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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 to do 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

- 1 Nicholson et al., *Critical Issues for Parents with Mental Illness and Their Families* 1 (2001).
- 2 *Id.*
- 3 Andrea Reupert & Darryl Maybery, *Families Affected by Parental Mental Illness: A Multiperspective Account of Issues and Interventions*, 77 *Am J Orthopsychiatry* 363 (2007) (hereinafter *Families Affected by Parental Mental Illness*).
- 4 *Id.*
- 5 Teresa Ostler, *Assessing Parenting Risk Within the Context of Severe and Persistent Mental Illness: Validating an Observational Measure for Families with Child Protective Service Involvement*, 31 *Infant Mental Health J.* 467 (2010) (hereinafter *Assessing Parenting Risk*); Victoria Hendrick & Kathleen Day, *UCLA Center for Healthier Children, Families and Communities, Parental Mental Illness* (2000) (hereinafter *Parental Mental Illness*). Available at: <http://www.healthychild.ucla.edu/Publications/Documents/Parentalmental0600.pdf> (last visited December 6, 2011).
- 6 *Id.*
- 7 *Families Affected by Parental Mental Illness*, *supra* note 3 at 363.
- 8 Margaret G. Spinelli, *Maternal Infanticide Associated with Mental Illness: Prevention and the Promise of Saved Lives*, 161 *Am J Psychiatry* 1548 (2004).
- 9 See National Resource Center for Permanency and Family Connections, *Child Welfare Issue Brief, Supporting Parents with Mental Health Needs in Systems of Care 2* (2011). Available at: www.tapartnership.org/docs/Supporting%20Parents%20With%20Mental%20Health%20Needs%20Issue%20Brief.pdf (last visited December 4, 2011).
- 10 *Parental Mental Illness*, *supra* note 5.
- 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.

Mallon & Peg McCartt Hess, eds., 2005)(hereinafter *Risk and Resilience in Child Development*).

- 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. Vander-vort, *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.