolly might like to try the rattle." Kristy responded quickly. Annette was quite pleased to see Kristy try to involve Guy in showing the rattle to Dolly, even though he was more interested in continuing his drawing.

Annette noted that Guy's anxiety level seemed much more controlled than last week, as much of his energy was being channeled into the vigorous arm movements he used while scribbling. She also noted that, while he never allowed himself to get too close to Kristy, he watched her very closely. Dolly was alert throughout the visit and more focused, too. She seemed to like the rattle, grasping it briefly and following it closely as Annette invited Kristy to move it back and forth and up and down in front of her. Kristy, too, was more animated in facial expressions and in the amount of talking she did to Guy and Dolly. She was clearly enjoying herself; so much so that she literally jumped in her chair when Annette said, "Kristy, would you like to have Guy help you put things away before he and Dolly have to leave?"

Kristy visibly slumped in her chair. Guy got up and began to run around the room, saying, "No, no, no!" Dolly tensed up and pushed her face into her mother's body. As had been planned, Annette began to clap her hands and sing a "clean up" song. Kristy clapped Dolly's hands together, but she couldn't quite manage to sing along. Annette guided Guy to the table and held the bag while he put the crayons and paper in. Annette said, "Mommy, will you bring these again?" Kristy and Guy looked at each other and Kristy nodded. As Annette gave the bag to Kristy, he threw his arms around her legs and put his head on her knee.

Annette began to talk softly to all of them, saying, "It's really hard to stop having fun now, right? But now it's time to leave. Guy, after Mommy helps Dolly get into her car seat and to Mrs. Makowski's car, she is going to walk you out to Mrs. Rogers' car and help you get into your car seat. Let's go see if Mrs. Makowski and Mrs. Rogers are here."

As could be expected, the separation was even harder than last week. There was certainly more awareness this week of what the separation meant to each of them. In addition, the foster parent and grandmother understandably looked miserable and maybe even a little angry at this more prolonged good-bye. Annette prompted Kristy to tell both children that she'd see them next time and they'd play some more. Without waiting for the cars to pull away, Kristy ran back into the building, got her things

and told Ms. Hillings that they needed to leave. Ms. Hillings put her arm around Kristy and silently began to walk her out. Annette wished that Kristy could manage to stay and talk about the visit, but she understood how upset Kristy was. She knew, too, how helpful it would be for Kristy to not give up right now. She wondered if there was anything she could say to be encouraging, but she couldn't think of anything that wouldn't sound unempathic or even patronizing. She had learned that, when she didn't know what to say, it was best just wait and see what would happen next. So she was extremely relieved when a tearful Kristy stopped long enough to say to Annette, "I don't want to talk now. We can talk when you come out." Annette nodded. "Thank you, Kristy, I know this was hard. We'll talk when I come out." During this exchange, Ms. Hillings kept her eyes focused on the floor then tugged at Kristy to continue walking. Annette felt both pained and hopeful and she was very glad that her weekly reflective supervision hour would follow this visitation.

Reflective Supervision

In a paper presented at the ZERO TO THREE National Training Institute (1996), Julie Larrieu, a researcher and practitioner highly regarded for her work with children and families in foster care, writes, "Working with abused children and abusive parents often evokes intense feelings. We may have feelings of disbelief, horror, guilt, helplessness and curiosity. We may wish to blame or we may wish to rescue. Issues of trust, safety, esteem, intimacy, independence and power are often touched. In working with these families, we may experience tremendous sadness, anguish, confusion, and bewilderment. Our own experiences of loss of control, being trapped, or being abandoned are aroused," (Larrieu, 1996). These powerful emotions are important to acknowledge when they arise. Time set aside for regular, reflective supervision provides the opportunity to become aware of, understand, and then move beyond those personalized experiences.

Best practice suggests that reflective supervision should take place on a weekly basis for (no less than) one hour each week. The supervisor will need to possess some expertise in matters related child welfare cases. Reflective supervision should provide the time and space to consider the relationship needs of the infant or toddler in question and his parents. Who is important to him? How has he experienced any

changes in her primary caregiving? How might he experience future changes in primary caregiving? Has he been able to make use of important relationships to help him make sense of his world? If he could speak, what would he want us to say on his behalf? What has the parent demonstrated so far about a capacity to recognize and respond to the infant/toddler's signals? Is there evidence that the parent can utilize support if it is made available? What is the best that can be hoped for between the infant/toddler and the parent? Reflective supervision also provides a consistent time and safe place for the IMH professional to reflect on her own thoughts and feelings in response to her work.

Third visitation at foster care agency

(Ninth week of children in care, third week with IMH services; second visit using Supported Visitation protocol; ASQ/ASQ-SE screening)

Annette was actually looking forward to focusing this visitation on the developmental screening that she was required to complete on both children. She would help Kristy explore the developmental milestones that made up the Ages and Stages Questionnaire (ASQ) and the questions on the ASQ-Social Emotional (ASQ-SE) about the children's social-emotional behaviors. Both tools were especially effective in helping parents to see their infants and toddlers as individuals with their own set of skills and their own unique personalities. Supporting the parents as they completed the screening usually helped move the intervention along in any number of ways, depending on the extent to which the parents could respond to the experience with their children and their understanding of the results.

As expected, when Guy arrived he ran to Kristy, saying, "Crackers!" Kristy said, "Okay. Let's sit down first." Annette noted that this completely eliminated the greeting tension of the previous sessions. As planned, Kristy had kept the same snacks and the same activities. The FCW had arranged for this session to be longer to accommodate the time needed to complete the developmental screening, so there was enough time to enjoy snack and play before moving to the assessment.

Annette was pleased that both children were reasonably on target in most areas. Dolly was showing very appropriate progress in developing both gross and fine motor skills. She tracked objects well and paid attention to everything presented to her. The most noticeable finding was that, in the areas of Communication, Problem Solv-

ing and Personal Social, Dolly was quite subdued. She watched, but didn't grasp. She stared, but didn't smile or coo. In other words, in areas that focused on her attention to herself, she was doing well, e.g., playing with her fingers when she brought her hands together. In areas that involved another person – or even her own image in a mirror – she generally attended without actively responding. Overall, Annette was quite relieved by Dolly's ASQ results and the fact that she was now eating well and, by report from Mrs. Makowski to the FCW, continuing to gain weight.

Guy's responses to the items were also generally on target, though there were some items in both gross and fine motor areas that hinted at his unsettled life. For example, although Guy walked very well, he tended to trip and stumble or fall when he ran. When he was asked to stack blocks, he always stopped short of stacking all of them, regardless of how many there were. Annette had learned in training (and had since observed) that many very young children in foster care seem to have difficulty with completing goals – whether in getting across a room or building a tower. It's almost as if they are living in a kind of emotional suspension, unable to look forward. Babies can't talk about such feelings, but they can show us, if we know to pay attention and learn how to interpret what they show us. Annette was very pleased to see that Guy was making good progress in many areas, which suggested an overall adjustment to his foster care placement. He had words (though he would NOT repeat "bye-bye"), he ate reasonably well with a spoon, he threw and tried to kick a ball, and he imitated actions when asked, like eye-blinking and using a cloth to wipe a table.

Guy was given a doll to hold so that some of the Personal Social tasks for his age could be assessed. Both mother and therapist (and Ms. Hillings) watched this usually all-motion-all-the-time toddler suddenly become a very gentle caregiver to the doll. He held it, rocked it, cooed to it and kissed it. He held it out to his mother as if asking her to take a turn. She did and then gave it back to him. As he continued to cuddle the doll, Kristy's eyes filled with tears. Annette said, softly, "He's imitating what he has seen you do for Dolly, Kristy, and what you used to do for him. You've taught him about taking care of people." Kristy very quietly replied, "I learned that from my grandma. She used to cuddle me and even rock me when I was too big to sit in her lap." Kristy buried her face in her hands and sobbed without sound. Dolly began to cry and Guy took the cloth he'd been using for the doll and tried to wipe his mother's face. Ms. Hillings left the room.

Annette paused a minute before saying, "You really miss your grandma, Kristy. I'm sorry she's not still with you." Very abruptly, Kristy sat up, wiped her eyes, brushed Guy away, laid Dolly on the floor, stood up and went to sit on the couch. "I'm fine. I'm just fine. And I got Ms. Hillings." When she noticed that Ms. Hillings was not in the room, she became agitated and asked if the visit could end. Annette said that it would be another 20 minutes before the children could leave as both Mrs. Rogers and Mrs. Makowski had arranged to leave the agency and return at the end of this longer visitation time. Kristy curled up and turned her back to the room. Guy stood in the middle and rocked while he sucked his fingers. Dolly closed her eyes, whimpered and then was silent. After a few minutes, Annette began to talk to the children. "I know that you're feeling scared, but mommy is going to be okay. Mommy is very sad and needs to sit on the couch." After a couple of minutes, she asked Kristy if she could please put Dolly on the couch with her. Kristy shifted to make her lap available, but didn't say anything. Annette took Dolly to her and asked Guy to come with her. He climbed on the couch and sat next to his mother and sister. Then he reached over and stroked his mother's leg.

IMH assessment and diagnostic tools

Best practice suggests that the IMH therapist keep in mind a continuum of "optimal" to "good enough" to "inadequate" parenting when making observations and writing recommendations. While it is important to work toward optimal levels of nurturing, optimal parenting should not be the required criteria for the infant/toddler to be returned home. It must be noted that inherent differences exist between legally driven child welfare system goals of least harmful parenting versus mental health system goals of optimal parenting. The IMH therapist will assess whether or not the parent(s) in question can meet "good enough" standards and, if so, will describe what kind of support is needed by the parents to ensure the infant/toddler's safety and well-being. To make these determinations, the IMH therapist will use a range of formal assessment and diagnostic tools to better understand the parent's and infant/toddler's capacities, limitations, and risks.

As a part of the thorough assessment of the infant/toddler, qualified IMH therapists may use the revised *Diagnostic Classification for Zero to Three* (DC: 0-3R) (ZERO TO THREE, 1997) to identify and describe an infant/toddler who is considered at

risk for significant disturbances and/or disorders of relating to others. Like the *Diagnostic and Statistical Manual IV* (DSM-IV) for older children and adults, the DC: 0-3R guides professionals in forming a better assessment and treatment plan when there are infant/toddler mental health concerns.

Other frequently used tools are the developmental screeners, the Ages & Stages Questionnaire (ASQ) and the ASQ-Social Emotional. Both versions of the ASQ can be used for both the IMH therapist and parent to better understand the infant/toddler's developmental status. More thorough developmental assessment tools include the Infant Developmental Assessment (IDA) and the Devereaux Early Childhood Assessment - Infant/Toddler (DECA I/T). Formal observation tools commonly used in Michigan include the Massie-Campbell and the PICCOLO.

Eleventh week of children in care

During Annette's next individual visit with Kristy, Kristy had indicated her willingness to continue infant mental health services. Even though Kristy's first words to Annette as they sat down on the couch sounded almost angry as she looked directly at Annette and said, "Ms. Hillings thinks this is all a waste of time; that nobody's going to listen to you," something in her face was seeming to say, "I want to believe that you can help me."

Annette said, "Kristy, Guy and Dolly do need you. And, although they're way too little to tell you, something that they need very much is for you to believe in yourself. I believe in you and your FCW has been telling you that she believes in you, but we can't give you that – we can just try to help you keep trying."

Kristy had looked away as Annette spoke. She had looked down at her hands, her nails bitten to the quick, then she curled them into fists and said again, "Ms. Hillings said it's just all a waste of time. She says that them lawyers just want the judge to take my kids. She said she ain't goin' tomorrow." Annette had held her breath until Kristy said, "I asked the foster care worker to pick me up."

Annette felt even more encouraged as, together, they looked at Annette's court report. Annette reviewed the events of the last two months and treatment goals that she and Kristy had set last week. Both Guy and Dolly were responding pretty well to the Supported Visitation sessions. At this week's session, Guy had been much more settled during the snack and activities, and his being able to take Kristy's hand and walk with her to Mrs. Rogers' car – still

crying, but not hanging onto Kristy's legs and trying to stop her – was an incredible leap for him. Annette tried to draw attention to this new step in Guy and Kristy's relationship by saying, "I think Guy is beginning to trust that he'll see you again next time. Right, Guy? You and Mommy will be back here in this room next time, right?" When they got to the car, Guy gave his mother a big hug and his crying diminished to a quiet whimper.

Dolly, too, was taking a greater interest in what happened during her time with her mother and brother. This week, she actually babbled a little as she played with the now familiar rattle and she looked and looked and even reached out to touch the little cloth doll that Kristy had brought to her. Annette felt that Dolly was increasingly alert and showing clear signs of relaxing while interacting with her mother.

The treatment goal that pertained directly to Kristy's caregiving was easy to set: 1) Kristy would continue to learn new ways to encourage her children's development while being with and interacting them. The next one was harder: 2) Kristy would continue to meet regularly with Annette to a) plan, discuss and review the Supported Visitation sessions, and b) to begin to address her history of depression. The last goal was clearly scary to Kristy, but she nodded her head in agreement: 3) Kristy will explore the necessary steps to achieving a living situation that would make it possible for Guy and Dolly to be returned to her care. This last goal was written expressly so that Kristy would clearly know that Annette and April would be working collaboratively with Kristy to support those steps. Annette said, "You know, Kristy, you and your children can't live together with Ms. Hillings." Kristy's facial expression got really hard and cold. She said, "We don't gotta talk about that right now, do we?" Annette said, "No, but we will, you know." Kristy looked down again and whispered, "I know."

IMH therapist court reports

MI-AIMH has published *Guidelines for Comprehensive Assessment of Infants and their Parents in the Child Welfare System* (2005) to provide details for a very thorough relationship-based IMH assessment. For a more succinct quarterly report to the court, there is an outline (below) created by a McGregor-funded collaborative between the Merrill-Palmer Institute's Infant-Parent Program and the Parents and Children Together (PACT) program, both of Wayne State University. This outline was published in the *Michigan Child Welfare Law Journal* (Nota et al.,

1999) and in *Courts, Child Welfare and Infant Mental Health* (2008):

- I. Reason for assessment; referral information
- II. Background history
 - A. Infant's birth information
 - B. Number and duration of any previous placements
 - C. Parents' previous foster care involvement
 - D. Known/reported history of:
 1. Substance abuse
 2. Domestic violence
 3. Sexual abuse/assault
 4. Abuse/neglect of parent as a child
 5. Criminal justice involvement
 6. Cognitive and/or physical limitations
- III. List of observation dates, times, people present and locations
- IV. Observations
 - A. Infant or toddler
 1. Developmental status (gross & fine motor, communication, social/emotional, cognitive)
 2. Eating patterns
 3. Sleeping patterns
 4. Response to current foster placement
 - B. Parent
 1. Demographics
 2. Appearance
 3. Response to/perception of infant
 4. Expectations re: infant/toddler re: foster care status and development
 5. Parent's environment (community, dwelling, equipment for an infant/toddler)
 - C. Parent-infant/toddler caregiving relationship
 - D. Available/potential supports
- V. Assessment
 - A. Relationship

1. Strengths
2. Weaknesses
- B. Prognosis
 1. Ability to appropriately use intervention/support
 2. Parenting capacity
- C. Recommendations
 1. Preservation
 2. Placement (visitation schedule and/or permanency planning)
 3. Intervention plan

IMH therapist in court

The courtroom and its procedures often feel intimidating to IMH therapists unfamiliar with the legal system (Vandervort, Gonzalez, & Faller, 2008). It is also helpful to remember that the court experience will likely feel much more intimidating to the parents. Because so much is at stake for them in an environment that gives them almost no control, the offer of emotional support from the IMH therapist before, during, and after court proceedings is essential. The IMH therapist will inform the family about the content of the report and/or testimony ahead of time. Honesty with parents about the strengths and the concerns that have been observed and will be reported to the court are critical to maintaining trust in the relationship.

Recommendations in an IMH therapist's court report will speak to how to move the infant/toddler to a permanent and nurturing family as quickly as possible. While it is an underlying belief that infants and/or toddlers are best placed with their birth parents, it is also important to recognize that this is not always possible, certainly not if the birth parent(s) are unable to take advantage of and benefit from available resources. (Weatherston & Tableman, 2002).

Court hearing including testimony

Annette was both glad and nervous when she was called to the witness stand by the children's lawyer-guardian ad litem. She was also glad that she had included information about her professional qualifications, her MI-AIMH Endorsement, and her role as an IMH specialist as an attachment to her court report. She had

also attached a one page summary of the ASQ and the ASQ-SE. She was still asked a lot of questions about her qualifications, but no one seemed to doubt her competencies and her role. Annette was pleased that the attorney assigned to Kristy had asked her some child development and parenting clarification questions when it was his turn to cross-examine her because it meant that he had read it, and it gave her a chance to more firmly establish her obligation speak directly to the developmental and caregiving needs of Guy and Dolly.

The only really uncomfortable time was when the prosecutor had expressed his concerns about the lack of any evidence that Kristy was taking steps to move out on her own. He questioned Kristy's seriousness in getting her children back. He asked Annette, point blank, if her work with Kristy included this important step toward reunification. Annette said, "I have been serving this family for just over five weeks. The Supported Visitations have only been able to occur once a week. Most of my work to this point has been focused on getting regular sessions established – supporting mom's parenting skills during the visits with the children and establishing separate meeting times with mom to prepare for those sessions and to discuss them afterwards." The attorney asked, "Why do you need so much time to discuss the visits?" Annette replied, "Since they only have one hour a week together, I want to provide as much help as I can to maximize the benefits of their time together." The attorney then surprised Annette by saying, "If the visits were more frequent, do you think you could support the other parts of the parent-agency agreement?" Annette said, "Yes, I believe we could."

The judge ordered continuation of IMH services, and that visitation be increased to twice weekly – with IMH support for at least one of those visits and two if possible. The judge had expressed concern that both the FCW's and Annette's reports had noted Kristy's continuing signs of depression and ordered a psychological evaluation. Kristy had shot a suspicious look at Annette, who could only mouth, "It's okay" back to her.

Annette noted that the judge had watched closely as both Guy and Dolly protested the good-bye from their mother. Kristy very appropriately used the same words that had become routine during the visitation sessions, saying to Guy, "I'll see you next time. We'll have snack, we'll draw, we'll play, and we'll read a story. Give me a hug now. Bye-bye." Guy cried a little as he hugged his mother, but there was so much going on that he was easily distracted in this new environment and he left without further protest. Dolly had slept through much of the

proceedings, as infants often do when the environment is too much for them to take in. She woke up as Kristy put her in Mrs. Makowski's arms and Kristy kissed her forehead and said a soft good-bye. Dolly squirmed a little and closed eyes again as her grandmother carried her out of the room. The judge called out to Kristy, "Keep that up, young lady!"

Out in the hallway, the FCW and Annette went over the hearing with Kristy. April immediately smiled and said, "I want you both to call me April, okay?" Then she said that she would arrange for the second visit now that the judge had ordered it, and they both tried to convince Kristy that the psychological evaluation would be okay; that it didn't mean that she was crazy. Annette said, "We'll talk about it, Kristy." April then said to Annette, "I'll call you, Annette. We'll get things moving." Annette was really glad that Kristy could see that they were working together to help her; that there wasn't any evidence of "secret meetings" or people "working against her." Still, she knew that Kristy was going to have a hard time with this new focus on her – how she behaved and where she lived. Annette wondered how Kristy would talk about the hearing to Ms. Hillings. She was sure that Ms. Hillings still held more influence with Kristy than she did. At some point, Kristy would need to turn her back on Ms. Hillings, who had stood by her when Kristy had, twice within the last two years, been abandoned by important people in her life. This would be a tall order for anyone. And, Annette reminded herself, at 21? With two babies? With no family and no other friends? She wondered, as she had many times before in her work, how easy would it be for her to respond to a demand that she start a brand new life?

Theoretical rationale for long term work – the impact of early abandonment and depression on parenting

Even in cases where parents and infants/toddlers respond well to intervention, longer-term work with the IMH therapist can greatly benefit a family and may help to prevent another referral to CPS. IMH services were originally developed as a prevention service, i.e., to prevent relationship disturbances that could lead to abuse, neglect, delays in development, and even later mental illness as the infant/toddler grows older. Parents with mental illness symptoms that are accompanied by risk factors such as unresolved grief and loss, abandonment, or trauma need time and therapeutic support to separate these

experiences from their identity and behavior as a parent. According to Lieberman & Van Horn (2008), "In joint parent-child sessions, sustained therapeutic exploration of how the parent's problems affect the parent's feeling and behaviors toward the infant is most feasible in the first year of life.... The therapist can draw inferences about how the parent's conflicts, pathogenic beliefs, and distorted cognitions are visited upon the baby and transform the child into a transference object that is bereft of individuality while serving the parent's psychological needs.... The primary interpretive mechanisms of classical infant-parent psychotherapy are wrapped up in a dual message: compassion for what the parent endured as a child and forthrightness in helping the parent recognize the damage that the old pain now inflicts on the new baby. This two-pronged message is conveyed through carefully orchestrated statements designed to support the parent in finding new ways of coping with the past and becoming the parent she wants to be." (p. 66).

Narrative summary of second 3 months (and second court hearing)

This period had started pretty well for Kristy, and her relationship with Guy and Dolly was a good barometer for the progress she was making. Guy started using more language to communicate with his mom and, even though he still strongly protested the separations, the benefits of twice-weekly visits with Kristy and Dolly were quite evident as he quickly settled into a comfortable routine during their time together. Dolly, too, had responded well to the increased time, and really enjoyed her floor time with mom and brother as they applauded her new motor skills, particularly when Kristy helped her to practice sitting up.

Though it was not surprising that Ms. Hillings had backed away from driving Kristy to the visits, especially when the time doubled, Kristy clearly felt abandoned by her friend. She responded with anger and then some fear as Ms. Hillings threatened to "throw her out" if she didn't stop "harassing her" about being her "taxi driver." Clearly troubled by the cooling of their relationship, Kristy's moods were quite unpredictable during the first month after the court hearing. She sometimes challenged Annette and April when either of them made statements about her frame of mind or the well-being of her children. If they said something positive, she countered with something negative, and vice versa. She was particularly resentful about the pending psych eval – until it actually happened.

Her response to the doctor's suggestion of medication was, as expected, quite negative, but it led to a surprising step: Kristy decided to get a job and save some money to get her own apartment. She said that the doctor was the one who was crazy and she'd "show him she didn't need to be doped up!" She went back to the restaurant where she'd worked before and was hired for evening hours. Her mood definitely improved after her first paycheck. After her second paycheck she got a pay-as-you-go cell phone. She began to be more cooperative and, in general, more pleasant to everyone – including Ms. Hillings. Things seemed to be headed in a very positive direction. She made a couple of friends at the restaurant, one of whom started driving her to her visits.

Two weeks before court, Kristy failed to come to the agency for her visit with Guy and Dolly. When April went out to the apartment, Ms. Hillings told her that she had told Kristy she couldn't live there anymore, that she'd "had it." She wouldn't talk about what that meant and she said she didn't know where Kristy was.

Guy had been quite distraught when his mother didn't appear for the visit. He seemed to quickly pick up the fact that everyone else was as surprised and confused as he was. Mrs. Rogers tried to calm him down, but he was not easily consoled. The more he cried, the more she kept glancing over at Annette and muttering, "I knew it, I knew it, I knew it!" Dolly became quite agitated as Guy wailed, and Mrs. Makowski sounded very worried. "No! This can't happen," she said, "Not after her good work!"

When Kristy failed to show for the second visit that week, April told everyone that visits would be cancelled until she'd had contact with Kristy. She, too, was at a loss for what to do. She told Annette that she had tried to find Kristy at the restaurant, but had been told that Kristy had called in sick every day that week. Again, Mrs. Makowski voiced great concern, her voice filled with angst as she said, several times, "Why now? Why just before court?" Annette and April agreed that, whether or not Kristy appeared for court, their reports were going to reflect quite an important setback and would no doubt result in some hard to hear recommendations and decisions.

Early the following Monday morning, Annette got a call from Kristy. Her voice was very faint when she said, "I just wanted you to know that I'll be there this afternoon." When Annette asked if she was okay, Kristy sniffed a couple of times and said, "Yeah. I gotta go now." Annette then called April, who also had heard from Kristy; they had talked for a little while before Kristy had started crying and said that she had to hang up. April said that

Kristy said she was too embarrassed to call Annette, but that she had told Kristy that if she was going to continue working to get her children returned, she had to continue working with Annette and that she'd better call. April said that she'd then called and convinced Mrs. Rogers and Mrs. Makowski to bring the children for the visitation that afternoon. They agreed to talk again the next morning to discuss possible changes to the court report that Annette had already started writing.

No one was prepared for what happened at the visit: Kristy was already there, sitting in the waiting room with April, when Annette arrived. When Kristy saw her, she stood up and met her at the door, saying, "I'm sorry, Annette. I'm really sorry and I won't ever do this again." Annette looked at Kristy's distraught face and said, "I'm sorry, too, Kristy. I'm sorry about whatever you're going through."

Then, as Guy entered and saw her and ran to her, she repeated her statements of apology to Mrs. Rogers, who looked shocked, nodded brusquely and turned away. Kristy was more cautious when Mrs. Makowski came in carrying Dolly, but she issued the same apology as Dolly was placed in her arms. Mrs. Makowski froze and looked really hard at Kristy. Then she did something that caused everyone in the room to choke up: She put her arms around both Kristy and Dolly and rocked them a little, saying, "Oh, you poor, poor child!" Kristy buried her head in Mrs. Makowski's shoulder and began to cry. Annette and April stared at each other for a minute, and April whispered something that they had discussed off and on, "I wonder if Mrs. Makowski would take Kristy in? I'm going to work on that." Then louder, "Okay, everybody, let's get this visit going right now!"

As expected, the judge had been very stern with Kristy at the hearing, and the cross-examination questions that were asked by both attorneys and the judge were especially difficult to answer. Annette was asked in several different ways whether she thought Kristy was able to parent her children responsibly. Again and again, Annette referred them to what she had written in her report. She had taken extra care to make her descriptions of all observed interactions very clear. Her updated developmental assessments were reported in great detail. She had done her best to illustrate the full range of Kristy's attitudes and behaviors during the past three months, and had ended with recommendations that the supported visitations and separate sessions with Kristy be continued. Annette hoped to convey that, as she'd learned long ago and observed time and time again in her work, no one can be better

than their best, but anyone can take their best to another level if the time and level of support is right.

In the end, the judge had responded favorably to the new request that had been carefully detailed in writing and put before the court that day – Mrs. Makowski was willing to take Kristy in to live with her and to support her efforts to meet the goals that would allow her to have her children returned to her care. He was quite open in his reaction to Kristy's disappearance and her seemingly heartfelt apologies and promises to make amends. After issuing a very stern warning to Kristy, saying, "You have one more chance, young lady. One more chance to convince this court that you mean what you say. Don't let us down. Don't let your children down. Oh, I know you might stumble, but you can't afford to let yourself fall. Do you understand?"

Then, still speaking quite firmly, he agreed to let Kristy try living with Mrs. Makowski. Annette was to meet with Kristy at the Makowski house to continue her work with Kristy and to further observe Kristy and Dolly together. The agency-based visitations were to continue. Kristy was to continue working, saving money and, in general, demonstrating her recognition of all that it meant to be the mother of two children. He further surprised everyone by specifically asking Mrs. Rogers if she would continue to commit to bringing Guy to every visitation session so that he wouldn't be left out of this new arrangement. The last surprise of the day was Mrs. Rogers saying, "I'll certainly do what I can to give them this chance, Your Honor."

Facilitating and supporting inevitable transitions

For many professionals, it is often easier to believe that infants/toddlers will not remember what is happening to them as they are separated from parent(s), sibling(s), and familiar surroundings. When removals and/or changes in placements do occur, some child welfare workers have reported that they have found it easier to do so when the infant/toddler is asleep, so that everyone (especially the infant/toddler) is spared from the young child's painful expressions of distress and anguish. Others may believe that infants/toddlers will not remember the disruptions of removal and/or replacement, despite the infant/toddler's demonstration of great distress. In fact, it is an underlying principle of IMH that the experiences of the first three years "affect the course of development across the lifes-

pan” (Shirilla & Weatherston, 2002, pg. 2), whether or not the child is able to verbally express the memory of the trauma later in life.

Removals, placements and moves are traumatic to infants/toddlers and children. Therefore, whenever possible, removal and/or replacement should be avoided to save the infant/toddler from the confusion and grief of an abrupt change in caregivers. When removal and/or replacement cannot be avoided, IMH therapists and child welfare workers should provide as much support to the infant/toddler as possible. For instance, the infant/toddler should be awake during all major transitions. Significant changes to the infant/toddler’s life while he is asleep may lead to sleep disturbances, e.g., the young child may work hard to avoid sleep so as to avoid any other changes or loss of control in his life. Even if they are not yet using words themselves, infants/toddlers deserve to be told what is happening to them, where they are going, and when they will next see the people from whom they are being taken. The infant/toddler’s personal belongings should move with him, e.g., blanket, pillow, clothing, toys, books, photographs, transitional or security objects, etc.

The decisions that must be made by the legal system carry heavy consequences; the relationship and attachment needs of infants/toddlers must be considered. Whenever possible, services that are required to keep the infant/toddler safely at home will be made available quickly. If safety cannot be ensured, IMH therapists will recommend that every effort be made to place the infant/toddler with siblings and with relatives, kin, or licensed foster care, and that the first placement be the only placement until the children are returned or made available for adoption.

If a transfer to another placement cannot be avoided, the infant/toddler will need to have the opportunity to say goodbye to the caregiver(s) and places that have become important. The infant/toddler should again be allowed to take his own clothing, blankets, toys, books, and security objects to ease the shock of the change in environment and caregivers. This is particularly important for infants/toddlers who have no access to language that can help them understand why abrupt changes are occurring and for how long.

Narrative summary of the next 3 months (and third court hearing) and projected outcome for this family/case (and what cannot be projected)

As Annette walked to her car after court, she chuckled about Guy and Dolly’s “star performances” at the hearing. As usual, Guy and Dolly were both on Kristy’s lap during the hearing, and they had clearly gotten so accustomed to the setting that they showed no hesitation in participating in the proceedings. Dolly periodically squirmed and tried to get down to stand next to her mother, and then immediately reached her arms up to Kristy to be picked up again. This game was repeated many times, without any sign of frustration by Kristy. Guy was quite content to be drawing (still one of his favorite activities) with some new markers and big sheets of paper that his mother had brought, but he frequently wanted her to exclaim over what he had drawn, and his mother obliged as much as possible while listening to the proceedings. Although Annette had completed and reported on the developmental screening updates, one hardly needed official scores to see that the children were doing well. Annette wished that those who think that only bad things happen when children are removed could see this evidence that, when the children were in nurturing placements, and when their lives and relationships could be reasonably predictable, they were very likely to make good developmental progress.

A lot had happened since the last court hearing. First, after a month of positive progress, April had agreed to let the visitations be moved to Mrs. Makowski’s house. Mrs. Rogers had agreed with the FCW that this was a logical next step and said that she would continue to transport him, especially since Mrs. Makowski’s house was much closer to her than was the agency.

Kristy had really stepped up to the plate since her terrible time before the last hearing. She treated Mrs. Makowski with respect and seemed able to both seek and take child-rearing advice from her. The one struggle they had was over Kristy’s wishes for time to be with the friends she had made while working at the restaurant. Kristy told Annette that Mrs. Makowski made her feel like a little kid and, in her sessions with Annette, Kristy really struggled with her anger and resentment. She felt like she didn’t really have any choice but to do anything Mrs. Makowski wanted.

After almost two months of increased tension and Kristy’s complaints during their individual sessions,

Annette asked her if she had thought about what Mrs. Makowski might be worried about. Kristy stopped and stared at Annette. After a long pause, Kristy said, "Maybe I know." After drawing her legs up close to her body and wrapping her arms tightly around them, Kristy began to talk.

"Mrs. Makowski never even knew about me until the night that Steve died," she began. "She didn't know me, she didn't know that Steve and I was livin' together, she didn't know that he got me pregnant or nothin' until she saw me. I knew that his mama lived somewhere around here, but every time I brought her up he told me to shut up. He just never talked about her or about any family or nobody." Annette started to ask a question but decided that it was really important for Kristy to say only what she wanted to say, in whatever way she wanted to say it, whenever she felt trusting enough to say it, so she just nodded and waited for Kristy to continue.

After a couple of minutes, Kristy continued, saying, "I remember that I was real happy that night – feels so stupid now – that my friends at the restaurant were teasing me and talking about giving me a baby shower. I wanted to tell Steve about it and I called to him as I opened the door." She paused another minute or more before whispering, "He was slumped over on the couch. I screamed and screamed and Ms. Hillings came runnin' from her place. She called 911, but it was too late. I knew he was dead. Anyway, I rode in the ambulance to the hospital. They asked me a bunch of questions about drugs he used, but I couldn't answer anything about him except that I knew he sometimes he did stuff like that, but he always told me that he was fine – not to worry – that he would...he would...he would always take care of me." After a very long pause, Kristy said, "Then they said that they had his records. That really scared me. I didn't know nothin' about him ever being in the hospital before. Then, all of a sudden, this woman was there telling me she was his mother. I just freaked and ran from there. I never even heard about no funeral or nothin' and I never seen her or heard nothin' about her till they took the kids and I went to court and they told me that's who had Dolly."

Kristy was quiet for so long that Annette wondered if she was going to say any more. After several minutes, Kristy said, "That first time, when she brought Dolly to the agency? I saw her look at me as if I was the fault of everything. I suppose she thought that I used drugs, too, right?"

Annette waited a bit before saying, "Kristy, do you think that she thought you might disappear, too?" Kristy looked long and hard at Annette. "I guess," she said.

"I guess I couldn't blame her if she did think that. You know, my own mother did like that – just disappeared all the time till my grandmother came and took me and then I never seen her no more."

This time, Annette knew she was through talking, and she said, "Kristy, I'm really sorry that all of that happened to you – not once, but twice. I think you're right. I think Mrs. Makowski worries about you. What would you like her to know?"

"That I really want to be here for good and that I...I want to be a good mother," Kristy said. Annette said, as gently as she could, "Kristy, do you think you could ever tell her that? Kristy looked at her and whispered, "Maybe. I don't know."

At the next hearing, one month later, Annette testified that she didn't know, couldn't know what would happen down the road, but that, thanks to the funding in place for infant mental health services, she could continue to support this family, including Guy, until Dolly was three years old, regardless of foster care involvement. She was very careful not to make any predictions, any assumptions, even though the cross-examination was pretty detailed. Especially in response to the prosecutor's questions, she said that Kristy had started working very hard with her to try to understand how her own childhood fit or didn't fit with what she wanted for her children. Responding to questions asked by the children's attorney about effects of their time in foster care, she referred to the recently updated ASQ-SE scores, saying, "In preparation for this hearing, Kristy and I completed the Social-Emotional screening sheets for Guy and Dolly's current ages. In contrast to the number of concerns noted when the first screening was completed, six months ago, the only area of concern for Guy is that he is sometimes very clingy for the first 15 minutes or so of their visits. I do not feel that this is unusual behavior for a child who only sees his mother twice a week. All other areas, either by observation or, as is permitted, by report – in this case by his foster mother – are well within typical range for his age. Dolly's scores, too, indicate that she is progressing very well. Given her early history of Non-Organic Failure to Thrive, I have especially noted in my report that none of the questions pertaining to eating behaviors and meal-times were marked as areas of concern. She is very relaxed when being held by her mother and enjoys the games they play together."

Recapping all that had been presented and discussed before him, the judge asked, "Mrs. Makowski, do I understand correctly that you are willing for this mother

and her children continue to live with you, under your guidance, until mom has had some job training and is able to secure the means to move out on her own with her children?" Mrs. Makowski did not hesitate in her affirming response. Mrs. Makowski added, "Kristy and I have talked about this. I know she wants to be a good mother. And I want to help her and the kids." When he had questioned Kristy again about her intentions, he then turned to the foster care worker and said, "Ms. North, I assume that you and Ms. Granston will work together to have her son transition to live with his mother and sister under Mrs. Makowski's care, and that, at the next hearing, which will take place three months from now, this court will be very interested in knowing what progress mom has made toward getting ready for independent living, with full responsibility for her children's care."

Annette and April watched closely as Mrs. Rogers patted Kristy's back when she went up to collect Guy for the trip back home. Then they watched her shake Mrs. Makowski's hand as they left the courtroom. As they followed Kristy out to the hall to review the hearing with her and Mrs. Makowski, they looked at each other and shrugged...but this time, they were smiling. ©

Links to Zero to Three and American Bar Association documents about maltreated infants/toddlers

- ZERO TO THREE'S fact sheet that summarizes the goals and accomplishments of the Court Teams project as each community works to improve outcomes for maltreated infants, toddlers, and their families: http://www.zerotothree.org/about-us/funded-projects/safe-babies-court-teams/court_teams_final_fact_sheet.pdf
- ZERO TO THREE'S Court Teams Project Core Components: http://www.zerotothree.org/about-us/funded-projects/safe-babies-court-teams/court_teams_core_components.pdf
- American Bar Association Practice & Policy Brief -- Healing the Youngest Child: Model Court-Community Partnerships: http://www.americanbar.org/content/dam/aba/administrative/child_law/healing_young_children.authcheckdam.pdf
- Ensuring the Healthy Development of Infants in Foster Care: A Guide for Judges,

Advocates, and Child Welfare Professionals: <http://www2.americanbar.org/BlueprintForChange/Documents/Ensuring%20the%20Healthy%20Development%20of%20Infants%20in%20Foster%20Care.pdf>

- A Call to Action On Behalf of Maltreated Infants and Toddlers: <http://www.zerotothree.org/child-development/health-nutrition/childwelfareweb.pdf>

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- 2 In 2003, the Federal Child Abuse Prevention and Treatment Act (CAPTA) was reauthorized with specific language that requires the referral of all 0-3 year-olds involved in a substantiated abuse/neglect case to Part C. In Michigan, Part C is known as "Early On." When the CPS worker makes the referral to Early On, the service coordinator assigned will most likely come from education, public health or mental health. The IMH therapist can offer to support the eligibility assessment and/or participate in the Individualized Family Service Plan. Ultimately, the role of the Early On service coordinator is selected by the birth parent.
 - 3 The Michigan Association for Infant Mental Health endorses infant-family professionals from many disciplines. In order to earn the MI-AIMH Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health, the professional must document competency in 50 knowledge and skill areas and must meet minimum requirements for education, work, training, and reflective supervision/consultation. Endorsement levels include Infant Family Specialist (Level II), Infant Mental Health Specialist (Level III), and Infant Mental Health Mentor (Level IV). Those at Level III and Level IV must also pass a written exam. For more information, go to <http://mi-aimh.org/endorsement>.
 - 4 Parents and Children Together (PACT), formerly a program at Wayne State University, specialized in serving child welfare-involved infants, toddlers, and their families in Wayne County. PACT program staff built on the work of others [such as Larrieu (1996), Lewis & Vallier (1996), and Beyer (1999)] to develop an activity-based intervention that can be useful when trying to support attachment relationships between parents and infants/toddlers in foster care.

Endnotes

- 1 The Michigan Department of Community Health (MDCH) requires each county to have at least one home-based licensed mental health professional who serves families of children age 0-47 months and who is endorsed by the Michigan Association for Infant Mental Health as an Infant Mental Health Specialist (Level III), preferred, or Infant Family Specialist (Level II), minimum. For a list of IMH service providers in Michigan, including MDCH, private practitioners, and others, please go to <http://www.mi-aimh.org/michigan-infant-family-service-providers>.

Child Welfare Cases Involving Mental Illness: Reflections on the Role and Responsibilities of the Lawyer-Guardian Ad Litem

by Frank E. Vandervort, J.D.

Introduction

Child welfare cases involving mental illness suffered either by a child or his parent can be among the most difficult and perplexing that a child's lawyer-guardian *ad litem* (L-GAL) will handle. They may present daunting problems of accessing necessary and appropriate services as well as questions about whether and when such mental health problems can be resolved or how best to manage them. They also require the L-GAL to carefully consider crucially important questions—rarely with all the information one would like to have and too often with information that comes late in the case, is fragmented or glaringly incomplete.

This brief article will begin with a discussion of the scope of the problem of parental mental illness and its impact upon children. It will then suggest the need for a particular type of evaluation in order to attain a more comprehensive understanding of the nature of the mental health issues involved, their impact on each party's functioning, and how best to proceed with the provision of services. Next, it will address case planning by the L-GAL, doing so primarily through suggesting a series of questions that the L-GAL might ask herself about the parties to the case, others involved in the family's life, and the community resources available to address the needs of the children and families with whom she is working.

Scope of the Problem

Estimates suggest that approximately 30% of all adults experience a psychiatric disorder in any given year.¹ Of these, nearly two-thirds of the women are

parents as are half of the men.² It has been estimated that 21% - 23% of children live with at least one parent who is experiencing mental illness.³ Thus, at any given time, millions of American children are living with a parent who suffers from a mental illness. Growing up in a home with a parent who suffers from mental illness is a risk factor for a number of negative outcomes: developmental problems, behavioral problems and emotional problems; such children have higher rates of psychiatric problems, as well as social and interpersonal dysfunction.⁴

Parents with serious mental illness face multiple parenting challenges.⁵ These may include difficulty with age appropriate discipline, reading children's cues in order to respond to their needs, providing for the child's basic care, nurturance (e.g., a mentally ill parent of a young child may not properly bond with the child), communication, and being able to separate their needs from their child's.⁶ Additionally, they may be otherwise neglectful or abusive to their children.⁷ Having a parent with mental illness is a risk factor for severe child abuse and even infanticide.⁸ Identifying parents living with mental illness in order to provide needed assistance can be difficult because these individuals often actively avoid assistance.⁹ Despite the presence of these risk factors, most children with mentally ill parents will never have contact with the child welfare system. A substantial number will, however.

So, if most parents with mental illness never have contact with the child welfare system, what distinguishes those parents who do have contact with the system? That is, how do children with mentally ill parents come to be overrepresented in the child welfare system? First, mentally ill parents are at increased risk

for interpersonal isolation and lack adequate social support networks (i.e., many lack family members or friends that can step in to supplement what the parent is able to provide him- or herself).¹⁰ These parents' lack of family and social supports may mean that when a crisis takes place—such as psychiatric hospitalization or acute substance use—the parent will lack the wherewithal to provide for their child. For instance, I recently represented a mother who has long suffered from depression, which periodically escalates into an acute episode requiring that she be placed in a psychiatric facility. When she was hospitalized because her depression worsened and she became both suicidal and homicidal (from the stress of caring for a child who herself struggled with post-traumatic stress disorder), she had no family members or friends who could step in and care for her child. As a result, her daughter had to be placed into the foster care system.

Co-Morbidity

Those parents with mental illness who come to the attention of children's protective services and the court very often are struggling with a multiplicity of problems in addition to their mental illness (what social work and medical professionals refer to as co-morbidity), which may interact to increase the risk of harm to children and complicate treatment of both the mental illness and the co-morbid problem. These other problems may include, but certainly are not limited to, substance abuse,¹¹ domestic violence, single parent status, high stress, child maltreatment, and criminality that results in incarceration.¹² Each of these problems individually, as well as the combination of them interacting together, is very often exacerbated by poverty. Any one of these social maladies may prove a challenge to minimally adequate parenting—perhaps a very significant one in a given case. In combination, they interact with one another to substantially increase the likelihood that their child will come to the attention of child welfare authorities. Parents with interacting, co-morbid problems are at heightened risk to lose custody of their children permanently.

Need for Evaluation

While mental illness may present a challenge to adequate parenting, and places children at heightened risk for maltreatment, diagnosing parental mental illness and assessing the parenting capacities of a parent

at a given time can be difficult.¹³ Psychologist Teresa Ostler has pointed out that “Although maltreatment risk is higher in individuals with diagnoses of major depression, substance abuse, mania, schizophrenia, and antisocial personality disorder, the parenting skills of individuals within any given diagnostic category can vary greatly, making imperative a comprehensive, multifaceted approach to risk assessment.”¹⁴ Thus, there is a need for careful evaluation of the mental health status of the parent as well as his or her ability to safely parent the child. Similarly, each child's mental health functioning must be evaluated as must the interaction of the parent's capacities and the child's needs. To be the most reliable and helpful to legal professionals and the court, evaluations should be done early, they should be comprehensive, they should be done by a multidisciplinary team (no single discipline “owns” the problem of child maltreatment and no single discipline can itself resolve these problems), and they should be trauma informed.

Early

There are at least two reasons that children's lawyers should press for early evaluations in cases in which parental mental illness has been identified as an issue. First, as noted before, parents with mental illness may also be experiencing other, co-morbid problems. But those other problems are sometimes not easy to identify, and, in some cases, the parent will seek to hide other challenges to their ability to safely parent their children (e.g., substance abuse). While Children's Protective Services or foster care workers may screen for co-morbidity,¹⁵ they may not be qualified or skilled in identifying attendant problems or may not understand their importance. By obtaining a comprehensive evaluation by a more highly skilled team of evaluators at the earliest possible point in the case, it is more likely that these co-occurring problems in functioning will be identified. Early identification will provide a better understanding of the risks the child faced while at home and the problems that must be addressed before the child may be returned. Such early identification will serve the interest of all parties—the agency will know what it must do to meet the “reasonable efforts” requirements, the parents will be provided the best opportunity to regain custody of their children, and the children will be best served because when a decision to return the child to parental custody is made he or she will be replaced into a healthier environment.

Anyone who has practiced in this field of law for a period of several years has no doubt encountered cases in which the child enters the system based upon one form of maltreatment, but several months into the case the parent is found to have additional problems. For example, it is not unusual for a child to enter care because of concerns about neglect, only to discover months later that domestic violence has taken place in the home or that the child was sexually abused while at home.¹⁶ An early assessment of the child, the parents, and the family as a unit can help to identify behavioral and parenting problems on the part of the mother or father, their impact upon the children, and independent problems the children may face. For instance, some forms of mental illness may be heritable, so a child whose parent suffers from, say, depression or schizophrenia is at risk of developing these maladies.¹⁷

In addition to identifying co-occurring disorders that a CPS or foster care worker may be unqualified to identify, an early assessment can establish a baseline of parental functioning, child functioning and parent-and-child interactional functioning from which to measure progress after treatment services have been utilized. Too often in the child welfare system, we send individuals for treatment when it is not clear what we are treating or how we will measure whether the treatment has been successful. We simply say, “Go to counseling” or “Go to parenting classes.” By establishing a baseline of functioning as near as possible to the time the family enters the system,¹⁸ we will be better able to assess whether progress has been made at stabilizing the parent’s or the child’s mental health, whether the parent’s skills have improved, and to know what progress is yet necessary before reunification can be considered. In short, an early evaluation should help to inform lawyers’ advocacy and courts’ decision-making.

Finally, an early evaluation of the sort that is suggested here may identify cases where early, alternative permanency plans should be made because the parent’s problems with parenting are so substantial that making “reasonable efforts” to reunify would not likely be worthwhile.¹⁹ The Adoption and Safe Families Act included provisions, codified in Title IV-E of the Social Security Act, that permit child welfare agencies to seek and courts to grant early termination or to pursue other, alternative permanency plans in any case in which it is unlikely that the child can be returned

to the parent in a timely fashion, that is, within the 12 to 15 month timeframe provided for by federal law.²⁰

Comprehensive

Numerous commentators have recognized the need to evaluate various aspects of a child’s or parent’s functioning when they come to the attention of child protective authorities or enter the foster care system.²¹ These have included medical assessments, educational assessments, and mental health assessment, each discipline-specific. Legal decision-making, however, will be enhanced by more comprehensive assessments of each individual—mother, father and each child—as well as their interactional functioning. Comprehensive evaluations are conducted in order to identify functional problems and the services necessary to address those problems in functioning and to be of help to children and their parents.²² Comprehensive assessments examine all aspects of functioning and seek to identify maltreatment risk factors and to design a case-specific response to each.

In addition to mental health functioning, a comprehensive assessment would assess at a minimum the following: history of any child maltreatment, historic or current substance abuse disorders, historic or current domestic violence, medical needs, and educational status and needs of each child.

Multidisciplinary

No single discipline owns or has full responsibility for child maltreatment or child protection. Rather, to address the multifaceted challenges presented by the phenomena of child abuse and neglect, it is essential that various disciplines work together in order to address the problem systematically, both on a policy level and at the level of individual cases. Federal law recognizes the value of multidisciplinary assessment of children and families and provides financial support for the establishment and operation of teams of professionals from various disciplines to respond to child maltreatment.²³ Similarly, Michigan’s Child Protection Law has long required the Department of Human Services to establish regionally located multidisciplinary teams to assist the agency in comprehensively evaluating the needs of children and families.²⁴ Despite this statutory mandate, multidisciplinary teams have never been fully implemented and are not readily available in each community in the state to assist DHS and the

courts in case planning and decision-making. Despite the lack of access in Michigan to multidisciplinary assessment, there are a few multidisciplinary teams working in the state. The Family Assessment Clinic (FAC) at the University of Michigan School of Social Work is one such team, which provides an exemplar of how such a team can work.

Established in 1980, the FAC conducts comprehensive assessments in complex cases of child abuse and neglect either at the request of the Department of Human Services or pursuant to a court order. The FAC brings together social workers with advanced education and vast experience, psychologists, medical professionals who specialize in child maltreatment, a lawyer, and other specialists as the needs of a particular case may demand. At the time a case is referred, the referral source formulates specific questions for the team to address. For example, the questions to be addressed might be “Is the mother able to effectively parent her children?” “What services would assist the father in becoming a more effective parent?” “Would termination of parental rights serve the children’s best interests?” These questions provide a structure for the evaluation.

The evaluation begins with gathering and reviewing background information on the case and family members submitted by each party. This may include reports from DHS, mental health providers, or doctors treating members of the family, court documents, school records, and similar material. Each parent is provided a psycho-social evaluation by a different social worker. The children are seen individually for psycho-social evaluation by a social worker with a PhD. In addition to an interview, a variety of tools, such as the Child Behavior Checklist, are utilized as indicated. If psychological testing has not been done in the past year, then the adults are psychologically tested. Except in extraordinary cases, the psychologist conducts the testing without access to other information in the case. If the parties have been psychologically tested within the past year, then FAC obtains a copy of the test results as part of its information-gathering process. Children may receive psychological testing if their psycho-social evaluation indicates a need for this. As with adults, if the children have received psychological testing within the past year, then the results of that testing are obtained. If educational deficits are identified as an issue, either by the referring source or by the psycho-social evaluator, then an educational

specialist can be called upon to review records, see the child or take what other steps are necessary to evaluate the child’s educational situation. Similarly, if the case raises medical questions, then a physician will review medical documentation and may conduct an examination of the child. Unless the facts of a specific case indicate that it would be harmful to the child to do so, the parent and the child are seen together in a parent-child interaction, which is an opportunity for the clinicians to observe the parent parenting the child in an unstructured setting. After the parent-child interaction, the parents discuss the interaction with the clinicians and share their perceptions about what took place. Collateral sources of information regarding the family—members of the extended family, teachers, and treatment providers—are suggested by the parties and contacted so that information can be gathered from them regarding their perceptions of the family’s functioning.

At the conclusion of these steps, a meeting is convened during which the team members discuss each individual assessment and the interaction of the various family members, and seek to provide clear answers to the questions posed by the referral source. The team members seek to make clear, specific recommendations for services that are needed by the individual family members or steps that should be taken to ensure safety, permanency and well-being of the children involved in the case. The answers to the questions and the recommendations of the team are provided to the referral source through extensive written reports—a report of each psycho-social evaluation and a final, integrative report containing the team’s overall impressions. It is not unusual for these reports to run 40 pages or more in length.

There are several strengths to a multidisciplinary process of this type. First, it brings professionals from different disciplines together to carefully evaluate within their areas of specialty. Utilizing a multidisciplinary process develops a much deeper understanding of the individual and his or her interaction with other members of the family. Next, by conducting the psycho-social evaluations individually with different evaluators, the natural bias of individual evaluators are balanced against one another and a more objective picture of the functioning of each individual and the family as a unit is developed. There is a natural process of critical analysis and critique that goes on as individuals with differing perspectives weigh in on

what they see happening within the family and its constituent members. Finally, having professionals from varying disciplines involved allows the team to view individuals and families through different lenses. It also allows for more creativity in thinking about needs of the family and the resources available to best to meet those needs.

Trauma Informed

Over the past fifteen years, scientists have learned a great deal about the impact of traumatic experiences on children as they develop.²⁵ In the most general terms, the exposure to traumatic events can have meaningful impacts on how the brain functions. It may do so in a combination of ways that is diagnosed as post-traumatic stress disorder (PTSD).²⁶ PTSD results from exposure to a traumatic event or events that may alter chemical secretions in the brain and may result in architectural changes to the human brain. These changes in the brain, in turn, may result in behavior that is considered problematic. For an assessment of a child and family to be truly comprehensive, it should consider how the child's and parent's brain functioning and resulting behavior have been impacted by experienced trauma.

What is trauma? As referred to by mental health professionals, trauma is defined as an event that overwhelms the child's emotions and renders the child helpless, powerless or that creates a threat of harm or loss of a significant relationship. But exposure to a potentially traumatic event alone is only half of the equation. It is also the internalization of that event that impacts the child's perception of self (how the child sees herself, as bad or good), others (does the child see others as generally good and helpful or as bad and a threat to be feared), the world (does the child generalize the traumatic experience to the broader world) and the child's development (cognitive, emotional, social, physical).²⁷

What is the impact of trauma? As noted, exposure to trauma—particularly chronic exposure of the sort that may result from ongoing child neglect, abuse, or exposure to domestic violence in the home—can alter the chemical functioning of the brain as well as change the way in which neurons in the brain connect with one another (i.e., alter the architecture of the brain). Children impacted by trauma may engage in a variety of maladaptive behaviors ranging from hypervigilance (being excessively aware of everything

in their environment), to freezing in an emergency, to acting out aggressively. While these behaviors are maladaptive and can be challenging, they also make sense because they help children to protect themselves and to cope with their life situation. Children who have experienced trauma are susceptible of being diagnosed with multiple mental health disorders when they are viewed through a strictly mental health lens rather than through a more multifaceted trauma lens. The diagnoses these children receive may include attention deficit hyperactivity disorder, oppositional defiant disorder, depression, bi-polar disorder or schizophrenia. It is not unusual for children in the child welfare system to have been labeled with numerous mental health diagnoses. When a practitioner has a client who has numerous diagnoses, then it is important to seek out a trauma informed assessment in order to understand what is really happening with the child.²⁸

Typically, when children have been evaluated and are determined to be reacting to traumatic events, it will be important to connect that child with trauma informed treatment. Traditional treatments—both talk therapy and psychopharmacology—may help with some of the symptoms of trauma, but until the underlying trauma has been worked through in the treatment process, it should be anticipated that the child's emotional and behavioral problems will persist. Research has shown that several forms of treatment are helpful to use with traumatized children. Two of the most prominent of these are trauma informed cognitive behavioral therapy (TF-CBT) and Real Live Heroes. These are structured programs that have been proven effective and are increasingly available in communities in the state. The L-GAL should ask a treatment provider what his or her experience with these and other evidence-based, trauma informed treatments is, and to inquire about the treatment provider's credentialing. That is, how has the individual providing therapy been trained in the use of these trauma informed treatment modalities?²⁹

As with children entering the child welfare system, many of the parents we encounter in the system have unresolved histories of trauma.³⁰ The lack of treatment aimed at addressing these histories of trauma frequently leaves these parents with maladaptive patterns of behavior including depression, impulsivity (reacting angrily when a child's behavior displeases them) or substance abuse. Too often in the child welfare system we treat the symptom (e.g., the substance abuse)

rather than the underlying cause of that behavior (i.e., the trauma that is driving the substance abuse). For instance, many young women whose children are in the child welfare system engage in substance abuse as a means of coping with multiple life stressors.³¹ In 2009 the Pennsylvania Coalition Against Rape published a monograph summarizing the research that links substance abuse by women to their earlier victimization and providing guidance to counselors in responding to these complex cases. The report states: “Victims of sexual assault, including childhood sexual abuse, may use alcohol or drugs to numb or escape from painful memories or PTSD symptoms. When they attempt to stop using the drug, symptoms reappear and the likelihood of relapse increases.”³² The report goes on to state:

The relationship between sexual violence and addiction is complex and often reciprocal in that sexual violence may be a precursor to or consequence of substance use, abuse, or addiction.

A prior history of victimization may predispose someone to drug and alcohol use, abuse and addiction, while drug and alcohol problems may be a risk factor for victimization.³³

Because of the strong link between sexual victimization and substance abuse, it is reasonable to screen for a history of sexual victimization in every woman whose children enter the child welfare system. Failure to identify this history early on in the case and provide services to address her history of sexual victimization sets the stage for relapse, depriving a young mother of a meaningful opportunity to stabilize her life and regain custody of her children and deprives her children of the possibility of reunification.

In short, a comprehensive assessment of the trauma histories of each family member, and the relationship between those traumatic experiences and current functioning, is essential to a full understanding of the family’s needs and to identify the services necessary to address the reasons the children came to the attention of the child welfare system. A child’s lawyer-guardian *ad litem* should press for such an evaluation in each case to aid in case planning.

Case Planning

Understanding the parent’s and child’s diagnoses, if any, is essential, although not sufficient for developing a plan to address the individual needs of each party. It is necessary because it helps to define what the issues are; it is not sufficient because mental health problems are of varying seriousness and duration. Some are more readily treated than others. Some—such as character disorders—may be highly resistant to treatment and may require intensive treatment over many years before meaningful progress can be expected. An individual may have an acute incident of mental illness which does not recur or a mental illness may be long-standing and recurrent, suggesting that effective treatment may be much more difficult or simply unavailable.

What is perhaps more important than arriving at a correct diagnosis is to develop an understanding of the individual’s ability to function in their role as parent. What impact does the person’s mental illness have on his or her day-to-day functioning? As noted earlier, mental illness very often interacts with other challenges (e.g., substance abuse, domestic violence, poverty) resulting in a very complex set of needs that must be unraveled and individually addressed. A parent who struggles with mental illness may be able to parent effectively whereas a parent who suffers from a similar mental illness and who also is addicted to alcohol or drugs may not.

A comprehensive assessment will identify the issues that the parent and child must address and will suggest services necessary to address those problems. When reunification is the goal, the L-GAL should advocate for services that are of sufficient quality, intensity and duration to provide a realistic opportunity for the child to reunify with the parent within the 12-15 month timeframe established in the law. For instance, a parent who suffers a serious mental illness yet is thought to have the capacity to parent may need parenting classes that are hands on rather than didactic, more than one time per week and that last well beyond the six or eight sessions typical of parenting classes. Similarly, he or she may need more intensive counseling services than is typical.

An important question that the L-GAL must grapple with is whether there is a realistic expectation that the family’s problems can be addressed in the 12-

15 months the law currently provides for reunification efforts.³⁴ If not, the L-GAL should consider whether to pursue a permanent plan other than reunification early in the case. Federal child welfare legislation provides that the child welfare agency may seek an early petition to terminate parental rights or take other action that is deemed best for an individual child in any case at any time.³⁵ Similarly, Title IV-E provides that in individual cases of child abuse or neglect in state courts, judges may make any decision which will serve the child's best interests.³⁶ Thus, the L-GAL should make an informed judgment about whether a permanency plan other than reunification is needed where reunification is unlikely. Where it is simply unrealistic to believe that the child can be reunified within the timeframes set by the law, it is harmful to the child to delay alternative permanency planning. Further, the provision of services which have no realistic hope for success is a waste of very limited resources and can deprive families with more realistic hopes of reunification more focused and intensive services that could prove successful.

In case planning for child clients, it is important that L-GALs be aware of issues regarding the use of psychotropic medication. We will address two issues here. First, the use of psychotropic medications in children is not well studied.³⁷ As a result, it is not at all clear why certain drugs are useful and others are not in treating childhood mental illnesses. Similarly, we do not know much about either the short- or long-term side effects of these powerful medications on children.³⁸ Secondly, there is a growing body of evidence that suggests that children in the child welfare system, particularly children of color, are overprescribed psychotropic medications.³⁹ Counsel for children should ask about the use of psychotropic medications by their child-clients and may need to seek a second opinion for the child to ensure that medication is not being used excessively.

Michigan law assigns to the child's L-GAL the duty to monitor the implementation of the treatment plan the agency has developed and the court has ordered.⁴⁰ To do so, the L-GAL should ask a series of questions: Are the services being provided? If not, what are the barriers to the provision of needed services? Are the services tailored to the needs of the specific child and family? Are the services of the appropriate intensity and duration to provide a realistic opportunity to reunify within the legally prescribed

timeframe? Are there more appropriate programs that could provide a more tailored fit for the family? If the proper services are being provided, is the parent utilizing those services? If not, why not? Is the parent simply uncooperative or are there other reasons that the services are not being accessed? If the parent is utilizing the services, are they making progress toward the goals? If not, what is causing the lack of progress? Are the services the correct ones? Are they of sufficient intensity—is it the right service but simply not enough of it—and duration? Is it the case that the parent simply cannot make progress because of the severity of his or her mental illness and related problems? Any of these questions may suggest advocacy by the L-GAL which may range from pressing the case worker to seek a different service for the child or parent to advocating within the community to get the family into a different program to the filing of a motion seeking to enforce or change the court orders implementing the treatment plan.⁴¹

Again, where services have been provided but have proven unsuccessful, at any point in time the facts of a specific case may suggest to the L-GAL that an alternative permanency plan may merit consideration. The L-GAL should closely monitor the implementation of the case service plan and should advocate for adjustments in either the goal or the means of achieving the goal as needed.

Some Considerations

A few things for L-GALs to consider: First, it is important the L-GALs be aware of what services are available in your community. This may require some proactive action on the L-GAL's part to learn what programs and services are available, particularly those beyond the services which are typically utilized by the child welfare agency. It is important to know what your local community mental health agency can provide and what other programs—both public and private—may exist that could be of assistance to a particular child and family. For example, are there trauma focused cognitive-behavioral treatments or other evidence-based programs available in your community?⁴² If not, is there a means of procuring such treatments from nearby agencies?

Because each child and parent is unique, and may need a unique service or array of services, the L-GAL may need to press the court to order services outside those typically ordered in child welfare cases. Doing

so starts with educating the court about the need for the particular service. For instance, in a recent case the agency caseworker was opposed to getting community mental health's infant mental health services involved in a case in which both parents had long-term mental health challenges. The worker believed that because the parents were of normal IQ they didn't need the more intensive services that the infant mental health program could provide. We brought to a hearing a worker from the infant mental health program who testified about the additional services they could provide. After hearing the testimony, the court ordered that the infant mental health services be utilized. These additional services were helpful in providing a more intense level of service and in resolving the case more quickly in a fashion that was most conducive to the child's health and well-being.

As this example makes clear, it is especially important that children's L-GALs be aware of infant mental health services available in the local community. The direct, hands-on work done by infant mental health professionals can provide children and families the best opportunity to make healthy adjustments in their behavior, provide the strongest opportunity to reunify, and go far toward meeting the "reasonable efforts" requirements as set out in the law.⁴³

As lawyers we sometimes think of our jobs only as advocating for individual clients, and certainly this is our primary task. But more broadly, as advocates for children and families, we may need to work together with other system players—judges, workers, CA-SAs, etc.—in order to build the capacity of our local child welfare systems to provide needed assessment and treatment services to our individual clients. For instance, in Hillsdale County, players in the system wanted to build a system which could more systematically assess the trauma experiences of children involved in the system. Working with all the relevant community players, they were able to establish a program that systematically assesses children entering the child welfare system for traumatic experiences. By identifying the needs, they could use their limited resources more rationally and in a more focused way, thus providing children the best opportunity to be reunified with their parents in the most expeditious fashion.

Next, because of the disjointed way in which mental health services are often provided, it is not unusual to see children and parents in the child wel-

fare system who have been assigned a laundry list of diagnoses—depression, bi-polar disorder, oppositional defiant disorder, conduct disorder, schizophrenia and the like. When one sees a case in which this has happened, it may be especially helpful to seek out a trauma-informed assessment. The experience of a traumatic event or events can result in a multiplicity of long-term impacts on a person's emotional condition and their behavioral adaptations. Take for example child sexual abuse. One child so abused may become withdrawn, depressed, and resort to the use of drugs or alcohol to cope with this traumatic event. Another child may turn his rage outward, resorting to verbal and physical aggression as a means of coping with that trauma. The first child may be diagnosed with depression while the second may be labeled oppositional defiant. Over time children such as these will receive varying diagnoses from different providers. It may be the case that in each case the better diagnosis is post-traumatic stress disorder.

One condition that seems to be under-diagnosed is fetal alcohol exposure (fetal alcohol spectrum disorder—FASD). Researchers are discovering that more children than we had previously believed are exposed to alcohol in utero. The degree of the impact from such exposure may vary from mild to severe. The severity of fetal alcohol exposure, its interaction with other maladies, and its consequences for a child varies greatly.⁴⁴ FASD is a leading cause of mental retardation.⁴⁵ FASD may be difficult to diagnose in infants, and older children and adults may intentionally mask the symptoms of FASD. As such, it will be important that children be screened for such exposure. This screening can begin with L-GALs systematically considering whether their child-client was exposed to alcohol in utero by inquiring of the parties, family members and other professionals whether the child's mother drank while pregnant. When there is concern that a child was exposed to alcohol during gestation, an appropriate medical examination should follow.

A final consideration is the role of neglect in child welfare cases in which mental illness is an issue. A parent who is mentally ill may be at increased risk of caretaking that we might label neglectful rather than abusive. The parent may not be aware of a child's needs due to his mental illness or a parent may expose her child to dangers because of poor judgment in terms of whom she allows to have access to her children. Similarly, a child with mental illness can be

a demanding presence for a parent. Even the most well intentioned parent may be overwhelmed by a child's needs, their emotional outbursts, or challenging behavior.

Lawyers as a group are quick to discount the severity of cases which involve mere neglect. For instance, I have frequently heard lawyers say, "Well, this case just involves neglect. It isn't a case of abuse," or make similar statements. Some are wont to immediately equate neglect with poverty. While poverty does play a role in neglect, most impoverished parents are able to provide non-neglectful homes for their children. It is true that most of the cases that come to the court involve forms of maltreatment that fall within the "neglect" rubric. We should not, however, underestimate the impact of neglect on a child; its consequences can be devastating—it tends to be chronic, it recurs much more frequently than does physical abuse, and it may encompass a host of problems from lack of adequate housing to failure to provide proper nutrition, and from failure to prevent a known harm such as domestic violence from impacting the child to failure to provide proper care for a child's mental health needs.⁴⁶ What we classify as neglect may actually do more long-term harm to children than physical abuse.⁴⁷ This is particularly true of infants and young children who may suffer permanent brain impairment as a result of what we call neglect.⁴⁸

It is critical that children's L-GALs take neglect seriously. Allegations of neglect must be independently and carefully investigated.⁴⁹ Where neglect is present, it is important that the child's L-GAL attempt to identify its causes and contributing factors and that a plan of services be provided that is tailored to address the specific concerns of the individual child.

L-GAL Decision-Making Regarding Permanency

The ultimate question for the L-GAL is whether to support a child's return home or to pursue an alternative permanency plan for the child-client. There are a host of imbedded questions the L-GAL may be called upon to address—e.g., should the child receive service a or b? Should parenting time be expanded, shortened or suspended and the like? But the question that is most vexing is whether a child will receive the minimal level of care and nurturance by the parents so that it is safe for him or her to be reunited. This section is

an effort to provide some thoughts on grappling with this most difficult question.

First, it is important to recognize that there is no formula for making these judgments. Rather, it requires nuanced consideration of an array of facts and the application of carefully considered professional judgment for an L-GAL to come to a responsible decision about the position they will take. Every case is different and must be assessed on its own merits.

Earlier in this article it was suggested that the L-GAL should advocate for a comprehensive assessment of the child's and family's needs. It would be best if the family members could be reassessed ahead of the permanency planning hearing by the same team of evaluators that conducted the initial assessment. As was mentioned, the initial assessment can establish a baseline from which progress or the lack of progress should be measured. It is important that the family's functioning be reevaluated to determine what level of progress has been made and what concerns remain after services have been provided. Such a reevaluation can be an invaluable tool for the L-GAL faced with a difficult decision regarding the long-term direction of the case.

In making a judgment about what permanent plan to support, it is important that the L-GAL comprehensively assess the risk and protective factors at work in the individual case.⁵⁰ In general, this requires the consideration of three domains of factors—individual characteristics of the parties involved (each child and each parent), contextual factors, and stressful life events. Each individual in the family has a unique constellation of challenges and abilities for coping with the demands of everyday living. The individual state of each family member must be considered first in isolation from others. For example, a parent suffering from depression may be capable of meeting her own needs, living an independent life with only minimal treatment (e.g., medication and / or periodic therapy). It may be helpful to ask questions such as these regarding the parent: Has the parent cooperated with services? Has the parent benefitted from the service, and how so? What is the parent's current level of functioning? What is the prognosis for the parent over the long-term? What has been the parent's pattern of living? Has she or he been stable? Are they able to do what we consider typical of a parent—maintain a home, work, be in communication with the child's school, etc.?

Similarly, each child's functioning must be assessed individually. Some children will need more attentive, in-tune, and more actively involved parents while others will be more self directing and will need less in the way of supervision, guidance and support. Here are some considerations: How old is the child? How independent? Is the child resourceful at getting his or her needs met? Does the child have significant relationships beyond the immediate family—with extended family members, with informal or formal mentors—that can be a source of support to the child upon return home? Is the child active in community groups such as school activities, church, athletics, arts programs, scouting or the like?

It is important that the L-GAL consider the context in which the child will live depending upon what permanency plan is adopted and implemented. To give consideration to these factors, it is important that the L-GAL consider risk factors that “originate outside the individual, within the family, school, peer group, neighborhood, community, or society.”⁵¹ In order to make a fully informed judgment regarding the child's permanency plan, the L-GAL should consider these factors. If returned home, how do you predict the child will fare in the family, in school, and in the community? Does the parent's behavior in some way present an ongoing risk to the child? Is the parent's mental health situation stable? Will the parent require ongoing treatment? If so, how will cooperation with those services be monitored? Will the parent be in a position to provide necessary support and guidance in a way that is safe and nurturing? Is the parent more or less resourceful at getting the needs of their children met? All parents rely more or less on their extended families and community in rearing their children. Is there a supportive extended family that can lend assistance to the parent and children when necessary? Are there programs (such as a family reunification services, after school programs, a tutoring program or a community agency such as the Boys and Girls Club) that can be of assistance and in which the child should be enrolled in the short- or long-term? What school will the child attend? Is the school able to provide supportive services to the child that would be of assistance? Parents with mental illness may be socially isolated and have poor or non-existent family and peer relationships. Connecting the child with supportive programs and adults outside the immediate family may ameliorate the effect of this social isolation.

It is also important to attempt to assess stressful life events that may impinge upon the child if return home. If a parent's mental health problems are ongoing, does the parent have a plan to cope with those challenges? How has the parent coped with the challenges that inevitably arise while the case is pending? Are they generally aware of the issues and making constructive efforts to address their problems or do they deny their existence? Are they easily overwhelmed such that they become immobilized when things beyond their control cause stress? Does the parent have family or friends who can assist with childcare if the parent becomes debilitated? The community can sometimes be a source of stressful life events, such as when families live in violent neighborhoods. Does the child's parent have a realistic understanding of these matters and a reasonable plan to keep themselves and their child safe?

Risk factors should be considered in light of protective factors. Is the parent able to recognize their mental health challenges? Is the parent consistent with treatment? Are they able to recognize how their mental health problems impact their behavior? Are they able to plan for the possibility of a recurrence of an acute incident? Can the child meet some of his or her own needs (for example, a teen may be able to do some basic self-care that a younger child cannot)? It is crucial for a child's development that he or she have a strong and supportive relationship with at least one adult, be that a parent or another person.⁵² Are there relatives and friends that are able to assist the family in times of need? Does the child have supports outside the home that are independent from the parent such as extended family members, friends, mentors or the like that they can turn to for support? Does the child have a particular talent—such as in the arts, music, or athletics—that can be a source of esteem and accomplishment and provide exposure to positive life experiences? If so, is there some action on the part of the L-GAL that could enhance this talent and allow the child to build on it? For instance, is there a local art museum that may have a program for children that could provide the child a creative outlet?

These are among the questions that it may be helpful for the L-GAL to consider when determining whether to support return home or to seek an alternative permanent plan for the child. But they are by no means the only questions. Again, each case is unique and it must be considered carefully on its own merits.

What is most important is that the L-GAL engages in a careful examination of the case to make a reasoned judgment about what the outcome ought to be.

Conclusion

Child welfare cases in which mental illness is suffered by a parent or child present a series of unique challenges to L-GALs across the state. When an L-GAL is appointed to represent children in such a case, it is important that he or she seek an early and comprehensive assessment of the challenges and needs of each family member. Such an assessment provides a baseline from which to work toward family reunification or for making decisions about alternative permanency plans.

The L-GAL should engage in his or her own systematic assessment of the case. In doing so, it is important that the L-GAL take steps proactively to be aware of services available in the community to address the needs of children and families in which mental illness plays a role. Ultimately, the L-GAL must make a determination about whether to support family reunification or some alternative permanency plan. This article has suggested a non-exclusive set of questions for the L-GAL to consider when weighing risk and protective factors and making this most important and difficult decision. Becoming informed about the issues presented in this article is important and should be an on-going concern of children's advocates. ©

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Endnotes

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- 11 See Judy Fenster, *Substance Abuse Issues in the Family, in Child Welfare for the 21st Century: A Handbook of Practices, Policies, and Programs* 335, 336 (Gerald P. Mallon & Peg McCartt Hess, eds., 2005) (noting that the "lifetime comorbidity of substance abuse and mental illness in the general population has been estimated at ranging from 51% to 86%").
- 12 *Assessing Parenting Risk*, *supra* note 5 at 469 – 470; Leslie Doty Hollingsworth, *Birth Mothers Whose Parental Rights are Terminated, in Child Welfare for the 21st Century: A Handbook of Practices, Policies, and Programs* 469-481 (Gerald P. Mallon & Peg McCartt Hess, eds., 2005).
- 13 *Assessing Parenting Risk*, *supra* note 5 at 470
- 14 *Id.*
- 15 Michigan Children's Protective Services workers use structured decision-making tools that look at co-morbidity—child maltreatment in the context of substance abuse, parental mental illness, domestic violence, and a host of other factors that may escalate the risk to the child. See MCL § 722.628d (2011).
- 16 See, e.g., *In re Snyder*, 223 Mich App 85 (1997); *In re Gilliam*, 241 Mich App 133 (2000).
- 17 Mark W. Fraser & Mary A. Terzian, *Risk and Resilience in Child Development: Principles and Strategies of Practice, in Child Welfare for the 21st Century: A Handbook of Practices, Policies, and Programs* 55,56 (Gerald P.

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- 18 Indeed, some research suggests that such an assessment before the child is removed from the home, while CPS is involved in providing family preservation services, can keep children safely in their homes and eliminate the need to remove in the first place. This seems to be because the true extent of the family's problems can be identified and a plan developed to address identified needs. See Kathleen Coulborn Faller, Mary B. Ortega, and Elaine Pomeranz, *Can Early Assessment Make a Difference in Child Protection: Results from a Pilot Study*, 2 J. Pub Child Welfare 71 (2008).
 - 19 But see, MCL § 712A.19a(2)(2011) (which seems to suggest that reasonable efforts are always required but for a very small group of the very most serious cases).
 - 20 See rule of construction following 42 USC § 675 (2011)(This rule of construction was added to the statute by the Adoption and Safe Families Act, Act of November 19, 1997, P.L. 105-89, Title I, § 103(a); 42 USC 678 (2011)(providing state trial courts the authority to issue orders that will serve the best interests of children in any case); *In re Rood*, 483 Mich 73 , 104, n. 47(2009)(citing the DHS appropriations act which provides "If a conflict arises between the provisions of state law, department rules, or department policy, and the provisions of title IV-E, the provisions of title IV-E prevail."). Read together, these provisions of law permit the DHS to petition for, and the court to grant, termination of parental rights in any case at any time as the needs of the child warrant. It was never the intent of Congress in enacting the ASFA that every family must be provided rehabilitative services as MCL § 712A.19a(2) seems to suggest.
 - 21 See, e.g., Elena Cohen, Donna T. Hornsby & Steven Priester, *Assessment of Children, Youth, and Families in the Child Welfare System*, in *Child Welfare for the 21st Century: A Handbook of Practices, Policies, and Programs* 87 - 101(Gerald P. Mallon & Peg McCartt Hess, eds., 2005)(hereinafter *Assessment*).
 - 22 *Id.* at 88.
 - 23 42 USC § 5106a(a)(2)(A)(2011).
 - 24 See MCL § 722.629 (2011).
 - 25 See generally Bruce D. Perry, *The Boy Who Was Raised as a Dog: And Other Stories from a Child Psychiatrist's Notebook: What Traumatized Children can Teach Us About Loss, Love, and Healing* (2006).
 - 26 PTSD is not a diagnosis that fits children all that well. At the present time, there is a great deal of discussion in mental health circles about the need for a new diagnosis that more accurately reflects the impact of trauma on children's development. There is a movement to add a developmental trauma disorder to the Diagnostic and Statistical Manual of Mental Disorders. See, e.g., Bessel A. Van der Kolk, *Developmental Trauma Disorder: Toward a Rational Diagnosis for Children With Complex Trauma Histories*, available at: http://www.hogg.utexas.edu/uploads/documents/dev_trauma_disorder.pdf (last visited December 7, 2011).
 - 27 See *The Boy Who Was Raised as a Dog*,^{supra} note 25; Connie Black-Pond & James Henry, *A Trauma-Informed Child Welfare System Practice: The Essential Elements*, XI Michigan Child Welfare Law Journal 11 (Winter 2007-2008).
 - 28 At this point in time, obtaining a trauma informed assessment or treatment can be difficult in some communities in the state as not every community has these services readily available. However, among other steps, local DHS offices and CMH outlets should be consulted to determine what trauma informed services are available.
 - 29 For a more complete discussion of the impact of trauma on children and what their lawyers should do about it, see Frank E. Vandervort, *The Impact of Traumatic Stress and Alcohol Exposure on Youth: Implications for Lawyers, Judges and Courts*, XI Michigan Child Welfare Law Journal 42 (Winter 2007-2008).
 - 30 National Child Traumatic Stress Network, *Birth Parents with Trauma Histories and the Child Welfare System: A Guide for Child Welfare Staff* (n.d.), available at: www.nctsn.org/sites/default/files/assets/pdfs/birth_parents_trauma_history_fact_sheet_final.pdf (last visited December 4, 2011); see also, *Birth Mothers Whose Parental Rights Have Been Terminated*, ^{supra} note 12.
 - 31 Judy Fenster, *Substance Abuse Issues in the Family, in Child Welfare for the 21st Century: A Handbook of Practices, Policies, and Programs* 335, 336 (Gerald P. Mallon & Peg McCartt Hess, eds., 2005)
 - 32 Pennsylvania Coalition on Rape, Sarah Dawgert, *Substance Use and Sexual Violence: Building Prevention and Intervention Responses: A Guide for Counselors and Advocates* 1 (2009). Available at: <http://www.pcar.org/sites/default/files/file/TA/SubstanceUseandSexualViolenceBuildingPreventionandInterventionResponses.pdf> (Last visited December 7, 2011).
 - 33 *Id.* at 21-22.
 - 34 There appears to be a conflict between Michigan's statutory law and Title IV-E regarding whether early termination is appropriate in cases that do not involve the most severe acts of child abuse or outright abandonment of young children. MCL § 712A.19a(2) seems to suggest that reunification efforts must be made in every case that does not involve aggravated circumstances or that very narrow group of cases in which Title IV-E mandates that the state seek termination at the first disposition. However, this state statutory provision is in direct conflict with other portions of Title IV-E which provide for the child welfare agency and court to make early permanency decisions in any case. See 42 USC §

- 675(2011)(rule of construction);42 USC § 678 (2011). In *In re Rood*, 483 Mich. 73 (2009), the Michigan Supreme Court observed that the DHS appropriations act addresses conflicts between state and federal law such as this. It wrote: “If a conflict arises between the provisions of state law, department rules, or department policy, and the provisions of Title IV-E, the provisions of title IV-E prevail.” *Id.* at 104, n. 47.
- 35 42 USC § 675 (2011) (rule of construction).
- 36 42 USC § 678 (2011).
- 37 Martha M. Dore, *Child and Adolescent Mental Health, in Child Welfare for the 21st Century: A Handbook of Practices, Policies, and Programs* 148,158-159 (Gerald P. Mallon & Peg McCartt Hess, eds., 2005).
- 38 *Id.*
- 39 Laurel K. Leslie, et al., Multi-State Study on Psychotropic Medication Oversight in Foster Care (September 2011). Available at: <http://tuftsctsi.org/About-Us/Announcements/-/media/23549A0AA4DE4763ADE445802B3F8D6F.ashx> (last visited December 5, 2011).
- 40 MCL § 712A.17d(i)(2011).
- 41 MLC § 712A.17d(j) (2011) requires the L-GAL to identify common interests among the parties and to seek a cooperative resolution of issues that arise in the case. Similarly, MCL § 712A.19d(f) provides that the child’s L-GAL has a duty to “file all necessary pleadings and papers.”
- 42 For a more in depth discussion of evidence based treatment programs to address trauma, see Frank E. Vandervort, *The Impact of Traumatic Stress and Alcohol Exposure on Youth: Implications for Lawyers, Judges and Courts*, XI Michigan Child Welfare Law Journal 42 (Winter 2007-2008)(hereinafter *The Impact of Traumatic Stress and Alcohol Exposure on Youth*).
- 43 Kathleen Baltman & Nichole Paradis, *Infant Mental Health: What Judges and Lawyers Should Know About Relationship-Based Assessment and Intervention* in this volume.
- 44 See *The Impact of Traumatic Stress and Alcohol Exposure on Youth*, *supra* note 42.
- 45 *Id.*
- 46 See generally, Diane DePanfillis & Howard Dubowitz, *Family Connections: A Program for Preventing Child Neglect*, 10 Child Maltreatment 108 (2005)(discussing the persistent nature of neglect); Michael D. DeBellis, *The Psychobiology of Neglect*, 10 Child Maltreatment 150 (2005)(discussing the impacts of childhood neglect on brain development).
- 47 *Id.* (discussing how neglect may cause changes in the ways in which children’s brains develop and result is poor neuropsychological and psychosocial outcomes).
- 48 *Id.*; see also, Tiffany Watts-English, et al., *The Psychobiology of Maltreatment in Childhood*, 62 J. of Social Issues 717 (2006) (noting that neglect can have adverse effects on brain development and result in cognitive deficits and language delays among other problems).
- 49 See MCL § 712A.17d(c)(imposing duty to do an independent investigation on the child’s L-GAL).
- 50 See Mark W. Fraser & Mary A. Terzian, *Risk and Resilience in Child Development, in Child Welfare for the 21st Century: A Handbook of Practices, Policies, and Programs* 55-71(Gerald P. Mallon & Peg McCartt Hess, eds., 2005).
- 51 *Id.* at 57.
- 52 *Families Affected by Parental Mental Illness*, *supra* note 3 at 363.

Representing Parents with Severe Mental Illness in Child Welfare Cases

by Joshua B. Kay, J.D., Ph.D.

Parents with severe mental illness¹ are at greater risk than others of becoming involved in the child protection system, and their cases are more likely than others to result in termination of parental rights.² Among women with severe mental illness, 26-75% lose custody to one or more of their children, rates far higher than for women without mental illness.³ Lawyers who represent mentally ill parents in child protection matters face a number of challenges, including maintaining a productive attorney-client relationship, advocating for appropriate services and reasonable accommodations for their clients' disabilities, and refuting assumptions about their clients' parenting abilities that may be far worse than whatever parenting deficiencies their clients actually have. A great deal of client counseling, investigation, and strong advocacy in and out of court is required.

This article discusses the challenges faced by advocates for parents with severe mental illness. It begins with a description of what is known empirically about how severe parental mental illness influences the risk of child maltreatment. A discussion of the current state of clinical assessment, treatment, and reunification services follows, highlighting gaps between the mental health and child welfare systems that must be bridged if these parents are to receive proper treatment. The article closes by discussing advocacy strategies for attorneys who represent these parents in child protection matters.

Parental Severe Mental Illness and Child Maltreatment

"State agencies and courts frequently intervene on behalf of the children of mentally ill parents not because the parent has harmed the child but because they believe that mentally ill individuals cannot be adequate parents."⁴ The assumption that people with mental illness are dangerous and inherently unfit to be parents results in agencies and courts anticipating

neglect or abuse such that mentally ill parents may end up having their rights terminated not because of what they have done but "because of what they might do."⁵ Furthermore, regardless of what prompts Children's Protective Services to initiate the case, the stress of litigation combined with poor treatment and social support may make mentally ill parents relapse or be symptomatic, making it even more difficult for them to battle any presumption of unfitness.⁶

People with severe mental illness have frequent contact with mental health and social service professionals, including those within the government, who often end up being the source of a child protection referral.⁷ These sources have considerable credibility with CPS, so there is likely to be intervention in response to a report.⁸ Parents with mental illness are more likely than nondisabled parents to be living in poverty.⁹ Unlike people with the financial resources to buy private help for their problems, people living in poverty are more likely to come to the attention of the state.¹⁰ A reliance on the public system of care carries risks, including that parenting is subject to close scrutiny.¹¹ The state enjoys a presumption of legitimacy that parents in the child protection system, particularly those with mental disabilities, cannot match.¹² For parents with severe mental illness, the combination of close scrutiny and assumptions about parental fitness may be devastating. Parents may even be less willing to seek help for their mental illness given their understandable concerns about losing custody of their child.¹³

Given the short child welfare case timelines prescribed by Adoption and Safe Families Act of 1997 (ASFA),¹⁴ mentally ill parents with long-term treatment needs are at a disadvantage, especially without effective services,¹⁵ and successful family preservation and reunification services are not the norm.¹⁶ It "takes time to find habitable homes, to master skills that have never been taught, and to learn to nurture chil-

dren.¹⁷ Furthermore, since judges may view mental illness as a permanent, recurring, virtually intractable problem, such that the judge does not see a possibility of sufficient, lasting change within the ASFA time-frame, the judge may not want to keep the child with the parent, even if the parent has complied with the service plan and demonstrated that he or she can care for the child.¹⁸

In contrast to prevailing assumptions, research suggests that most parents with severe mental illness can provide appropriate parenting for their children with proper treatment and support.¹⁹ In fact, predictors of problem parenting are often found to be the same for disabled and nondisabled parents.²⁰ Nevertheless, it would be inaccurate to claim that severe mental illness has no effect on parenting. Rather, research shows that it is important to move from unsophisticated assumptions about the influence of specific parental mental illnesses on parenting to a more nuanced understanding of how a parent's actual level of functioning is what matters in each case.²¹

Research generally indicates that mothers with serious mental illness have less adequate parenting skills and behaviors than mothers without mental illness.²² Carol Mowbray and her colleagues reviewed research that found that mothers with severe mental illness are less emotionally available to their children, less reciprocal in their interactions with their children, less involved as parents, less positive toward their children, less encouraging, less affectionate, less responsive, and less able to differentiate their own needs from those of their children.²³ The question, however, is not whether parental mental illness has an impact on parenting and child maltreatment, but how and when.

Some studies have found that the mere presence of psychiatric disorder in a parent is associated with an increased risk of child maltreatment.²⁴ For example, a large Canadian study found that diagnoses of depression, mania (i.e., bipolar disorder), and schizophrenia were associated with a risk for child maltreatment.²⁵ More predictive of child maltreatment than specific diagnosis, however, was the presence of antisocial behaviors, such as violent or criminal acts.²⁶

Neither specific diagnosis nor the mere presence of psychiatric disorder appears to hold up as a predictor of child maltreatment when more detailed factors are studied. More useful is the determination of whether specific risk factors are present, such as *active* mental illness symptoms, comorbid substance abuse or depen-

dence, the parent having experienced child abuse or neglect or other significant adversity in childhood, social isolation, and a history of violent behavior.²⁷ These factors likely vary in the amount that they increase the risk of maltreatment, and they are interactive with each other.²⁸ Prior positive treatment response and insight into one's own illness may be protective factors.²⁹

The severity and chronicity of dysfunction due to mental illness are far more important than specific diagnosis as predictors of parenting difficulties.³⁰ In addition to differences between diagnostic groups, there is a lot of variability in the degree of functional impairment within each diagnosis.³¹ This variability within diagnosis (i.e., from individual to individual within a given diagnostic category) renders any assumptions based on diagnosis alone highly suspect. Instead, specific risk factors need to be evaluated.

For example, the degree of insight into one's own mental condition, which is associated with improved mental health outcomes because it improves one's ability to recognize when a relapse may be imminent and to adhere to treatment regimens, has been found to be associated with observed parenting behaviors and the risk of maltreatment.³² Specifically, the lack of insight is associated with problematic parenting during parent-child observations as well as with an elevated risk of child maltreatment, as assessed by a multi-disciplinary parenting assessment team using empirically supported assessment tools and techniques.³³

In another study, Hollingsworth found that specific diagnosis was not predictive of custody loss in women with persistent severe mental illness.³⁴ Instead, indicators of mental illness severity, such as the number of hospitalizations for mental illness that the mothers had experienced or the duration of their mental illness, were predictive of custody loss.³⁵ Similarly, a large study of mothers in Philadelphia found that those with severe mental illness who had a history of psychiatric hospitalization were at particular risk for child welfare involvement and having a child placed in foster care.³⁶

Yet even a history of hospitalizations is not necessarily predictive of aspects of parenting that are particularly relevant to possible child welfare involvement, such as parental stress, nurturance, and satisfaction with the parent-child relationship. Mowbray and her colleagues found that high parenting stress *appeared* to be associated with specific psychiatric diagnosis and the number of

hospitalizations the parent had experienced, but those associations actually were driven entirely by the current level of psychiatric symptoms suffered by the parent.³⁷ In other words, it was actually the current degree of impairment and not the history of hospitalizations or the specific diagnosis that was associated with parenting stress. Similarly, the degree of parental nurturance and mother's satisfaction with the parent-child relationship were associated with the parent's current degree of symptoms and present ability to function in the community.³⁸ Specific diagnosis made little contribution to the prediction of parental nurturance and parental satisfaction.³⁹ A primary conclusion of the study is that "specific mental illness diagnosis in itself is neither an independent nor very useful predictor of parenting problems or strengths."⁴⁰ Importantly, "mothers with severe and persistent mental illness are not necessarily at higher risk of problematic parenting than mothers with less serious or more acute mental illness, if current symptoms are under control and community functioning is positive."⁴¹ Therefore, any assumptions based only on the diagnosis itself could well be erroneous. It is critical that the parent's actual, current degree of impairment be assessed carefully, and advocates must educate child welfare professionals and court personnel about this fact.

Furthermore, such assessments of active mental health symptoms would need to be ongoing throughout a case, as would assessments of parenting skills. Mowbray and her colleagues demonstrated that when symptoms of mental illness abate, parenting stress decreases and parental nurturance increases over time.⁴² Furthermore, initial symptom levels did not have a lasting effect on parenting.⁴³ Therefore, parenting impairments due to severe mental illness can improve as symptoms improve, and even current, severe mental illness symptoms – much less a history of hospitalization or any specific diagnosis – may not accurately predict *future* parenting.⁴⁴ Treatment of symptoms and setting a parent up with services that can help him or her ongoing, such as Community Mental Health services, need to be priorities.

In addition to active psychiatric symptoms, the total number of risk factors in a family is important for predicting child welfare involvement and reunification.⁴⁵ In a study that examined predictors of permanent custody loss in mothers whose children were removed from their care, neither the fact that a

mother had a psychiatric disorder nor any specific psychiatric diagnosis was predictive.⁴⁶ Instead, the cumulative effect of multiple risk factors was important.⁴⁷ Risk factors assessed in this study included substance abuse, psychiatric history, criminal record, educational achievement, the parent's own childhood abuse history, depressive symptoms, and domestic violence.⁴⁸ No one factor led to successful prediction of permanent custody loss, and the authors emphasized the need for intensive, multidisciplinary interventions in all cases.⁴⁹ Convenient though it might be to believe that there is a simple association between parental severe mental illness and child protection outcomes, the picture is actually highly complex and calls for much more in-depth, targeted assessment and service provision.

Finally, a study of 44 mothers with severe mental illness looked particularly at caregiving attitudes and high-risk maternal behavior.⁵⁰ Maternal behavior was rated for sensitivity during a parent-child observation using an assessment tool that has been shown to be associated with maltreatment risk.⁵¹ Among these mothers, a "role reversal" attitude, in which the mother expected her young child to support her, was associated with insensitive maternal behavior during the parent-child observations.⁵² The attitudes of the mothers toward parenting and toward their children were measured using a fairly short self-report instrument that had previously been shown to have good validity and reliability.⁵³ The researchers suggest incorporating the instrument into evaluations of parenting competence among mothers with mental illness.⁵⁴

The research on parents with severe mental illness yields several critical lessons. It is important to remember that most parents with severe mental illness do not pose any particular risk for child maltreatment and, in fact, do not mistreat their children.⁵⁵ In short, the mere presence of parental mental illness is not a strong, specific predictor of child maltreatment.⁵⁶ After all, there is a great deal of variation between mentally ill parents, even within any given diagnostic category, in their degree of symptom severity, level of parenting competence, and level of functioning in the community.⁵⁷ Risk of child maltreatment in parents with severe mental illness is influenced by a number of factors, some of which may be linked directly to the parent's mental illness but are important to assess in their own right in order to have a more complete, accurate picture of what the presenting issues are in any given case.⁵⁸ The fact that their child maltreatment

risk is influenced by many factors makes parents with severe mental illness similar to other parents: as noted earlier, many predictors of child maltreatment risk are the same in disabled and nondisabled parents.⁵⁹ The research makes it clear that once a parent with mental illness is involved in the child welfare system, it is not enough to stop at a diagnostic assessment. A much more detailed, in-depth, evaluation is needed, and an array of intensive services must be brought to bear on the case.

Assessment, Treatment, and Reunification Services: More Gaps than Bridges

Not only do assumptions about parents with severe mental illness play a role in whether child welfare involvement is initiated, but biases, shoddy assessments, low-quality or misdirected treatment, and a dearth of tailored reunification services make it very difficult for these parents and their children to exit the child protection system successfully.⁶⁰ Child welfare caseworkers and court personnel lack knowledge about mental illness and how mental disorders affect parenting skills.⁶¹ Caseworkers and court personnel also have little capacity to interpret the results of parenting assessments that they request or to determine whether the assessments were even done properly.⁶² Caseworkers make decisions about whether to remove children and terminate parental rights without adequate methods at their disposal for assessing parental fitness.⁶³ They lack resources for helping parents with mental illness improve their parenting.⁶⁴ Ackerson cites a study of Illinois child welfare caseworkers where the workers themselves reported they were not prepared to meet the assessment and treatment needs of the mentally ill parents on their caseloads.⁶⁵ The workers wanted training in the treatment and reunification services available, mental illness information, and client assessment.⁶⁶

Inadequate Assessment Has Tremendous Costs

Mental health professionals doing evaluations in the child protection setting often use psychometric testing, relying especially on intelligence and personality testing and assumptions about the parental competence and amenability to treatment of people with various intelligence scores and personality profiles, and they tend not to evaluate parenting in any valid manner.⁶⁷ The simple and problematic truth is that many

mental health professionals rely on psychological tests that are not appropriate for determining parenting competence.⁶⁸ Intelligence tests and personality assessments “bear, at most, an indirect relationship to parenting issues.”⁶⁹ Based on invalid and quite possibly misleading evaluations, mental health professionals often make judgments about the risk posed to children by their mentally ill parents without adequate evidence.⁷⁰ The ensuing errors can be tremendously costly and destructive as cases veer off in the wrong direction.⁷¹

There are valid measures of parenting competence available, though more test development is needed to broaden the array of tools at the disposal of psychologists.⁷² Available assessment instruments tend not to be specific to measuring parenting in those at risk for maltreatment, and they may not have been normed for use with populations such as parents with mental illness.⁷³ Furthermore, use of these instruments requires training and a clear understanding of each tool’s capabilities.⁷⁴ If they are used out of context or misinterpreted, misleading conclusions can follow.⁷⁵ There are several, however, that are worth using and would mark a great improvement over the typical, current level of practice.

Also worth noting is that mental health professionals often approach assessments in child welfare cases with the wrong standard in mind. Rather than determining whether the parent meets minimally adequate standards for competence, which is the concern in child protection proceedings, many evaluators are assessing for optimal or ideal parenting skills.⁷⁶ This bias is likely due to the fact that mental health professionals are trained to evaluate problems relative to optimum health and well-being, and then to work on helping people achieve that optimal degree of functioning if possible. Unfortunately, there is not broad agreement about what constitutes minimally acceptable parenting, which makes it even more likely that evaluators will use subjective ideas of adequacy based on their personal experience.⁷⁷

Rather than rely only on a few test instruments, focusing on diagnosis over actual level of functioning, and drawing overbroad, possibly misleading conclusions,⁷⁸ researchers recommend that the focus shift to more direct, thorough assessment of parenting skills and deficits as well as key risk factors, such as the amount and nature of social support available to the family and the health of the home environment.⁷⁹

In addition to determining the extent and severity of current, active symptoms,⁸⁰ and making sure that strengths as well as deficits are assessed,⁸¹ researchers recommend that evaluations take a “functional approach,” “emphasizing behaviors and skills in everyday performance.”⁸² The gist of this approach is that the parent’s capabilities and level of functioning will be thoroughly assessed, the child’s needs and abilities will be evaluated, and the parent and child will be observed together.⁸³ The greater context in which the family lives and their constellation of risk factors should be assessed as well.⁸⁴ These evaluations can draw on many sources and should bring in professionals from various disciplines. Although a good parenting assessment is expensive, it may save money compared to the costs of multiple, shoddy evaluations, going in the wrong direction in the case based on one misleading assessment, or inefficient case handling that stems from a dearth of information about the family’s functioning.⁸⁵ Just as important as the financial benefit, a good assessment will aide in service plan development and implementation and help the child protection system effectively assist the families that require its help. It is additionally worth noting that the value of functional assessment is not limited to cases involving parental mental illness.

Treatment and Reunification Services

Commonly prescribed reunification services, such as parenting classes, are not tailored to the needs of parents with mental illness.⁸⁶ These parents may stop participating in the classes or fail to benefit adequately from them.⁸⁷ Unfortunately, there are very few programs designed specifically for parents with serious mental illness.⁸⁸ One barrier is that there is little integration between the child welfare and public mental health systems.

In a study of the relationship between the child welfare and public mental health systems in New York, findings included that the two systems had little knowledge of each other and no integration.⁸⁹ Mental health providers had little familiarity with how the child protection system works and permanency planning issues, and child welfare workers had little understanding of the impact of mental illness on a family.⁹⁰ Personnel in the two systems did not communicate with each other and saw each agency’s responsibilities as utterly separate from those of the other.⁹¹ Recom-

mendations included having a single case manager in cases involving severe parental mental illness to coordinate care across agencies, as well as the availability of more comprehensive, integrated services, such that therapeutic visits would be available at mental health sites or mental health therapists would hold sessions at child welfare agencies.⁹² Others have echoed this call for greater collaboration between the mental health and child welfare systems.⁹³

Hollingsworth recommends services for parents with severe mental illness such as tailored parenting education, respite care, and pre-arranged substitute care for the children during hospitalizations, which amounts to a call for mental health agencies to get involved in child maltreatment prevention and treatment efforts, given that these services could be provided by these agencies in order to prevent the need for child welfare system involvement.⁹⁴ Either when parents are receiving mental health services or when they are involved in child welfare cases, Larrieu notes the need for intensive, multidisciplinary interventions in order to prevent permanent loss of custody.⁹⁵ Mowbray and her colleagues call for focused support for parenting and the family as a whole so that its support network can be strengthened, as well as an emphasis on enhancing parents’ independent functioning in their communities.⁹⁶ The development of intervention programs directed toward parents with mental illness, in which assessments and services are provided by professionals who are trained in empirically valid techniques, may increase the rate of reunification where appropriate and also increase the speed and accuracy of other permanency planning when children cannot be returned safely to their families.⁹⁷

Advocacy for Parents with Severe Mental Illness

Reasonable Efforts and Reasonable Accommodations

Under Michigan law, the agency must make “reasonable efforts” to reunify a family in most cases.⁹⁸ The efforts to be made by the agency are described in a “case service plan” or “parent agency agreement” that is designed to address the needs of the parents and children in order to facilitate the return of the children to the home.⁹⁹ Too often, the services outlined in these case plans are not tailored to the needs of parents with

severe mental illness.¹⁰⁰ The Michigan Supreme Court has discussed the fact that when the state fails to provide services that have been deemed necessary for reunification, a trial court is not required to order that the agency seek termination of parental rights, even if the case has exceeded statutory time frames that would usually require such an order.¹⁰¹ In doing so, the Michigan Supreme Court recognized and emphasized the importance of the reasonable efforts requirement in child welfare cases.¹⁰²

The reasonable efforts requirement in cases involving parental disability is augmented by the protections contained in the Americans with Disabilities Act (ADA).¹⁰³ The ADA requires that services provided by a public agency be modified as needed in order to reasonably accommodate a recipient's disability, including a psychiatric or cognitive disability.¹⁰⁴ The application of the ADA in child welfare proceedings has been discussed in detail elsewhere.¹⁰⁵ Briefly, a parent must first demonstrate that he or she has a disability, which is defined as "(A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment."¹⁰⁶ Disability is to be construed liberally so as to extend broad coverage of ADA protections.¹⁰⁷ Parenting is made up of many tasks and draws on many capabilities that would be considered major life activities.¹⁰⁸ The fact that the agency often sites parental mental illness as a point of concern and focus of need in petitions and other documents and testimony readily brings a parent under the ADA, because the agency regards the parent as being impaired in major life activities.¹⁰⁹

An ADA claim may be brought when family services are so inadequate that they discriminate against parents with disabilities.¹¹⁰ Under Michigan law, where the ADA applies, reasonable accommodations must be made in order for a trial court to find that the agency has made reasonable efforts.¹¹¹ An ADA claim must be raised affirmatively in order to bring ADA protections into play, and the claim must be made in a timely manner.¹¹² The claim cannot be raised for the first time at a termination of parental rights hearing.¹¹³ The ADA should be raised "either when a service plan is adopted or soon afterward."¹¹⁴ As soon as it appears that the agency "is unreasonably refusing to accommodate a disability," the claim should be made.¹¹⁵

When an ADA claim is raised, the first question asked of the parent's attorney is often what is needed in order to reasonably accommodate the disability. Although it is the agency's duty to make reasonable efforts – and thus to determine and implement what reasonable accommodations are needed – it is wise for a parent's attorney to ask the client what he or she might need in various settings, including court, as well as to ask about the disability itself and what kinds of impact the disability might have on the case.¹¹⁶ That knowledge enables the parent's attorney to give considerable guidance to the agency and courts about what accommodations are needed. Clients are often, but not always, their own best experts on what is helpful to them. Key information to gather includes a history of where the parent has received mental health treatment and with whom, what sorts of treatment the parent has received, with what providers the parent has been most comfortable, the parent's other sources of support, what a typical day looks like for the parent (which can give clues about community functioning), how long the parent has maintained residences, whether the parent is employed or has employment history (and any accommodations received there), any public benefits the parent receives, and the parent's own childhood history of adversity and education. Where clients identify struggles and challenges, it is important to explore how the parent has handled prior difficulties in his or her life. Armed with this information, it is absolutely critical that parent's attorneys raise ADA claims as early as possible in cases.

Dealing with Psychological Evaluations of Parenting Capacity

As discussed above, many psychological evaluations in child welfare cases use inappropriate methods and too few tools.¹¹⁷ Mental health professionals often lack training in parenting assessments and compare parents to an optimal parenting standard rather than a standard of minimally acceptable parenting competence.¹¹⁸ If a court relies on evidence gathered by these professionals, and if it simply agrees with them, then it effectively ends up applying the witnesses' standards and values.¹¹⁹ The deference given to mental health testimony by family court judges in child protection cases can support a biased presumption of unfitness combined with a "confirmation bias," where only evidence supporting one's assumptions is given full

credence.¹²⁰ In the face of such a strong presumption that expert testimony is valid and relevant, and without the resources to call experts of their own, parents' counsel face significant challenges in refuting mental health expert testimony.¹²¹

In a Michigan case involving termination of the parental rights of a mother with psychiatric disability, where the mother subsequently sued in federal court for alleged civil rights violations, the Sixth Circuit blasted the psychologist's report, which focused on intellectual functioning, as being filled with "vague and subjective appraisals"¹²²: "While critical thinking and reasoning skills are undoubtedly relevant, at some level, to the ability of a parent to raise her child, the State must make a specific and tangible showing, not a presumptive one, on the precise nature of the links between these capacities and a particular child's needs."¹²³ Invoking the rational basis standard, the court found that the state must "establish empirically that the kinds of intelligence most necessary to caring for a particular child are deficient in that parent."¹²⁴ The "State's consideration of [parental] disability is constitutional to the extent that it is rationally related to the State's legitimate interest in the health and welfare of [the child]."¹²⁵ Thus, the court described the standard on which parents' lawyers must focus as they consider how to challenge expert testimony.

Advocacy about psychological evaluations starts at the front end, when the service is being considered for inclusion in the case service plan. If an assessment is going to be ordered, the attorney should work from the beginning to ensure as much as possible that the psychologist will not overstep the evidence and will be limited to putting forward cautious and balanced conclusions.¹²⁶ It is critical that the attorney challenge the worker and the court to articulate a specific rationale for the assessment. Just what is it that the referral source or the court is trying to find? A well-articulated rationale for an assessment can lead naturally to specific, detailed referral questions – the questions actually sent to the psychologist – about parental functioning.¹²⁷ Referral information should include not only specific questions but also a request for recommendations about treatment options, parenting time, and other needed services.¹²⁸ In short, good assessments are driven by good referral questions, and a muddy rationale for requesting the assessment is likely to lead to overly broad referral questions and, in turn,

an inadequate or even inappropriate evaluation that lacks specificity and fails to produce useful recommendations.

If it is possible to do so, parents and their attorneys may benefit from having another psychologist review the evaluation report so as to point out its qualities and flaws. It may be that a parent's therapist, if the therapist is a psychologist, could also offer useful insights into the quality of the report, though many therapists lack the training to do so. At the very least, attorneys should read through reports carefully, look up information about each test used to make sure that it was up-to-date and used for the purpose for which it was made, and be familiar with applicable ethical requirements to determine that they were followed.¹²⁹ It may also be useful to double-check the psychologist's licensing status on the website of the Michigan Department of Licensing and Regulatory Affairs.¹³⁰

Client Counseling and Service Integration

Client counseling is critical to any attorney-client relationship, and it is particularly true when representing parents with mental illness in child welfare proceedings. These parents are thrust into dealing with multiple complex bureaucracies, including the Department of Human Services, private social service agencies, and the court system. Many clients are deeply frightened, and the experience can prompt a relapse of psychiatric symptoms.¹³¹ The stakes are high, and the timelines are short. Furthermore, psychiatric disability may be quite complex, and parents may have a long and highly relevant history that their attorneys need to know in order to advocate successfully. Building a relationship of trust takes some time, and parents' attorneys seem to have precious little of that given high caseloads, but it is only through trust and frequent contact that the attorney will be able to assist a mentally ill parent in a child welfare matter. Making sure that a parent is complying with the service plan and that any barriers are dealt with promptly is critical to a successful resolution of the case.

Finally, one basic but potentially very fruitful approach to gaining access to appropriate services is to have the court order the Department of Human Services (or a private DHS contract agency) to work with the parent to seek services from Community Mental Health (CMH). In far too many cases where

mental health needs are significant, there is little to no mention of CMH. Yet a number of CMH providers have key services, including wrap-around programs, respite care, intensive therapy services, group therapy, psychiatric care, and infant mental health services.¹³² Given that many of these parents will be “discharged” to CMH services when their involvement with DHS ends, it makes sense to pull CMH services into the mix as quickly as possible. While quality may vary, CMH is structured to assess and treat people with serious mental illness, whereas DHS is not. Requiring DHS to seek CMH involvement could be seen as a reasonable accommodation.

Conclusion

Parents with severe mental illness are involved in child welfare proceedings and end up with their parental rights terminated at a higher rate than any other group. Although a parent’s severe mental illness has an impact on parental competence, the mere presence of a psychiatric diagnosis is not a specific risk factor for child maltreatment. Instead, a number of more nuanced, detailed risk factors may be more predictive, and assessing and addressing those is a critical element in case planning. Unfortunately, high-quality assessments are not the norm, and assumptions and biases may drive conclusions drawn by evaluators. In turn, service plan development and implementation may be inadequate, and parents are left with their real needs unaddressed. Attorneys for parents with severe mental illness face many challenges but have a number of tools at their disposal to help their clients meet their goals, including raising claims under the Americans with Disabilities Act, educating and advocating with child welfare professionals both in and out of court, and limiting and challenging psychological evaluations of their clients. Most important, attorneys need to take the time to educate themselves to understand their clients’ needs, thereby laying the foundation for high-quality advocacy. ©

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Endnotes

- 1 Severe mental illness typically includes depression, bipolar disorder, and schizophrenia as well as variants of these major mood and psychotic disturbances. See, e.g., Carol Mowbray et al., *Parenting of Mothers with a Serious Mental Illness: Differential Effects of Diagnosis, Clinical History, and Other Mental Health Variables*, 26 Soc. Work Res. 225 (2002).
- 2 Sandra J. Bishop, Comment, *Parents with Disabilities Involved in Dependency Cases*, 27 Child Abuse & Neglect 233 (2003) (reviewing findings about parents with intellectual and psychiatric disabilities); Leslie D. Hollingsworth, *Child Custody Loss among Women with Persistent Severe Mental Illness*, 28 Soc. Work Res. 199 (2004); Jung Min Park et al., *Involvement in the Child Welfare System among Mothers with Serious Mental Illness*, 57 Psychiatric Serv’s 493 (2006); Teresa Ostler, *Assessing Parenting Risk within the Context of Severe and Persistent Mental Illness: Validating an Observational Measure for Families with Child Protective Services Involvement*, 31 Infant Mental Health J. 467, 470 (2010).
- 3 Colby Brunt & Leigh Goodmark, *Parenting in the Face of Prejudice: The Need for Representation for Parents with Mental Illness*, 36 Clearinghouse Rev. 295, 297-98 (2002); Ostler, *supra* note 2, at 470 (noting a rate of 26% in community samples and up to 60% in clinical samples); Roberta G. Sands et al., *Maternal Custody Status and Living Arrangements of Children of Women with Severe Mental Illness*, 29 Health & Soc. Work 317, 322 (2004) (studied 20 mothers with severe mental illness and found that they were rearing only 29% of their children). This high rate of loss of custody is not limited to cases involving termination of parental rights, but it is nevertheless suggestive of the significant challenges faced by parents with significant mental illness.
- 4 Brunt & Goodmark, *supra* note 3, at 295.
- 5 *Id.* at 301.
- 6 *Id.*
- 7 Susan Kerr, *The Application of the American with Disabilities Act to the Termination of the Parental Rights of Individuals with Mental Disabilities*, 16 J. Contemp. Health L. & Pol’y 387, 402 (2000).

- 8 *Id.* See also, Chris Watkins, Comment, *Beyond Status: The Americans with Disabilities Act and the Parental Rights of People Labeled Developmentally Disabled or Mentally Retarded*, 83 Cal. L. Rev. 1415, 1436 (1995).
- 9 Theresa Glennon, Symposium, *Walking with Them: Advocating for Parents with Mental Illness in the Child Welfare System*, 12 Temp. Pol. & Civ. Rts. L. Rev. 273 (2003).
- 10 Rosemary Shaw Sackett, *Terminating Parental Rights of the Handicapped*, 25 Fam. L.Q. 253, 290 (1991).
- 11 Glennon, *supra* note 9, at 292.
- 12 MARTHA A. FIELD & VALERIE A. SANCHEZ, EQUAL TREATMENT FOR PEOPLE WITH MENTAL RETARDATION: HAVING AND RAISING CHILDREN 306 (1999).
- 13 Barry J. Ackerson, *Coping with the Dual Demands of Severe Mental Illness and Parenting: The Parents' Perspective*, 84 Fam. in Soc'y 109, 112 (2003).
- 14 P.L. 105-89. ASFA contains a requirement that if a child has been the responsibility of the state for 15 of the past 22 months, a court must order a termination of parental rights petition unless certain exceptions apply. Michigan has adopted this requirement. M.C.L. 712A.19a(6).
- 15 Glennon, *supra* note 9, at 279.
- 16 Sarah H. Ramsey, Symposium, *Children in Poverty: Reconciling Children's Interests with Child Protective and Welfare Policies*, 61 Md. L. Rev. 437, 445 (2002).
- 17 Cynthia R. Mabry, *Second Chances: Insuring That Poor Families Remain Intact by Minimizing Socioeconomic Ramifications of Poverty*, 102 W. Va. L. Rev. 607, 660 (2000).
- 18 Brunt & Goodmark, *supra* note 3, at 299.
- 19 Glennon, *supra* note 9, at 291; Brunt & Goodmark, *supra* note 3, at 295.
- 20 Megan Kirshbaum & Rhoda Olkin, *Parents with Physical, Systemic, or Visual Disabilities*, 20 Sexuality & Disability 65, 74 (2002).
- 21 Corina Benjet et al., *Evaluating the Parental Fitness of Psychiatric Diagnosed Individuals: Advocating a Functional-Contextual Analysis of Parenting*, 17 J. Fam. Psychol. 238, 241, 246 (2003) (noting that the mere presence of mental illness is not a strong, specific predictor of child maltreatment and calling for a functional-contextual analysis of parenting competence).
- 22 Mowbray, *supra* note 1, at 225.
- 23 *Id.* at 225-26.
- 24 See, e.g., Christine Walsh et al., *The Relationship between Parental Psychiatric Disorder and Child Physical and Sexual Abuse: Findings from the Ontario Health Supplement*, 26 Child Abuse & Neglect 11 (2002).
- 25 *Id.* at 17.
- 26 *Id.*
- 27 Teresa Jacobsen et al., *Assessing Parenting Competency in Individuals with Severe Mental Illness: A Comprehensive Service*, 24 J. Mental Health Admin. 189, 192 (1997).
- 28 *Id.* at 193.
- 29 *Id.*
- 30 Barry J. Ackerson, *Parents with Serious and Persistent Mental Illness: Issues in Assessment and Services*, 48 Soc. Work 187, 190 (2003).
- 31 *Id.*; Mrinal Mullick et al., *Insight into Mental Illness and Child Maltreatment Risk Among Mothers with Major Psychiatric Disorders*, 52 Psychiatric Serv's 488 (2001) (discussing the high degree of variability in parenting skills within any given diagnostic category).
- 32 Mullick, *supra* note 31, at 488, 491.
- 33 *Id.* at 491.
- 34 Hollingsworth, *supra* note 2, at 207. It is important to note that the study examined losses of custody that lasted more than three months, and the custody losses were not necessarily due to child welfare involvement.
- 35 *Id.* at 204.
- 36 Park, *supra* note 2, at 496.
- 37 Mowbray, *supra* note 1, at 233.
- 38 *Id.* at 234-35.
- 39 *Id.* at 236.
- 40 *Id.* at 237.
- 41 *Id.* at 238. The implications of this will be discussed more fully below and include the fact that high-quality Community Mental Health programming must be brought into child welfare cases, since these programs are more specifically geared toward managing severe mental illness than are many of the programs offered through child welfare agencies.
- 42 Sang Kyoung Kahng et al., *Mothers with Serious Mental Illness: When Symptoms Decline Does Parenting Improve?*, 22 J. Fam. Psychol. 162, 165 (2008).
- 43 *Id.*
- 44 *Id.*
- 45 Julie A. Larrieu et al., *Predictors of Permanent Loss of Custody for Mothers of Infants and Toddlers in Foster Care*, 29 Infant Mental Health J. 48, 51 (2008).
- 46 *Id.* at 58.
- 47 *Id.*
- 48 *Id.* at 54.
- 49 *Id.* at 58.
- 50 Amy Leventhal et al., *Caregiving Attitudes and At-Risk Maternal Behavior among Mothers with Major Mental Illness*, 55 Psychiatric Serv's 1431 (2004).
- 51 *Id.* at 1432.

- 52 *Id.*
- 53 *Id.*
- 54 *Id.*
- 55 Ostler, *supra* note 2, at 480; Walsh, *supra* note 24, at 19.
- 56 Benjet, *supra* note 21, at 241; Ackerson, *supra* note 30, at 190; Hollingsworth, *supra* note 2, at 207; Larrieu, *supra* note 45, at 58; Mowbray, *supra* note 1, at 237, 238.
- 57 Mullick, *supra* note 31, at 488; Ackerson, *supra* note 30, at 190.
- 58 Ackerson, *supra* note 30, at 190; Larrieu, *supra* note 45, at 51, 58; Mowbray, *supra* note 1, at 233-35; Jacobsen, *supra* note 27, at 192; Ostler, *supra* note 2, at 470; Benjet, *supra* note 21, at 246.
- 59 Kirshbaum & Olkin, *supra* note 20, at 74.
- 60 *See* note 2, *supra*, regarding greater risk for child welfare involvement and eventual termination of parental rights.
- 61 Ackerson, *supra* note 30, at 189; Jacobsen, *supra* note 27, at 194.
- 62 Jacobsen, *supra* note 27, at 194-95.
- 63 Ackerson, *supra* note 30, at 189-90.
- 64 *Id.* at 190.
- 65 *Id.* at 189.
- 66 *Id.*
- 67 *Id.* at 190; Karen S. Budd, *Assessing Parenting Competence in Child Protection Cases: A Clinical Practice Model*, 4 *Clinical Child & Fam. Psychol. Rev.* 1, 4 (2001); Sackett, *supra* note 10, at 296. *See also* Katherine L. Rosenblum and Joshua B. Kay, *Psychological Evaluation of Parenting Capacity in Child Welfare Proceedings* in this volume for a more thorough discussion of frequently encountered, serious quality problems in psychological evaluations in child welfare cases regardless of parental mental illness.
- 68 Ackerson, *supra* note 30 at 190; Budd, *supra* note 67, at 4; Jacobsen, *supra* note 27, at 190; Ostler, *supra* note 2, at 470.
- 69 Budd, *supra* note 67, at 4. *See also* Jacobsen, *supra* note 27, at 190; Ostler, *supra* note 2, at 470.
- 70 Glennon, *supra* note 9, at 276; Jacobsen, *supra* note 27, at 190; Ostler, *supra* note 2, at 470.
- 71 Jacobsen, *supra* note 27, at 195.
- 72 Budd, *supra* note 67, at 4; Jacobsen, *supra* note 27, at 190.
- 73 *Id.*
- 74 Jacobsen, *supra* note 27, at 190.
- 75 *Id.*
- 76 Ackerson, *supra* note 30, at 191; Budd, *supra* note 67, at 3; Ostler, *supra* note 2, at 470; Benjet, *supra* note 21, at 239.
- 77 Budd, *supra* note 67, at 3.
- 78 Jacobsen, *supra* note 27, at 190 (noting that many evaluations use too few assessment tools, drawing conclusions beyond those supported by the data).
- 79 Ackerson, *supra* note 30, at 190.
- 80 Mowbray, *supra* note 1, at 233.
- 81 Ostler, *supra* note 2, at 470.
- 82 Budd, *supra* note 67, at 2; Benjet, *supra* note 21, at 246; Ostler, *supra* note 2, at 470.
- 83 Benjet, *supra* note 21, at 246.
- 84 Jacobsen, *supra* note 27, at 190.
- 85 *Id.* at 196. *See also* Rosenblum & Kay, *supra* note 67, in this volume, for a discussion of the costs of evaluations in child protection cases. One example of functional assessment is trauma-informed assessment. *See* Frank E. Vandervort, *Child Welfare Cases Involving Mental Illness: Reflections on the Role and Responsibilities of the Lawyer-Guardian Ad Litem*, in this volume, for a discussion of trauma-informed assessment and why it is such an important tool.
- 86 Ackerson, *supra* note 30, at 191.
- 87 *Id.*
- 88 *Id.*
- 89 Andrea K. Blanch et al., *Parents with Severe Mental Illness and Their Children: The Need for Human Services Integration*, 21 *J. Mental Health Admin.* 388, 391 (1994).
- 90 *Id.*
- 91 *Id.*
- 92 *Id.* at 392.
- 93 Jacobsen, *supra* note 27, at 196.
- 94 Hollingsworth, *supra* note 2, at 208.
- 95 Larrieu, *supra* note 45, at 58.
- 96 Mowbray, *supra* note 1, at 238.
- 97 Benjet, *supra* note 21, at 248.
- 98 *See* M.C.L. 712A.18f(4) and 712A.19a(2).
- 99 M.C.L. 712A.18f(2) & (3).
- 100 Ackerson, *supra* note 30, at 191.
- 101 *In re Rood*, 483 Mich. 73, 105, 763 N.W.2d 587 (2009) (citing M.C.L. 712A.19a(6)(c) as reflective of 42 U.S.C. 675(5)(E)(iii) and 45 C.F.R. 1356.21(i)(2)(iii)).
- 102 *Id.*
- 103 42 U.S.C. § 12101 *et seq.* (West 2009). *See also* P.L. 110-325 for changes to the ADA under the Ameri-

- cans with Disabilities Act Amendments Act of 2008, clarifying and easing qualification requirements for ADA protections.
- 104 In re Terry, 240 Mich. App. 14, 25, 610 N.W.2d 563 (2000) (holding that Title II of the ADA applies to services provided by DHS and its contract agencies to people with disabilities).
- 105 Joshua B. Kay, *Representing Parents with Disabilities in Child Protection Proceedings*, 13(1) Mich. Child Welfare L. J. 27 (2009).
- 106 42 U.S.C. § 12102(1).
- 107 42 U.S.C. § 12102(4)(A).
- 108 See Kay, *supra* note 105, at 31-32.
- 109 42 U.S.C. § 12102(1)(C).
- 110 Terry, 240 Mich. App. at 25. See also 42 U.S.C. § 12132, requiring that “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity....”
- 111 Terry, 240 Mich. App. at 26.
- 112 *Id.*
- 113 *Id.*
- 114 *Id.*
- 115 *Id.*
- 116 LAURA ROTHSTEIN & JULIA ROTHSTEIN, *DISABILITIES AND THE LAW* § 9:12 at 667 (3d ed. 2006).
- 117 Jacobsen, *supra* note 27, at 190. See text associated with notes 67-77; Rosenblum & Kay, *supra* note 67, in this volume.
- 118 Jacobsen, *supra* note 27, at 190.
- 119 Sackett, *supra* note 10, at 272.
- 120 For a discussion of confirmation bias, see, e.g., Raymond S. Nickerson, *Confirmation Bias: A Ubiquitous Phenomenon in Many Guises*, 2 Rev. Gen. Psychol. 175 (1998). Confirmation bias affects both the evaluation of information and how information is sought.
- 121 Daniel W. Shuman, *What Should We Permit Mental Health Professionals to Say about “The Best Interests of the Child”?: An Essay on Common Sense, Daubert, and the Rules of Evidence*, 31 Fam. L.Q. 551, 559 (1997).
- 122 Bartell v. Lohiser, 215 F.3d 550, 558 (6th Cir. 2000).
- 123 Bartell at 559.
- 124 Bartell at 559.
- 125 Bartell at 559.
- 126 Benjet, *supra* note 21, at 248.
- 127 Budd, *supra* note 67, at 6.
- 128 *Id.*
- 129 See Rosenblum & Kay, *supra* note 67, in this volume for a more detailed discussion of applicable psychology ethics rules and other information about determining the quality of a psychological evaluation.
- 130 <http://www7.dleg.state.mi.us/free/>.
- 131 Brunt & Goodmark, *supra* note 3, at 301.
- 132 See Kathleen Baltman & Nichole Paradis, *Infant Mental Health: What Judges and Lawyers Should Know About Relationship-Based Assessment and Intervention* in this volume for a highly detailed, informative discussion of these critically-needed services.

The Michigan Child Welfare Law Journal Call for Papers

The editorial board of *The Michigan Child Welfare Law Journal* invites manuscripts regarding current issues in the field of child welfare. The *Journal* takes an interdisciplinary approach to child welfare, as broadly defined to encompass those areas of law that directly affect the interests of children. The editorial board's goal is to ensure that the *Journal* is of interest and value to all professionals working in the field of child welfare, including social workers, attorneys, psychologists, and medical professionals. The *Journal's* content focuses on practice issues and the editorial board especially encourages contributions from active practitioners in the field of child welfare. All submissions must include a discussion of practice implications for legal practitioners.

The main text of the manuscripts must not exceed 20 double-spaced pages (approximately 5000 words). The deadline for submission is May 31, 2012. Manuscripts should be submitted electronically to kozakiew@msu.edu. Inquiries should be directed to:

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Message from the Chair

“I wish child welfare professionals could collaborate more often.” This thought ran through my head the other evening as I watched “Horton Hears a Who.” The jist of the movie is that Horton the elephant hears a cry for help coming from a speck of dust. He cannot see anyone on the speck, but he tries to help anyway. The speck of dust turns out to be home to the Whos, who live in their city of Whoville. Horton’s neighbors refuse to believe that anything could survive on the speck and torment Horton for his efforts to help the Whos. Even in the face of torment, Horton stands by the motto that, “A person is a person, no matter how small.” With a mantra and determination in his arsenal, Horton encourages all the Whos in Whoville to work together so their voices can be heard in order to spare them from inevitable doom. It worked. All the voices together formed a booming chorus that forced Horton’s neighbors to consider the ever so tiny Whos.

The bottom line: we, like Horton, should encourage everyone in our system to work together to make sure the smallest voices are heard, even in the face of our preconceived notions. We share so much common ground. For instance, we all want children to be safe and protected, we all want to save resources, and we are all busier than ever. Most of our differences relate to our experience level and “title.” However, those differences don’t equate to a conclusion that the adversarial way is the only way.

To the contrary, the concept of working collaboratively in child welfare is taking hold in other states, as well as

in Michigan. Where child welfare professionals once operated as independent silos, new collaborative teams are being formed to make the most of scarce resource, while securing positive outcomes for families. In Michigan, the Department of Human Services is in the process of rolling out its new family engagement model, “MiTeam,” which encourages working together to engage families. Various counties across the state bring resource providers together with attorneys and caseworkers to identify solutions for improving services, without breaking the bank. Such collaboration has resulted in more tailored service plans and better outcomes for families in those counties.

The Children’s Law Section for the State Bar has also reached out to other children’s groups and State Bar Sections to improve its collaborative efforts. The Section will host a conference at Shanty Creek Resort on May 11, 2011. The event includes presentations on topics that will interest attorneys who represent the Department of Human Services, children, and parents. It will be a great opportunity to build relationships that encourage collaboration.

It is easy to be cynical and dismiss collaborative propositions as overly “Pollyanna,” but the cynicism quickly fades when a child’s future is at stake. The critical decision points in a child welfare case call for the utmost care and consideration – which means working together. “After all, a person is a person, no matter how small.”

—Jodi M. Lastuszek

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