Identifying and Reducing Barriers to Reunification for Seriously Mentally Ill Parents Involved in Child Welfare Cases

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Abstract

Forming judgments about parenting capacity, a necessary part of permanency planning, is much more difficult when the parent has a serious mental illness. The time necessary for effective treatment for such parents is often longer than the court-ordered time limit for family reunification. This puts mentally ill parents at a distinct disadvantage in their efforts to preserve their families. Using Arizona as an example, this article discusses the barriers in both child welfare and mental health systems to accurate and effective assessment and treatment. It presents recommendations for research and suggestions for child welfare personnel to enhance the potential for mentally ill parents to reunify with their children.

Serious mental illness can profoundly affect an individual's ability to parent. Nonetheless, there is much research to support the idea that, given appropriate and adequate resources, some individuals with a serious mental illness can successfully parent their children. Child welfare agencies, charged with determining parenting capacity as they investigate more reports of maltreatment by a parent with a serious mental illness, must consider factors related to the parent's mental illness. Many caseworkers, however, have not been trained to conduct these complex assessments. Moreover, the increased focus on speedy permanency determinations (e.g., the 1997 SAFE Families Act) can require caseworkers to make "major decisions about custody and parenting rehabilitation based on incomplete or contradictory information" (Jacobsen, Miller, & Kirkwood, 1997, p. 189).

A strong knowledge and practice skill base in regard to working with parents with serious mental illness can help child welfare staff support the efforts of these parents to preserve their families despite the shortened permanency time frames. However, this information has not been accessible to many child welfare staff. Although research-based knowledge about causes, symptoms, assessment, and treatment of serious mental illnesses has greatly expanded over the past 10 years, it has appeared primarily in the mental health literature. Child welfare workers may not have benefited from the new knowledge because it has not appeared in journals they are most likely to read. Without access to this advancing knowledge, caseworkers are not able to be the most effective advocates for their parents within both the child welfare and mental health systems. Moreover, their decisions may be based on past dominant theories that have not stood up to empirical testing (Rubin, Cardenas, Warren, Pike, & Wambach, 1998).

To help bridge this gap, this article presents symptoms and best practice treatment models for schizophrenia, bipolar disorder, and major depression (see Tables 1 & 2). We

Table 1. *Treatment Time Lines for Major Mental Illnesses*

Psychiatric disorder	How symptoms progress	Empirically supported treatment models
Schizophrenia	• Onset in adolescence, early adulthood; typically 2–3 years for women later than men. • Symptoms can appear over months to years and may come to the attention of others (e.g., CPS) when they interfere with social roles or obligations. • Symptoms can recur independent of excellent treatment adherence.	• Psychotropic medication: Trials of antipsychotics. Conventional types such as Haloperidol are older and cheaper. Quick sedation, but therapeutic effect much longer; usually does not help negative symptoms. • Atypical (e.g., Risperdal): Therapeutic trials 4–6 weeks; full effect to 12 months. • Family psychoeducation. • Psychiatric rehabilitation, social skills training.
Major depression	• May be gradual onset until functioning severely affected; sleep deprivation, persistent sad mood, risk of suicide. • Symptoms can recur independent of excellent treatment adherence.	• SSRIs (e.g., Prozac): Some improvement within 1 week; full effect 4–6 weeks. • Cyclic antidepressants: 2–6 weeks. • Antidepressants: 3–4 weeks. • Cognitive–behavioral therapy.
Bipolar disorder	• Onset of first manic episode typically early adulthood, but may occur as early as childhood; full disorder has onset from childhood to adulthood. • Manic episode may be induced when antidepressants prescribed for depressive episode. • Symptoms can recur independent of excellent treatment adherence.	• Lithium: Effective for 70%–80%; 2–3 weeks for therapeutic effect; requires regular medical monitoring of blood level of the medication. • Divalproic sodium (Depakote); therapeutic effect in 5–10 days.

Note. CPS = child protective services; SSRIs = selective serotonin reuptake inhibitors.

describe present barriers to accurate assessment and treatment of serious mental illness within both the child welfare and mental health systems. Finally, we present recommendations for caseworkers presently struggling with these issues as well as for policy and research. We focus on the needs of women with serious mental illness, as they are most often the primary caretakers of children in the child welfare system. In addition, mental health research has only recently considered gender as an important variable (Mitchell & Kelley, 1997), so the information related to women's experience may be less accessible to child welfare practitioners.

Serious Mental Illness

The term *serious/severe mental illness* encompasses a wide variety of psychiatric conditions with differing symptoms. For the purposes of this article, we define *serious or severe mental illnesses* as including,

> a wide range of psychiatric diagnoses, but they have in common psychological symptoms that persist over time and are functionally disabling in daily living skills and in abilities involving social interactions, family relations and jobs or education. (Johnson, 1997, p. 247)

Given the differences in symptoms, functioning, and treatment across the major mental illnesses, it is important that child welfare agencies consider individual needs within the context of a parent's specific diagnosis.

Schizophrenia

Schizophrenia, one of the most disabling mental disorders, is characterized by the following symptoms: hallucinations (hearing, or sometimes seeing or smelling something that is not really there), delusions (thoughts or perceptions not related to reality), disorganized thinking or speech, bizarre behavior, flat emotions, and lack of motivation and energy. Although researchers have not determined the causes of, or cure for, schizophrenia, they observe clear physical changes in the brain using brain imaging technology (Nathan, Gorman, & Salkind, 1999). Schizophrenia typically develops during adolescence or young adulthood. Women's age at onset lags 3–4 years behind that of men's, whose mean age at onset is 19.9 years (Keith, Regier, & Rae, 1991). The later onset for women results in more women developing schizophrenia when they are already parents (Stromwall & Robinson, 1998). Symptoms can continue undiagnosed, untreated, and potentially unnoticed or misunderstood by the individual's social network for long periods of time. Co-occurring substance abuse can complicate awareness and diagnosis.

Of people with schizophrenia, approximately 60% improve significantly with treatment (Nathan, Gorman, & Salkind, 1999), with about 25% returning to high functioning. Another 10–15% are left with continuing symptoms and lowered functioning even when treatment adherence is high. Typically, symptoms lessen with age (Adler et al., 1995). Thus, the historic stereotype of chronic, unchanging psychiatric disability is no longer applicable.

Child welfare workers whose caseloads include parents with an undiagnosed or untreated schizophrenic disorder

TABLE 2. *Major Psychotropic Medications and Side Effects*

MEDICATION CLASS	DESCRIPTION	COMMON SIDE EFFECTS
Antidepressants	SSRIs: Prozac, Zoloft	Anxiety, loss of sexual arousal, weight gain or loss.
	Other: Effexor, Serzone, Wellbutrin	Restlessness, insomnia, headaches, seizures if dosage is too high.
Mood stabilizers (bipolar disorder)	Lithium carbonate	Risk of birth defects if taken by pregnant women. Nausea, hand tremors, increased urine and thirst.
	Depakote	Risk to pregnant, nursing mothers. Risk of liver failure, white blood cell count problems. Nausea, drowsiness, dizziness, rash, hair loss, and itching. Higher risk of side effects with higher doses.
Typical (older generation) antipsychotics	Haldol, Mellaril, Thorazine	Muscle spasms, cramps, and posturing movements, restlessness, muscle rigidity, and tremors (extrapyramidal side effects), Tardive dyskinesia—involuntary movements such as grimacing, sucking, and smacking of lips, and spasmodic movements of the extremities. Usually begins after several months of treatment, and may be irreversible.
Atypical (newer generation) antipsychotics	Clozaril, Risperdal, Zyprexa	Weight gain, excessive drooling, fatigue, sexual dysfunction, tremors, low blood pressure, liver disorders. Not for nursing mothers. Clozaril can affect white blood cell production, a rare but potentially fatal complication, and require blood monitoring.

Note. SSRIs = selective serotonin reuptake inhibitors.

may observe extreme suspiciousness, irrational beliefs about any aspect of life, or statements that the parent is being directed to do something, such as voices telling the parent how to deal with a situation in an unusual or unsafe manner. The parent may report that the unseen voices are critical; for example, stating that the parent or child is evil, or the voices can be benign or even supportive. The parent may have grandiose beliefs, such as believing she is the Queen of England.

In parents receiving treatment, the child welfare worker may observe incomplete symptom reduction and common side effects of medications. Older medications (e.g., haloperidol), developed in the 1950s, are cost-effective but are accompanied by serious side effects (e.g., lethargy, difficulty waking in the morning) that can interfere with parenting. One patient described this as "feeling like a zombie all the time" (Perkins & Leiberman, 1998, p. 274). Irreversible Parkinson's-like symptoms also can occur. Often, there is significant weight gain despite strong efforts to manage weight. Obesity is a risk factor in many serious health problems such as Type II diabetes, stroke, and some cancers (Henderson et al., 2000; Phillips, 2000). For some women, this weight gain results in obesity which itself is a risk factor in many life-threatening health problems such as Type II diabetes, stroke, and some cancers (Henderson et al., 2000; Phillips, 2000). Newer antipsychotic medications (e.g., Clozaril, Risperdal) provide clearer thinking and less blunting of affect for many individuals. Although these newer drugs offer hope for dramatic symptom reduction, they are expensive (Perkins & Lieberman, 1998) and also have serious side effects, including weight gain of up to one pound a week (e.g., Allison et al., 1999; Henderson, et al., 2000; Phillips, 2000).

Major Depression

Major depression is a mood disorder that affects the individual's emotional state and thinking. Its symptoms include ongoing sad mood, difficulty concentrating, sleep disturbances (lack of ability to get to sleep and early waking), changes in appetite and/or weight (either lesser or greater), social withdrawal, and risk of suicide. Irritability, excessive anger, and anxiety may also be present. Depression can begin at any age, and both medication and psychotherapy have demonstrated effectiveness in reducing symptoms (Craighead, Craighead, & Illardi, 1998). Although it is highly treatable, depression can be a lifelong condition in which periods of wellness alternate with recurrences of illness.

Depression affects twice as many women as men (Pajer, 1995); one of seven women will develop the illness at some time in their life. Women's greater vulnerability is thought to be due to a combination of biological, genetic, psychological, and social factors. Women sometimes have a different longitudinal course and respond better to different medications than men (Pajer, 1995). In addition, medications may need to be adjusted premenstrually if a woman is taking birth control pills, is pregnant, or has just had a baby (postpartum; Pajer, 1995). Common side effects of antidepressant medications in women include (see Table 2) anxiety, insomnia, weight gain or loss, and even seizures if the dosage is too high. These can interfere with a person's willingness to take medication as well as with parenting functioning.

Caseworkers should screen for depression when physical abuse or neglect (especially when accompanied by substance abuse) appear to be present (Chaffin, Kelleher, & Hollenberg, 1996; Kotch, Browne, Dufort, Winsor, & Catellier, 1999). Evidence of major depression in a child welfare parent may include not keeping up one's home; failing to provide meals for children or oneself; poor memory resulting in missed meetings or failing to keep previously agreed-upon obligations; beliefs that one's children are better off without her, resulting in missed visitations or abandonment; and suicidal thoughts and attempts.

Bipolar Disorder

Bipolar disorder, previously termed manic depression, is also considered one of the mood disorders. Diagnosis requires at least one episode of depression and one episode of mania, characterized by rapid speech and hyperactive behavior, decreased need for sleep, irritable or elated mood, poor judgment, or reckless, impulsive behavior. Manic episodes can include hallucinations or delusions, leading to a misdiagnosis of schizophrenia. About 1% of the general population is affected by bipolar disorder (Johnson, 1997). It occurs equally in men and women and has a strong genetic component.

Mood stabilizers (e.g., lithium) are effective in preventing recurrence of manic and depressive episodes (Keck & McElroy, 1998). Psychosocial treatments include cognitive–behavioral therapy in addition to, but not in lieu of, medication. These individuals have a high rate of co-occurring substance abuse: 60% will develop a substance abuse disorder within their lifetime (Regier et al., 1990; Strakowski, Sax, & West, 1998). Integrated mental health and substance abuse treatment is now the standard, but this has been unavailable in most localities until recently (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998), and there continues to be a dearth of high-quality services (Drake et al., 2001).

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Mental Health Barriers to Assessment and Treatment of Serious Mental Illness

A parent diagnosed with one of the major mental illnesses is no longer doomed to a lifetime of poor functioning as a "chronic mental patient." Present research identifies mental illnesses as brain disorders (Rubin et al., 1998). Psychotropic medications and psychosocial interventions that actively involve consumers in managing their symptoms (Anthony, 1993) provide treatment for reducing symptoms. Many people recovering from psychiatric disorders experience widespread improvement across life domains, including those of self-care, social, cognitive, vocational, and parenting. "Parents within any given diagnostic category can have parenting skills ranging from excellent to maltreating" (Mullick, Miller, & Jacobsen, 2001, p. 489). Thus, a caseworker's knowledge of a parent with a serious mental illness is a starting point, but reveals little about parenting capacity.

Accurate assessment and effective treatment for parents is critical for parenting abilities to be optimized. Unfortunately, numerous barriers to such assessment and treatment exist for parents trying to regain custody of their children, and for caseworkers helping families reunify. Primarily, the barriers prolong treatment time for months or even years. This, in turn, conflicts with permanency planning time frames. Some of the barriers to effective treatment include the often debilitating side effects of medications used to treat serious mental illnesses, the lack of definitive drug treatments necessitating a "trial-and-error" approach, not knowing the causes of these illnesses, the stigma attached to having a serious mental illness and the concurrent belief that a parent with a serious mental illness is "crazy" and cannot or should not be a parent, and the continuing belief that mental illness is the fault of the person and she or he can voluntarily act differently. The side effects of psychotropic drugs may, for example, put a parent in a Catch-22 position. Lethargy, blunting, tremors, and weight gain may interfere with the parent's ability to parent, but not taking the drug(s) means she or he is actively ill. The side effects of drugs are, in fact, one of the most common reasons why patients discontinue their medications (Johnson, 1997; Megna & Dewan, 1999). Other barriers include the time needed for both the drug and psychotherapy treatment to achieve significant symptom remediation. With medication, the time to achieve a therapeutic dosage varies by drug (see Table 2). Moreover, with both psychotherapy and drugs the time to achieve a therapeutic dosage varies by individual.

In addition, the mental health service system contains barriers that interfere with timely assessment and treatment. Contemporary mental health care is provided almost exclusively through managed care, the administrative management of treatment providers. Capitation, in which providers are paid a flat fee for each covered individual regardless of the severity of the individual's condition, provides a strong incentive to undertreat or avoid high-cost patients (Young, Kapur, & Murata, 2001). The cost of treatment can be as high

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as $125,000 per year and result in clinical decisions driven by costs rather than patient well-being. Caseworkers who are attempting to interact with such individuals as described in the following case example, and who are not privy to the clinical decisions that resulted in overmedication, could attribute the parent's behavior to other causes, such as laziness.

> *Case example.* An outpatient mental health program distributes medication to patients who are prescribed drugs to be taken twice daily. Because of budget constraints, distribution is provided only in the morning. The patients are given their nightly dose to take with them and take later. Given the clinic's concern that patients might not take the evening medication without supervision, they are given higher doses of medication in the morning and lower doses for evening. This results in an increase in lethargy and difficulty in functioning during the day because they are overmedicated.

Even when parents voluntarily seek treatment, systemic financial barriers exist. Within any public system, both financial and psychiatric need must be established. States typically establish diagnostic categories that qualify for the highest level of treatment if the individual's level of functioning is low. Yet clinicians are often determining outside levels of functioning on the basis of office interviews of highly symptomatic patients. Psychiatric symptoms of grandiosity and denial of illness may interfere with the patient's accurate description of functioning, and clinicians may not have sufficient time or funding to seek out family or social network informants. In this way, parents can be denied treatment because their condition is not rated as severe. Additionally, privately insured parents may have a low level of psychiatric coverage. High copayments for services are common and are increasing. Parents may need a referral to mental health treatment through their primary care physician, who may be paid for avoiding expensive referrals.

Rationing of more effective, but more expensive psychotropic drugs is also common in either the public or private system. There have been over 10 years of positive clinical experience with the second generation of antipsychotic drugs. Nonetheless, patients must often endure long periods of failed trials of lower cost, higher side effect first-generation medications before a more effective but higher priced second-generation drug is tried. In addition, the criterion for deciding that a drug is effective may be too high (Essock et al., 1996)—that is, a partial response that improves only some of the individual's symptoms may be considered adequate. For the estimated 200,000–500,000 U.S. patients with schizophrenia whose symptoms are only partially relieved by the older, cheaper medications (Conley & Kelly, 2001), a trial on a newer medication might give them an opportunity for better symptom control and fewer side effects. This might be especially critical for a parent in the Child Protective Services (CPS) system trying to reunify with her or his children. Additionally, this trial-and-error approach can seriously prolong the time for significant symptom reduction, and hence for meeting parenting goals within permanency planning time frames.

Other systemic obstacles include an absence of attention in mental health assessment and treatment on parenting and children (White, Nicholson, Fisher, & Geller, 1995). Marital relationships, family roles, and connections are often ignored (Mowbray, 1999; Nicholson, Geller, & Fisher, 1996; Scott, 1992) and children are rarely mentioned (Oyserman, Mowbray, & Zemencuk, 1994; White et al., 1995). For example, the intake form for Arizona's Behavioral Health System does not ask whether the client has children.

Even when parenting capacity is assessed, there is great variety in the procedures and measures used (Jacobsen et al., 1997). The tools used to measure parents' psychological status are only indirectly related to parenting capacity; for example, a diagnosis is provided but functioning is not assessed. There is no measure of functioning as a parent. Additionally, instruments used to assess parenting capacity have not been systematically validated on mentally ill parents. Some tools measure optimal rather than the more appropriate standard of minimal parenting capacity, and some do not account for cultural diversity in child-rearing practices or external barriers to adequate parenting faced by economically impoverished parents (Jacobsen et al., 1997). Finally, some assessments are based on the use of only a few tools or on seeing the parent in only a single context. For example, a person may function highly at home, but less well in a clinical interview (Jacobsen et al., 1997). Thus, caseworkers cannot necessarily rely on these assessments for insight into a client's ability to parent.

Gender issues present additional challenges to effective and timely assessment and treatment. Past research in mental health treatment rarely used gender as a variable, and male study participants often outnumbered female participants (Mitchell & Kelley, 1997). Gender differences and special needs of women have tended to be ignored (Oyserman et al., 1994). For example, in regard to sexuality, deinstitutionalization affected men and women with schizophrenia differently because in part of gender differences in the expression of schizophrenia (Miller, 1997). Women with schizophrenia are more sociable, more likely to date, to be sexually active, and to engage in sexually inappropriate behaviors than men (Miller & Finnerty, 1996). In addition, Miller and Finnerty (1996) found, in comparison to nonmentally ill women, women with schizophrenia spectrum disorders were more likely to have been raped, engaged in prostitution, and to have been victims of violence during pregnancy. Thus, deinstitutionalization may have made women more sexually vulnerable and contributed to their increased pregnancy rates (Miller & Finnerty, 1996). In addition, women of reproductive age and child-bearing potential were not traditionally included in psychopharmacologic studies. Consequently, adequate data to help psychiatrists fine-tune medication regimens for pregnant women may not be available (Nicholson et al., 1996).

A major clinical barrier to timely treatment is that common symptoms of many serious mental illnesses include the inability to recognize one's own mental illness and to understand that medical care is required (Amador et al., 1994). For example, 40%–50% of persons diagnosed with bipolar disorder and schizophrenia experience some degree of impaired self-awareness (Francell, 2001). This can impede a parent's willingness to seek and comply with treatment.

Social stigmatization also may affect an individual's willingness to seek treatment. Individuals experiencing symptoms may worry that their family or friends will reject them or disapprove of their seeking mental health treatment. They may fear termination by an employer, or that they may adhere to the individualistic philosophy that prescribes that individual effort can help overcome any personal obstacle. These barriers to seeking help can prolong the time it takes for parents to receive assessment and treatment, thus, once again, conflicting with shortened permanency planning time frames.

The barriers imposed by the nature of mental illnesses and their social contexts also interact with a legal barrier. U. S. law primarily protects the freedom of individuals from involuntary psychiatric treatment. Unless the individual is a "danger to himself or others," she or he must voluntarily seek treatment. Arguably, CPS involvement can signal "dangerousness," but there is often insufficient attention to CPS concerns within the mental health system (Nicholson & Blanch, 1995). Thus, interested others, such as family members or CPS workers, must bring the home situation to the attention of the mental health system.

Child Welfare and Permanency Planning Barriers

In addition to barriers in the mental health system, there are legal, organizational, and conceptual barriers within the child welfare system itself to reunifying parents with serious mental illnesses with their children. Since the 1980s, a prevailing focus in child welfare has been on permanency planning and expediting the process of determining the outcome for children in out-of-home care. Legislation has been enacted to prevent children from "drifting" in out-of-home care by changing the conditions of, and shortening the time frames for, permanency decisions. The Federal Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-172) established "reasonable efforts" requirements to prevent the removal of children from their own homes; and for children removed, to reunify them with their parents as soon as possible (Costin, Bell, & Downs, 1991). Time frames for permanency planning also were established, with a dispositional hearing required within 18 months of placement in out-of-home care.

Even more critically, the Federal Adoption and Safe Family Act of 1997 (P.L. 105-89) (ASFA) established the "health and safety of the child" as the most important consideration in determining what reasonable efforts toward family preservation or reunification are required (Genty, 1998), and it mandated earlier and more decisive permanency hearings, thereby limiting the amount of time agencies are required to fund family reunification services. Most important to parents with a serious mental illness, ASFA affirms and clarifies specific exceptions that permit states to refuse reunification efforts, and requires states to initiate or join termination of parental rights (concurrent planning) proceedings for children who have been in care 15 of the most recent 22 months (Genty, 1998). Exceptions to the reunification effort requirements involve violent criminal acts, repeated instances of abuse, lengthy terms of incarceration, and when a parent's rights to another child have been terminated in a prior proceeding (Genty, 1998). This includes many mentally ill parents who have previously lost custody of children. Finally, ASFA also allows states to forgo efforts to reunify on the basis of a finding of mental incapacity or illness. Presently, seven states cite mental health disorders as a single reason for withdrawing family reunification services (National Conference of State Legislatures, 1999). These legislative efforts were clearly intended to help children and their families achieve permanency. Nonetheless, they represent serious obstacles to parents with serious mental illnesses given common time lines and barriers to treatment.

In addition to national legislation, the U.S. Department of Health and Human Services (DHHS) has supported efforts to restrict the time in care by providing grants to states for court improvement projects. In 1996, nine Model Court Improvement Project pilots were funded, including the Pima County Court Improvement Project in southern Arizona. This project has recently been implemented statewide.

TABLE 3. *Judicial Time Lines for Child Welfare Permanency Planning in Arizona*

JUDICIAL PROCESS	LEGAL TIME LINE	PURPOSE
Filing of dependency petition	Within 72 hr of removal.	To petition the court for temporary custody and protection of children whose parents/guardians have demonstrated inability/unwillingness to do so.
Preliminary protective hearing	Within 5 days of petition.	Allows parties to address issues of temporary custody, visitation, placement, and initial case plan. Protects rights of all parties. Preceded by a mandatory prehearing conference to negotiate agreements for services and establish working relationship.
Settlement conference	Within 30–45 days of preliminary protective hearing.	Provides opportunity for all parties to discuss allegations of petition and to reach an agreement. If there is no agreement, the court may elect to schedule mediation or an additional "facilitated settlement conference," in which an impartial judge hears privately from each party and provides advice as to the likely legal outcome.
Adjudication hearing	Must occur within 90 days of service of the dependency petition—one 30-day extension is permitted for extenuating circumstances.	Determines whether or not the allegations contained in the dependency petition are true, based either on the evidence presented, an agreement of the parties, or a default judgment. Justifies continued court involvement; child is adjudicated dependent ward.
Disposition hearing	May be held at the time of the adjudication or within 30 days of same.	Provides for judicial review and approval of long-term case plan submitted by the agency. The case plan must describe specific goals, interventions, and time frames. The agency caseworker is responsible for implementing, monitoring, and modifying the case plan as appropriate.
Review hearing	Scheduled every 45–180 days.	Judicial review of progress toward the case plan goals. Modification of the plan and other orders may be entered.
Permanency planning hearing	Within 12 months of removal date/or within 30 days of disposition if reunification is not ordered.[a]	Determines whether child can be returned to parent without substantial risk of harm, and what permanency plan is most likely to provide safety and security for the dependent child. This significant hearing reviews evidence of progress toward the case plan and likelihood of resolution in a short time. The court has discretion to allow a 90-day extension of a reunification plan if the extension is seen as reasonable and in the child's best interests.
Termination of parental rights	Initial hearing scheduled within 30 days of permanency planning hearing in which the outcome includes an order to file a motion to terminate. If a parent wishes to contest termination, the trial must be set within 90 days of the permanency hearing.	To determine whether the evidence demonstrates sufficient grounds to terminate parental rights and whether the termination is in the best interest of the child. Parents may submit voluntary relinquishments in lieu of involuntary proceedings. Parents may file appeal.
Guardianship hearing	Initial hearing scheduled within 30 days of permanency planning hearing in which the outcome includes an order to file guardianship petition.	Secures legal custodian for a child while preserving the legal parent–child relationship; often seen as practical alternative to termination and adoption when children live in kinship homes.
Adoption hearing	——	Secures permanent legal parents for a child following the termination of parental rights.

Note. Dash indicates data were not reported.
[a] Refers to circumstances in which reunification may not be appropriate or warranted.

Another obstacle to reunification is the prevalence of a deficit-focused approach to families. Although the child welfare climate may be recognizing the need to look at client strengths, the overarching themes are still problem identification and problem solving, rather than strengths and empowerment. This predisposes one to focus on the negative aspects of having a serious mental illness rather than on the strengths the parent brings to help him or her manage the illness symptoms and parent adequately.

The goals of the Arizona Model Court Improvement Project are to "improve the procedures and time lines within which … cases are processed, to improve accountability … and most importantly, to decrease the time children reside in out-of-home placement" (Foster Care Review Board, 1998). Specific targets for change include more timely hearings, immediate intervention for families involved in the child welfare system, dedicated days for dependency hearings, and consistent review of each case by one judge throughout the court process (Foster Care Review Board, 1998). See Table 3 for the events and time frames that families in the Arizona child welfare system experience as a result of both ASFA and the Model Court Improvement Project.

Both the implementation of ASFA and the Model Court have challenged child welfare agencies to strive for new levels of efficiency. Strict time limits and frequent hearings have given rise to a sense of urgency about casework actions and decisions. In Arizona, efforts to enact the requirements of Model Court also created new alliances between child welfare agencies, courts, and mental health systems, benefiting many families. However, ASFA also represents a shift from the long-standing value that children are best served by growing up in their natural families to one that acknowledges the idea that there are certain circumstances that should preclude in which it may be unnecessary to extend reunification services (Stein, 2000). Given the premise that effective assessment, intervention, and support may help clients control symptoms of mental illness, this aspect of the law may be biased against these parents with serious mental illnesses. This raises concern that efforts to streamline the child welfare system may serve to undermine efforts to assist such individuals to achieve and maintain active parenting status. Stein (2000) noted that "if ASFA succeeds in placing more children in adoptive homes it may be at the expense of parents who are in greatest need of assistance" (p. 591).

As time lines are shortened and tasks are multiplied (e.g., concurrent planning), child welfare staff must serve multiple-risk parents: those who suffer, often in combination, from serious mental health, substance abuse disorders, and domestic violence. These conditions, which create barriers to working, parenting, and maintaining health and stability, demand a high level of proficiency in assessment, case planning, service provision, and decision making on the part of the caseworker. Although linkages have recently been initiated between child welfare and substance abuse, domestic violence, and even incarcerated parents, there has been little attention to the intersection of child welfare and the adult mental health system, and little research to guide the worker in providing child welfare services to parents with serious mental illnesses.

The success of policy and programming designed to streamline child welfare systems is largely dependent, to a large degree, on those who carry out public policy, and the conditions under which they function (Stein, 2000). Caseworkers' attitudes toward family members and treatment teams influence choice of case plans and case management decisions. Thus, it is important to consider conditions in which certain factors influence these decisions: caseworker turnover and deprofessionalization of child welfare are two such factors. Caseworker turnover, for instance, has been reported to be as high as 100% in some instances (Jordan Institute for Families, 1999), and 90% of states have reported difficulty in recruiting and retaining caseworkers (General Accounting Office, 1995). One traditional response to such recruitment problems has been to lower the hiring requirements for caseworkers, that is, to deprofessionalize child welfare. Almost half the states responding to a 1987 survey did not require entry-level workers to have

completed baccalaureate degrees (Russell, 1988); this is in contrast to the 1950s when almost 50% of child welfare workers were professional social workers (Leighninger & Ellet, 1998). Most recently, out of 64 new CPS employees trained in one state, 52% had neither social work nor counseling degrees; 52% had no previous social welfare experience; and only 17% had master's degrees (not necessarily in social work; Arizona Department of Economic Security, 2002). Thus, many child welfare staff are undereducated and inexperienced. They may also receive little on-the-job training for working with those who have a serious mental illness, evaluating their parenting adequacy, or even recognizing appropriate types of evaluations by others (Jacobsen et al., 1997; Scott, 1992). In the new core training in one state, only 3.5 days out of 12 weeks of training are allocated for "specialized family assessment," which includes four sections on substance abuse, four sections on domestic violence, and only one section on mental illness. Moreover, the mental health section is first on substance abuse, with three subsections on co-occurring substance abuse and mental illness (Arizona Department of Economic Security, 2002). Given this lack of relevant experience and education and training, many workers may be unable to accurately assess the ability of a person with a serious mental illness to parent. Additionally, they are unable to plan well for reunification if they lack an understanding of the treatment needs and barriers to treatment that such parents encounter.

Another obstacle to reunification is the prevalence of a deficit-focused approach to families. Although the child welfare climate may be recognizing the need to look at client strengths, the overarching themes are still problem identification and problem solving, rather than strengths and empowerment. This predisposes one to focus on the negative aspects of having a serious mental illness rather than on the strengths the parent brings to help him or her manage the illness symptoms and parent adequately. Finally, even if a worker believes in a client's ability to parent adequately, they are confined by permanency planning legislation and policies that limit the worker's options to achieve success. ASFA curtails individualized casework decisions by specifying setting forth circumstances in which agencies are required to pursue termination of parental rights. Although the law allows for specific exceptions to termination, most alternative case plans no longer include the parents.

Recommendations

A substantial body of research emphasizes children's need for permanency and the detrimental effects of languishing in out-of-home care. Nevertheless, although guidelines for limiting the length of placements are necessary, it is both unrealistic and unreasonable to set an arbitrary deadline for all cases: One size does not fit all. To operationalize the social work principle of uniqueness, more research is needed, and agencies and staff must be creative in providing casework and other services to these parents with serious mental illnesses.

Recommendations for Child Welfare Practice

Most important, caseworkers must be informed that there is legal basis for prolonging reunification goals. Agencies and caseworkers should note that implicit in the concept of reasonable efforts is the expectation that child welfare agencies will make good faith efforts to accurately assess families' needs and develop and implement appropriate service plans (Youth Law Center, 2000). Termination of parental rights requires that the agency prove an even higher standard of diligent efforts. In *Mary Ellen C. v. Arizona Department of Economic Security*, 193 Ariz. 185,971 P.2d 1046 (App. 1999), the court found the following:

> It is well established that the State, before acting to terminate parental rights, has an affirmative duty to make all reasonable efforts to preserve the family relationship … case law has been inconsistent, however, in establishing whether this affirmative duty entails an obligation to make a reasonable effort to rehabilitate a parent who suffers from a disabling mental illness. We hold in this opinion, that although the State is not obliged to undertake futile rehabilitative measures, it is obliged to undertake those which offer a reasonable possibility of success (p. 1, paragraph 1, 1999 WL 16748, Arizona Appellate Division 1).

The decision in this case reversed the termination of parental rights ordered by a lower court because the State made only a negligible effort to provide rehabilitative services to a mother with diagnosed mental disorders. Thus, agencies have legal precedent for making greater efforts at reunification for such families.

Caseworkers also can use a relatively undefined provision of ASFA that provides for a finding of "compelling reasons" not to pursue termination of parental rights. These reasons must be specified for individuals rather than a class of clients and could include the child's bonding with a parent with a mental illness. Workers may need to advocate in support of the parent–child relationship when it can be safely maintained. Moreover, whereas some parents may not be able to achieve a level of functioning that would permit safe reunification, caseworkers should explore alternative case plans such as guardianship, or "coguardianship" arrangements in which a relative or other responsible adult is appointed to guide decision making and ensure protection of the child (Henry, 1999).

Unfortunately, many workers may feel poorly equipped to interface with both the parents and the mental health system. Agency managers need to ensure the provision of adequate training to (a) address workers' (and maybe their own) preconceived ideas or fears about mental illness, (b) educate workers on the symptoms and treatments for common serious mental illnesses, and (c) educate workers on interaction with someone in an active illness state or who is experiencing the many side effects of the "treatments." Additionally, caseworkers can be empowered to support clients dealing

with medication side effects; for example, side effects of the drug lithium include increased thirst and urination. Caseworkers may want to offer water and/or facilitate the use of a restroom during office visits, child visitations, and court appearances. Better preparation for working with parents with serious mental illnesses can also empower caseworkers to be stronger advocates for such parents when interfacing with the mental health system.

If child welfare workers are to propose service plans to reunify mentally ill parents with their children, a systematic assessment of parent, child, and environmental factors is essential—one in which the agency sees beyond the parent's diagnosis to their individual strengths and needs. The assessment should reflect an ecological approach that takes into account the whole person in broad life circumstances (Mowbray et al., 2000) and includes a comprehensive service plan addressing problems commonly associated with serious mental illness (e.g., poverty, health problems, substance abuse). Components of such an assessment should include investigation of the (a) parent's ability to seek help; (b) child's physical, mental, and developmental status; (c) impact of the parent's disorder on the child; (d) nature of the relationship between parent and child; (e) parent's ability to meet the child's needs; (f) parent's ability to manage stress; (g) nature of the parent's motivation and acceptance of responsibility; (h) quality of support available to the family; (i) adequacy and effectiveness of the current treatment for the parent; and (j) likelihood of sustainability of parenting adequacy over the course of childhood.

It is also helpful to reframe serious mental illnesses as conditions, not unlike chronic physical illness or disability, which may interfere with one or more aspects of parenting. Many parents with disabling physical conditions (e.g., spinal cord injuries, visual impairments) must have to develop strategies to compensate for their physical limitations. A similar approach to assessing parents with mental illness, focusing on individual and environmental capacities and strengths rather than diagnoses, would assist practitioners in recognizing and mobilizing the parents' resources. From this perspective, parents might be assisted to develop strategies to reduce risks related to their illness and build in compensatory supports for themselves and their children.

One model for such an approach is family group conferencing. This provides for involvement of all interested family members and support persons in developing innovative strategies for ensuring children's safety while preserving family relationships. For instance, other adults might be enlisted as a supplementary support system for children of mentally ill parents (Dunn, 1993); a plan for ongoing services and monitoring (e.g., child care, family assistance) might provide the continuing support necessary for children to safely remain with a mentally ill parent, and a safety plan could be developed and implemented in case the parent experiences an acute episode. Advocacy, linkage with concrete services, and mobilization of social supports are critical.

Child welfare staff must understand that the rationing of services in the mental health system is a formidable barrier to effective and timely assessment and treatment of parents with mental illness—financially, clinically, and legally. In response, workers must take on strong advocacy roles for such parents. For example, workers may need to advocate for a mother suspected of depression: She needs a full evaluation, including a full reproductive history, data on victimization (verbal, emotional, physical trauma) and on the social context in which the woman exists, on personality style, including strengths such as coping skills (Pajer, 1995), and on measures of insight (Mullick et al., 2001). Workers can also initiate contact with the mental health agency and serve as a social network informant for a client to assist the individual in qualifying for appropriate treatment. Another critical task for child welfare practitioners is evaluating both a parent's progress in treatment and the level of risk resulting from his or her mental illness. Workers need more specialized training and experience to accurately evaluate their clients' progress. For instance, they need to be familiar with specific symptoms and be able to appraise the parents' level of risk during acute episodes.

Recommendations for System Improvement

The family-centered service perspective emphasizes that "the welfare of the child is intricately interwoven with the welfare of the family" (Tracy & Pine, 2000, p. 104). In order for mentally ill parents to have a meaningful opportunity to preserve their families, system improvements are needed. Limitations that perpetually plague the child welfare system include lack of professional training, high worker turnover, large caseloads, and lack of in-service or cross-categorical training. These challenges unduly impact families with serious mentally illnesses and must be addressed.

The tendency of human service agencies traditionally is to take a categorical approach to all problems, although risk factors do not come neatly packaged. Because the needs of our mutual clients cut across categorical lines of training, philosophy, and intervention, human service agencies must develop integrated service approaches. To accomplish this, collaboration between agencies and universities will need to be strengthened and cross-disciplinary, cross-system training provided as the basis for more effective work with clients suffering multiple stressors and involved in multiple systems (Tracy & Pine, 2000).

In addition, child welfare agencies need to become involved in the development of appropriate services to meet the needs of this population (e.g., specialized parenting programs for parents with serious mental illness, shared family care). Integrated treatment models emphasize the development of a shared value base and common priorities. Mental health and child welfare collaborators will find much common ground. Additional recommendations for cross-system collaboration include blending funding streams, creating liaisons across system boundaries, advocating for benefit preservation (such as housing when clients must enter residential treatment), and planning for treatment continuity.

Recommendations for Research

There is little research or information in the child welfare literature on working with parents with a serious mental illness. To improve practice, the differences and similarities between maltreating parents with serious mental illnesses and other maltreating parents in characteristics, and in service effectiveness must be studied. Research is also needed on how specific symptoms interact with parenting, on identification of red flags during an acute episode, on critical factors in the determination of risk. Studies of the experience of the serious mental illness client in the child welfare system could reveal what these parents found helpful. And finally, hard data on the impact of serious mental illness on case disposition, that is, investigations, dependency actions, and termination of parental rights would identify the scope of the problem.

In conclusion, parents with serious mental illnesses pose special challenges for the child welfare system. With increased understanding of their needs and treatment options, caseworkers can make real contributions to maintaining the strengths of these families. With increased cross-system collaboration, the child welfare and mental health systems can provide integrated assistance when these parents and children are most in need of intervention for both child safety and parent treatment. Without such action, these families will continue to be at a disadvantage in a one-size-fits-all climate.

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