

University of Michigan Law School

## University of Michigan Law School Scholarship Repository

---

Articles

Faculty Scholarship

---

2012

### Representing Parents with Severe Mental Illness in Child Welfare Cases

Joshua B. Kay

University of Michigan Law School, jbkay@umich.edu

Available at: <https://repository.law.umich.edu/articles/2393>

Follow this and additional works at: <https://repository.law.umich.edu/articles>



Part of the [Family Law Commons](#)

---

#### Recommended Citation

Kay, Joshua. "Representing Parents with Severe Mental Illness in Child Welfare Cases." *Michigan Child Welfare Law Journal* 14, no. 2 (2012): 44-54.

This Article is brought to you for free and open access by the Faculty Scholarship at University of Michigan Law School Scholarship Repository. It has been accepted for inclusion in Articles by an authorized administrator of University of Michigan Law School Scholarship Repository. For more information, please contact [mlaw.repository@umich.edu](mailto:mlaw.repository@umich.edu).

# Representing Parents with Severe Mental Illness in Child Welfare Cases

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

Parents with severe mental illness<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup> 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."<sup>4</sup> 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."<sup>5</sup> 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.<sup>6</sup>

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.<sup>7</sup> These sources have considerable credibility with CPS, so there is likely to be intervention in response to a report.<sup>8</sup> Parents with mental illness are more likely than nondisabled parents to be living in poverty.<sup>9</sup> 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.<sup>10</sup> A reliance on the public system of care carries risks, including that parenting is subject to close scrutiny.<sup>11</sup> The state enjoys a presumption of legitimacy that parents in the child protection system, particularly those with mental disabilities, cannot match.<sup>12</sup> 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.<sup>13</sup>

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

dren.<sup>17</sup> 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.<sup>18</sup>

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.<sup>19</sup> In fact, predictors of problem parenting are often found to be the same for disabled and nondisabled parents.<sup>20</sup> 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.<sup>21</sup>

Research generally indicates that mothers with serious mental illness have less adequate parenting skills and behaviors than mothers without mental illness.<sup>22</sup> 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.<sup>23</sup> 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.<sup>24</sup> 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.<sup>25</sup> More predictive of child maltreatment than specific diagnosis, however, was the presence of antisocial behaviors, such as violent or criminal acts.<sup>26</sup>

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.<sup>27</sup> These factors likely vary in the amount that they increase the risk of maltreatment, and they are interactive with each other.<sup>28</sup> Prior positive treatment response and insight into one's own illness may be protective factors.<sup>29</sup>

The severity and chronicity of dysfunction due to mental illness are far more important than specific diagnosis as predictors of parenting difficulties.<sup>30</sup> In addition to differences between diagnostic groups, there is a lot of variability in the degree of functional impairment within each diagnosis.<sup>31</sup> 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.<sup>32</sup> 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.<sup>33</sup>

In another study, Hollingsworth found that specific diagnosis was not predictive of custody loss in women with persistent severe mental illness.<sup>34</sup> 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.<sup>35</sup> 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.<sup>36</sup>

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.<sup>37</sup> 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.<sup>38</sup> Specific diagnosis made little contribution to the prediction of parental nurturance and parental satisfaction.<sup>39</sup> 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."<sup>40</sup> 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."<sup>41</sup> 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.<sup>42</sup> Furthermore, initial symptom levels did not have a lasting effect on parenting.<sup>43</sup> 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.<sup>44</sup> 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.<sup>45</sup> 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.<sup>46</sup> Instead, the cumulative effect of multiple risk factors was important.<sup>47</sup> 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.<sup>48</sup> No one factor led to successful prediction of permanent custody loss, and the authors emphasized the need for intensive, multidisciplinary interventions in all cases.<sup>49</sup> 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.<sup>50</sup> 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.<sup>51</sup> 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.<sup>52</sup> 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.<sup>53</sup> The researchers suggest incorporating the instrument into evaluations of parenting competence among mothers with mental illness.<sup>54</sup>

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.<sup>55</sup> In short, the mere presence of parental mental illness is not a strong, specific predictor of child maltreatment.<sup>56</sup> 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.<sup>57</sup> 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.<sup>58</sup> 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.<sup>59</sup> 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.<sup>60</sup> Child welfare caseworkers and court personnel lack knowledge about mental illness and how mental disorders affect parenting skills.<sup>61</sup> 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.<sup>62</sup> Caseworkers make decisions about whether to remove children and terminate parental rights without adequate methods at their disposal for assessing parental fitness.<sup>63</sup> They lack resources for helping parents with mental illness improve their parenting.<sup>64</sup> 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.<sup>65</sup> The workers wanted training in the treatment and reunification services available, mental illness information, and client assessment.<sup>66</sup>

#### *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.<sup>67</sup> The simple and problematic truth is that many

mental health professionals rely on psychological tests that are not appropriate for determining parenting competence.<sup>68</sup> Intelligence tests and personality assessments “bear, at most, an indirect relationship to parenting issues.”<sup>69</sup> 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.<sup>70</sup> The ensuing errors can be tremendously costly and destructive as cases veer off in the wrong direction.<sup>71</sup>

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.<sup>72</sup> 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.<sup>73</sup> Furthermore, use of these instruments requires training and a clear understanding of each tool’s capabilities.<sup>74</sup> If they are used out of context or misinterpreted, misleading conclusions can follow.<sup>75</sup> 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.<sup>76</sup> 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.<sup>77</sup>

Rather than rely only on a few test instruments, focusing on diagnosis over actual level of functioning, and drawing overbroad, possibly misleading conclusions,<sup>78</sup> 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.<sup>79</sup>

In addition to determining the extent and severity of current, active symptoms,<sup>80</sup> and making sure that strengths as well as deficits are assessed,<sup>81</sup> researchers recommend that evaluations take a “functional approach,” “emphasizing behaviors and skills in everyday performance.”<sup>82</sup> 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.<sup>83</sup> The greater context in which the family lives and their constellation of risk factors should be assessed as well.<sup>84</sup> 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.<sup>85</sup> 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.<sup>86</sup> These parents may stop participating in the classes or fail to benefit adequately from them.<sup>87</sup> Unfortunately, there are very few programs designed specifically for parents with serious mental illness.<sup>88</sup> 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.<sup>89</sup> 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.<sup>90</sup> 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.<sup>91</sup> 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.<sup>92</sup> Others have echoed this call for greater collaboration between the mental health and child welfare systems.<sup>93</sup>

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.<sup>94</sup> 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.<sup>95</sup> 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.<sup>96</sup> 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.<sup>97</sup>

#### **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.<sup>98</sup> 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.<sup>99</sup> Too often, the services outlined in these case plans are not tailored to the needs of parents with

severe mental illness.<sup>100</sup> 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.<sup>101</sup> In doing so, the Michigan Supreme Court recognized and emphasized the importance of the reasonable efforts requirement in child welfare cases.<sup>102</sup>

The reasonable efforts requirement in cases involving parental disability is augmented by the protections contained in the Americans with Disabilities Act (ADA).<sup>103</sup> 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.<sup>104</sup> The application of the ADA in child welfare proceedings has been discussed in detail elsewhere.<sup>105</sup> 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."<sup>106</sup> Disability is to be construed liberally so as to extend broad coverage of ADA protections.<sup>107</sup> Parenting is made up of many tasks and draws on many capabilities that would be considered major life activities.<sup>108</sup> 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.<sup>109</sup>

An ADA claim may be brought when family services are so inadequate that they discriminate against parents with disabilities.<sup>110</sup> 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.<sup>111</sup> 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.<sup>112</sup> The claim cannot be raised for the first time at a termination of parental rights hearing.<sup>113</sup> The ADA should be raised "either when a service plan is adopted or soon afterward."<sup>114</sup> As soon as it appears that the agency "is unreasonably refusing to accommodate a disability," the claim should be made.<sup>115</sup>

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.<sup>116</sup> 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.<sup>117</sup> 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.<sup>118</sup> 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.<sup>119</sup> 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.<sup>120</sup> 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.<sup>121</sup>

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"<sup>122</sup>: "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."<sup>123</sup> 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."<sup>124</sup> 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]."<sup>125</sup> 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.<sup>126</sup> 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.<sup>127</sup> Referral information should include not only specific questions but also a request for recommendations about treatment options, parenting time, and other needed services.<sup>128</sup> 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.<sup>129</sup> 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.<sup>130</sup>

#### *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.<sup>131</sup> 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.<sup>132</sup> 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. ©

### About the Author

Joshua B. Kay, J.D., Ph.D.  
Clinical Assistant Professor of Law  
University of Michigan Law School  
Child Advocacy Law Clinic  
701 South State Street  
Ann Arbor, MI 48109-3091  
jbkay@umich.edu

### 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 (6<sup>th</sup> 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.