



Best Practices for Child Welfare Investigations Involving Parents with Mental Health Concerns



For more information, please contact Sara E. Gilloon, Director of Legal Services
at The Family Defense Center.

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I. PURPOSE OF RESEARCH

In the June 27, 2016 Settlement and General Release of *L.W v. Illinois Department of Children and Family Services, et al.*, Case No. 1:13-cv-08463 (N.D. Ill.) (the “Settlement”), the parties agreed, among other things, that the Illinois Department of Children and Family Services (“DCFS”) will promulgate a Mental Health Appendix (the “Appendix”) to DCFS’s Procedure 300 “Reports of Child Abuse and Neglect.” The Appendix will provide guidance on:

1. the manner in which parents, caregivers, and household members with mental health conditions are assessed;
2. conclusions that are made as to the impact of such conditions;
3. processes for clinical consultation in cases in which a mental health condition is a factor in the outcome of the investigation; and
4. documentation by Illinois DCFS investigators of mental health conditions, including access to records by DCFS with and without parental consent.

Developed in connection with the Settlement and the creation of the Appendix, this report discusses relevant disability law issues and attempts to identify best practices and model policies related to conducting child welfare investigations where the parent under investigation has, or is alleged to have, a mental health condition. This includes the procedures for gathering and considering mental health information of the parent. This report was researched and written in coordination with pro bono attorneys from a major Chicago-area law firm.

II. EXECUTIVE SUMMARY

The research for this report revealed no model state policies for gathering, assessing, and drawing conclusions from parental mental health information in the context of a child welfare investigation. But, subject matter experts have done a good deal of research and writing related to what would comprise a model system that supports children, parents, and the family as a whole. In particular, we found that Australia is a leader in research and pilot programs aimed at creating a system that works for families dealing with parental mental illness. Moreover, common themes emerged from the various books, articles, and websites addressing this topic. Experts’ opinions on best practices are highly aligned. In addition to discussing proposed best practices, the experts identify the practical obstacles to implementing these best practices that have prevented the creation of a model system to date, although common goals have been identified by the professional community.

In Section III, we summarize the results of our research as those results relate to the first three categories, noted above, that the Appendix will address. Section III(1) focuses on the first category, assessing parents with alleged mental illnesses or mental disabilities. One common theme that emerged from our research was the need to provide an individualized assessment of the parent’s strengths and needs within the parent’s support network. Assessments should avoid stereotyping mental illness and focus instead on whether accommodations can be made that would allow the parent to adequately care for his or her child. The Americans with Disabilities Act

(“ADA”) and Section 504 of the Rehabilitation Act of 1973 (“Rehabilitation Act”) also contain provisions that are applicable in the context of a child welfare investigation. The U.S. Department of Justice (“DOJ”) has interpreted these laws to prohibit child welfare services from removing a child from a home based on a stereotypical belief, unsupported by an individualized assessment, that parents with mental illnesses, or who are alleged to have a mental illness, are unable to care for their children.

In Section III(2), we focus on conclusions made as to the impact of mental health conditions on parenting, after considering the manner in which parents, caregivers, and household members with such conditions are assessed. We found consensus amongst researchers that conclusions should not be drawn exclusively from any particular diagnosis, and that multiple contextual risk factors are better predictors of parenting behavior and child outcomes. Furthermore, experts argue that state agencies must prove a nexus between a mental health diagnosis and a behavior caused by that diagnosis that diminishes a parent’s fitness to parent. The diagnosis alone is not enough.

Section III(3) addresses processes for clinical consultation in cases in which a mental health condition is a factor in the outcome of the investigation. Processes should be family-centered, include interagency collaboration, provide ongoing availability of services, and include components for educating caseworkers, parents, and children. In a family-centered approach, caseworkers would work with families to build on strengths and address difficulties, with the goal of keeping the family together and ensuring a safe environment for the children. Related to interagency collaboration, caseworkers should work together with mental health professionals and other service providers to draw on their respective strengths to understand the needs of the family, and help the family obtain the support it needs to function effectively and be a safe environment for the children. Services should be made available on an ongoing basis to the parents to address the particular needs of the parent in order to maximize the chance of the child remaining at home safely. Lastly, the research highlighted the importance of educating caseworkers about mental illness so they have the appropriate skills to handle cases where a mental health issue is alleged or is present. Educating parents about parenting skills and children about their parent’s mental illness are also important elements to a successful process. Section III(3) concludes with additional ideas for process, such as having parents develop a parenting directive to be used when the parent is experiencing a serious deficit in his/her ability to parent, voluntary therapy for the individuals in the family alone and together, and having the State collect and evaluate certain information related to mental health issues.

III. BEST PRACTICES

1. Manner of Assessment

In this section, we summarize best practices regarding the manner in which parents, caregivers, and household members with alleged mental health conditions are assessed during the course of a child welfare investigation. The articles we reviewed stressed a common theme: assessments of parents with mental health issues should be based on an evaluation of the individual’s strengths and needs as a parent, the interests of the child, and the extent to which reasonable support services or accommodations could allow the parent to competently care for his or her child. Child welfare caseworkers should avoid basing their assessments on stereotypes or stigmas associated with a parent’s disability. To the extent possible, the assessment should be conducted in the parent’s home and larger community, and involve collaboration among the

family, mental health providers, and other support systems available to the family. Additionally, the ADA and Rehabilitation Act prohibit government agencies from discriminating based on a parent's mental illness or disability, and require agencies to consider whether reasonable accommodations could be made that would allow the parent to retain custody of the child while protecting the welfare of the child.

A. *Individualized Assessment of Parental Strengths and Needs*

In their article, *Issues in Parenting by Clients with Severe and Persistent Mental Illness: A Survey of Experts*, authors Barry Ackerson and Meenakshi Venkataraman note that assessments of parents with mental illnesses can be challenging because child welfare workers often have little expertise with severe mental illness.¹ Child welfare workers are trained to assess if a child is being mistreated and to determine whether the child should be removed from the home. Parenting assessments in these situations are often based on models that have a narrow focus, lack well-conceptualized definitions of what constitutes competent parenting as opposed to optimal parenting, and often do not distinguish between measures of parenting abilities.² The authors note that the interaction between a parent's mental health issue, the influence of their social environment, and their ability to engage in the specific tasks necessary to be a competent parent requires a comprehensive approach to assessment that has not been adequately addressed in the academic literature as of yet.³

A thorough assessment is needed in order to understand the parent's diagnosis and its effect on his or her ability to parent.

As part of our research, we contacted Ella Callow, formerly at Through the Looking Glass, a nonprofit organization that serves parents and families dealing with mental health issues. She noted that a thorough assessment is needed in order to understand the parent's diagnosis and its effect on his or her ability to parent. The Illinois DCFS should develop an appropriate intervention model for parents with mental illnesses and train its staff on what an intervention should look like if a parent is brought in with a mental health issue. In order to

understand the parent's diagnosis of mental illness, Ms. Callow proposed that DCFS caseworkers ask the following questions:

- Does the parent have a therapist?
- Does the parent have other disabilities? Are those disabilities being properly treated?
- Is the parent on prescribed medication? What are the effects of the medication? Can the negative effects be minimized? Can there be triage while the negative effects occur (e.g., time the medication so that negative effects occur while the child is in school)?

¹ Barry J. Ackerson, PhD, LCSW and Meenakshi Venkataraman, M.A., *Issues in Parenting by Clients with Severe and Persistent Mental Illness: A Survey of Experts*, *Journal of Family Social Work*, 7:1, 35-52 (2003).

² *Id.*

³ *Id.*

- Does the parent have access to his or her prescribed medication? Can he or she afford to refill the prescription? Is the medication being properly administered?

Furthermore, research we reviewed on the topic stressed that any assessment of a parent with alleged mental illness needs to involve the entire family and to be conducted, as much as possible, in the home and larger community.⁴ The assessment must evaluate the individual's strengths as a parent as well as his or her weaknesses. As researcher Theresa Glennan notes, the strengths of parents with mental illnesses are often invisible to decision-makers. Welfare workers may focus on the parent's illness and overlook the parent's ability to provide love and care to his or her child. Child welfare workers must challenge their pre-conceived notions of deficiency and adopt a family-centered approach to the assessment that evaluates the parent in the context of his or her family support system.⁵

The strengths of parents with mental illnesses are often invisible to decision-makers.

B. Avoiding Assessments based on Stigmatization of Mental Illness

Theresa Glennan notes that parents with mental illnesses often face discrimination from child welfare services based on unfair stereotypes and pre-conceived opinions regarding individuals with mental illnesses (i.e., that they are responsible for their condition, unpleasant, undeserving of sympathy or assistance, unpredictable, and dangerous). Poverty and race are additional risk factors.⁶ Such discrimination is the result of "sanism," which Ms. Glennan describes as prejudice against an individual because of a mental trait or condition the individual has (or is judged by others to have). Sanism often results in covert discrimination based on unfair assumptions or stigmas regarding mental illness that are shared widely in society, including by many in the child welfare and legal systems. Sanism is particularly damaging in the child welfare context because it may discourage parents with mental illnesses from seeking treatment, based on a fear that their capacity to parent may come under scrutiny if they seek treatment. When a parent does seek treatment, the parent often seeks to hide his or her condition from the child. The parent is treated in isolation from the family. Parenting education is often not provided in the context of treatment for mental illness, and parents receiving treatment are often separated from their children when they receive treatment.⁷

Rather than basing their assessment on stigmas attached with mental illness or trying to treat the illness in a vacuum, child welfare workers should make their assessment of the parenting strengths of a parent with mental illness in the context of a service plan that addresses the parent's individualized needs and existing support system. Jeniece Scott, in her article on supporting parents with mental illness, proposes that service plans be based on a comprehensive assessment of parental needs conducted by qualified professionals.⁸ For a parent suffering from mental illness,

⁴ Judith A. Cook, Ph.D. and Pamela Steigman M.A., *Parents with Mental Illness: Their Experiences and Service Needs*, UIC National Research and Training Center on Psychiatric Disability (2000).

⁵ Theresa Glennan, *Walking with Them: Advocating for Parents with Mental Illnesses in the Child Welfare System*, 12 Temp. Pol. & Civ. Rts. L. Rev. 273 2002-2003.

⁶ *Id.*

⁷ *Id.*

⁸ Jeniece Scott, *Supporting Parents with Psychiatric Disabilities: A Model Reunification Statute*, University of Pennsylvania Collaborative on Community Integration, <http://www.bazelon.org/LinkClick.aspx?fileticket=Kxu0I14DT-A%3D&tabid=640>.

the assessors should include a person with expertise concerning the service needs of individuals with mental illnesses, including needs related to parenting. Child welfare agencies should develop policies that provide for an independent review of child abuse investigations and neglect referrals, removal of children from the home (including re-removals after reunification), and termination of parental rights to determine whether the agency is providing equal opportunity to parents with mental illnesses and avoiding stereotypes in its work. The review may be conducted using sampling methods and should include independent citizen input, including input from advocacy groups, research institutions, nonprofit organizations, disability service organizations, and other relevant experts. Analysis of independent review results should be used to modify procedures and practices as necessary to ensure equal treatment for parents with mental illnesses.⁹

C. Application of the ADA and Rehabilitation Act

Title II of the ADA and Section 504 of the Rehabilitation Act prohibit discrimination based on mental or physical disability.¹⁰ Specifically, Title II provides:

[N]o 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, or be subjected to discrimination by any such entity.¹¹

The ADA expanded on similar language contained in the Rehabilitation Act prohibiting discrimination against, or denial of services to, individuals with disabilities. Title II and Section 504 apply to all services provided by state and local child welfare agencies, including assessments, removals, family preservation, permanency plans, reunification, guardianship, and adoption.¹² A disability is broadly defined in the ADA as any “physical or mental impairment that substantially limits one or more major life activities” of the affected individual. The protections in the ADA apply to both individuals with a record of mental or physical impairment and individuals who are merely “regarded” by others as having such impairment. To be “regarded” as having a mental or physical impairment, the individual must establish that he or she was subjected to treatment prohibited under the ADA because of an actual or perceived mental or physical impairment, regardless of whether or not the impairment limits or is perceived to limit a major life activity.¹³

The DOJ and Department of Health and Human Services (“HHS”) have interpreted the ADA and Rehabilitation Act to prohibit removing a child from a parent based on a stereotypical belief, unsupported by an individual assessment, that people with a certain disability are unable to safely parent their children.¹⁴ In an August 2015 technical assistance bulletin to child welfare

⁹ *Id.*

¹⁰ Title II of the ADA applies to public entities, which include state and local governments and their departments and agencies, such as the Illinois DCFS. 42 U.S.C. §12131(1). Section 504 of the Rehabilitation Act applies to the programs and activities of recipients of federal financial assistance, which includes most state and local child welfare agencies. 29 U.S.C. §794(b)(1)(A), (B).

¹¹ 42 U.S.C. §12132.

¹² See *Investigation of the Massachusetts Department of Children and Families by the United States Departments of Justice and Health and Human Services Pursuant to the Americans with Disabilities Act and the Rehabilitation Act* (DJ No. 204-36-216 and HHS No. 14-182176), Letter to Erin Deveny, Interim Commissioner of Massachusetts Department of Children and Families, dated January 29, 2015, at 10.

¹³ 42 U.S.C. §12102(1)-(3).

¹⁴ See *Protecting the Rights of Parents and Prospective Parents with Disabilities: Technical Assistance for State and Local Child Welfare Agencies and Courts under Title II of the Americans with Disabilities Act and Section 504*

Child welfare agencies must consider whether reasonable accommodations could be made that would allow the parent to retain custody of the child while protecting the welfare of the child.

agencies, the DOJ and HHS advised that assessments of parents with disabilities must be individualized, fact-specific inquiries that evaluate the strengths, needs, and capabilities of the parent as a caretaker.¹⁵ The assessments must be based on “actual facts that pertain to the individual person [with the disability], and not on assumptions, generalizations, fears, or stereotypes about disabilities and how they might manifest.”¹⁶ Additionally, child welfare agencies must consider whether reasonable accommodations could be made that would allow the parent to retain custody of the child while protecting the welfare of the child. The DOJ and HHS technical assistance

bulletin advises that, in order to “ensure that persons with disabilities have equal opportunity to retain or reunify with their children, it may be necessary for the agency to reasonably modify policies, practices, and procedures in child welfare proceedings.”¹⁷ Assessments of parents with mental disabilities (and service plans developed based on such assessments) should not “require parents with disabilities to accept unnecessary services or complete unnecessary tasks to prove their fitness to parent when nondisabled parents would not be required to do so.”¹⁸

In a January 29, 2015 letter to the Commissioner of the Massachusetts Department of Children and Families (“Massachusetts DCF”), the DOJ and HHS provided further guidance regarding the application of the ADA and Rehabilitation Act to assessments of parents with mental disabilities.¹⁹ The DOJ and HHS investigated whether the Massachusetts DCF discriminated against one of its clients, Sara Gordon, on the basis of her disability and denied her opportunities to benefit from supports and services, including her own existing family support structure. Ms. Gordon suffers from a cognitive developmental disorder. Two days after Ms. Gordon gave birth to her child, the Massachusetts DCF removed the child from her custody while she was still recovering from childbirth at the hospital.²⁰ The DOJ and HHS investigation found that Massachusetts DCF “failed to individually analyze Ms. Gordon to determine what services and supports were appropriate for her in an effort to prevent [her child’s] continued out-of-home placement.”²¹ In particular, the investigation criticized the Massachusetts DCF for acting on assumptions based on Ms. Gordon’s disability and for failing to consider whether appropriate support services would allow Ms. Gordon to retain custody of her child. The investigation suggested that in-home parenting classes catered to Ms. Gordon’s learning patterns would allow her to develop the skills necessary to raise her daughter. It also noted that Ms. Gordon lived with her parents, and that Ms. Gordon’s mother quit her job in order to help raise Ms. Gordon’s child. However, the Massachusetts DCF failed to assess whether Ms. Gordon’s family support system would allow her to adequately care for her child.²² By focusing on stereotypes associated with Ms. Gordon’s diagnosis rather than considering options that would allow her to retain custody of

of the Rehabilitation Act, by the U.S. Department of Health and Human Services and the U.S. Department of Justice, dated August 10, 2015.

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ Investigation, *supra* note 12.

²⁰ *Id.* at 5.

²¹ *Id.* at 11.

²² *Id.* at 16.

her child, the DOJ and HHS found that the Massachusetts DCF discriminated against Ms. Gordon in violation of the ADA and Rehabilitation Act.²³ The DOJ and HHS advised the Massachusetts DCF to immediately provide training for social workers to understand their obligation to ensure the civil rights of parents with disabilities.²⁴

2. Conclusions Child Welfare Agencies Make Regarding the Impact of Mental Health Conditions on Parenting

This section focuses on conclusions that are made as to the impact of mental health conditions on parenting, after considering the manner in which parents, caregivers, and household members with such conditions are assessed.

Researchers contend that conclusions should not be drawn exclusively from any particular diagnosis. Instead, multiple contextual risks are better predictors of parenting behavior and child outcomes, including severity of symptoms, community functioning, environmental barriers (i.e., physical, attitude, assistance, or policy barriers), poverty, an inadequate social support system, and the presence or absence of parenting knowledge and skills.²⁵ One principle in assessing risk, identified in a best interests case practice model, is that the relevance of complicating factors such as mental illness with respect to parenting behavior “is the extent to which they, singularly or in combination, diminish the capacity to provide sufficient care and protection to the child or young person.”²⁶ Ella Callow agrees with this principle of risk assessment, and contends that state agencies should have to identify and support with evidence a **nexus** between a mental health diagnosis and a behavior caused by that diagnosis that diminishes a parent’s fitness to parent. The diagnosis alone is not enough.²⁷

State agencies should have to identify and support with evidence of a nexus between a mental health diagnosis and a behavior caused by that diagnosis that diminishes a parent’s fitness to parent.

An expert advocating for modification of state laws to ensure compliance with the ADA through a model “reunification” statute argued that the disability of a parent should not constitute a basis for a determination that a child is in need of care, that the child should be removed from custody of the parent, or that parental rights should be terminated.²⁸ Such determinations should focus on whether a parent is likely to engage in conduct causing harm or risk of harm to a child, and not on a parent’s disability per se. A parent’s disability is relevant only to the extent that it results in conduct that constitutes abuse or neglect, and for purposes of identifying what preventative or reunification services the parent needs. In making the determinations, a court should consider whether all needed preventative and reunification services have been identified and provided; whether these services have been appropriately tailored to the specific needs of the

²³ *Id.* at 1.

²⁴ *Id.* at 23.

²⁵ See Ackerson & Venkataraman, *supra* note 1 (summarizing results from a survey of multiple experts on the impact of severe mental disorders on parenting abilities, important issues in conducting assessments with these families, and implications for the development of services).

²⁶ Dr. Leah Bromfield, Dr. Karen Sutherland and Robyn Parker, *Families with Multiple and Complex Needs—Best interests case practice model, Specialist practice resource* (2012), www.dhs.vic.gov.

²⁷ Discussion with Ella Callow.

²⁸ Scott, *supra* note 8.

parent, including treatment and support services needed to address limitations caused by a psychiatric disability; and whether the parent has been provided with sufficient opportunities to gain skills or correct deficiencies. The determinations should be based on current and objective evidence of whether a child is at risk of abuse or neglect, and not on unfounded assumptions based on a parent's disability or on past conduct that is not likely to recur.

Experts have found that child welfare agencies must provide "reasonable accommodations" by modifying their policies and practices to ensure that individuals with disabilities have equal opportunity to retain or reunify with their children. As an example, the DOJ and HHS technical assistance bulletin notes that agencies must consider whether accommodations, such as allowing the parent to share custody of the child with a relative or providing caregiving instructions or classes catered to the parent's disability, would allow the parent to retain custody of his or her child.²⁹ As noted above, the DOJ and HHS found that the Massachusetts DCF should have evaluated whether reasonable accommodations could be made to allow a parent with a mental illness to keep custody of her child, rather than focusing exclusively on the parent's diagnosis.³⁰

Furthermore, Susan Kerr, author of an article addressing the application of the ADA to parents with disabilities, proposes that, instead of looking at whether a parent's mental illness or disability is capable of being cured, the courts and social services agencies should look instead to whether the situation that led to the State's intervention in the parent-child relationship in the first place (i.e., the reported endangerment or neglect of the child by the parent) can be remediated through treatment or services provided by the State, the parent's family or support group, nonprofit organizations, or other resources.³¹

In the Australian context, a review of court files involving parents with disabilities suggested that State agencies develop a professional module on disabilities and parenting for the child protection worker. This should focus on empirical research on parental disability, inappropriate use of risk assessment as a proxy measure of parenting performance, and appropriate measures of identifying parenting performance. The module should also offer training on appropriate methods for identifying parents' support needs and suitable services, and supports to assist parents. Furthermore, judges and magistrates should be informed that clinical diagnoses have limitations in determining clinical outcomes.³²

3. Processes for Clinical Consultation

Having considered guidance on best practices for how parents, caregivers, and household members with mental health conditions should be assessed and how conclusions as to the impact of such conditions on parenting should be drawn, this section considers the recommendations that emerged related to an effective process for clinical consultation in cases in which a mental health condition is a factor in the outcome of a child welfare investigation. This section considers

²⁹ HHS & DOJ, *supra* note 14.

³⁰ Investigation, *supra* note 12.

³¹ Susan Kerr, *The Application of the Americans with Disabilities Act to the Termination of Parental Rights of Individuals with Mental Disabilities*, *Journal of Contemporary Health Law & Policy* Vol. 16 Issue 2 (2000). *See also*: Chris Watkins, *Beyond Status: The Americans with Disabilities Act and the Parental Rights of People Labeled Developmentally Disabled or Mentally Retarded*, *California Law Review* Vol. 83 Issue 6, December 1995.

³² Katie Kovacs, *Review: Parents with a disability and child protection matters*, *National Child Protection Clearinghouse Newsletter* Vol. 10, No. 1, Winter 2002.

recommendations regarding the implementation of internal processes within the department handling the investigation and the coordination with other service providers that were identified to be beneficial in child welfare investigations. The main recommendations are that investigations and interventions should include: (A) a family-centered approach,³³ (B) interagency collaboration,³⁴ (C) ongoing availability of services,³⁵ and (D) ongoing education of: (i) caseworkers about mental illness,³⁶ (ii) parents, including with parenting skills training, and (iii) children about their parent's mental illness. One author highlights that, while common themes can be identified from research, each family is unique and does not fit a formula for service delivery.³⁷ This section concludes with ideas for action in the long-term.

A. Family-Centered Approach

Few tools are available to educate caseworkers about issues related to mental illness and to assist them in working with parents to design a set of services to support parenting.

In the article “*Walking with Them: Advocating for Parents with Mental Illnesses in the Child Welfare System*,” author Theresa Glennan highlights that parents can fall into the gap between the mental health system, which treats individuals and doesn't focus on parenting, and the child welfare system, which judges the parent's capacity to quickly meet the needs of his or her children. Despite recognition that integrating adult mental health services and children and family services helps parents recover, protects the welfare of children, and

enhances the quality of life for the family unit, the gap between mental health work with adults, on the one hand, and child care work with children and family, on the other hand, remains difficult to bridge.³⁸ Few tools are available to educate caseworkers about issues related to mental illness and to assist them in working with parents to design a set of services to support parenting. The first step in providing “reasonable accommodation” to maintain or reunify families is to understand

³³ See, e.g., Cook & Steigman, *supra* note 4; Beth Hinden, Kathleen Biebel, Joanne Nicholson, Alexis Henry and Lawrence Stier, *Steps Toward Evidence-Based Practices for Parents with Mental Illness and their Families*, at 13 (March 15, 2002) (A study of five nonprofit organizations that focus their efforts on providing services to families in which a parent has a mental illness concluded that some of the core components of successful programs are comprehensive family case management, access to a comprehensive array of services, coordination of multiple services, facilitation across multiple providers, crisis intervention services, education about child development and parenting skills training.)

³⁴ Cook & Steigman, *supra* note 4; Vicki Cowling, *Meeting the Support Needs of Families with Dependent Children Where the Parent has a Mental Illness*, Australian Institute of Family Studies, Family Matters No. 45 Spring/Summer 1996. This is an edited version of a paper presented during the Institute's Fifth Australian Family Research Conference in Brisbane, in November 1996 (inter-agency cooperation and collaboration); Dominiek Coates, *Working with families with parental mental health and/or drug and alcohol issues where there are child protection concerns: inter-agency collaboration*, Child and Family Social Work 2015, Commonwealth of Australia, doi: 10.1111/cfs12238.

³⁵ Cook & Steigman, *supra* note 4.

³⁶ Cook & Steigman, *supra* note 4 (stigma); Cowling, *supra* note 34; Dominiek Coates and Deborah Howe, *Working with Families Who Experience Parental Mental Health and/or Drug and alcohol Problems in the Context of Child Protection Concerns: Recommendations for Service Improvement*, Central Coast Local Health District, New South Wales, Australian and New Zealand Journal of Family Therapy 2015, 36, 325-341, doi: 10.1002/anzf.1113 (working with such complex and crisis prone clients impacts negatively on staff well-being and leads to emotional exhaustion and burnout).

³⁷ Cowling, *supra* note 34, at 24.

³⁸ Jo Tunnard, *Parental mental health problems: messages from research, policy and practice*, Research in Practice, p. 6-7, (UK) (2004).

the service needs of the family members.³⁹ This requires a comprehensive assessment of: each individual's potential illnesses, strengths, and weaknesses; observations and analysis of the social, emotional, and economic supports needed by the family; and observations and analysis of what is needed to assist the parent in parenting competently and creating a safe home environment.⁴⁰

An example of one program that currently offers integrated services is the Mothers' Project in Chicago, which is offered by the organization Thresholds.⁴¹ According to the program's website, parents in this program are working to provide safe, healthy, and nurturing environments for their children, while also receiving support with mental illness, homelessness, and/or the effects of abuse, neglect, or other traumatic experiences. Most of the parents in this program are transitioning from adolescence to young adulthood. The Mothers' Project focuses on helping parents acquire independent living skills, and provides education and support to develop healthy parenting skills. The Mothers' Project has a transitional living program ("TLP") that provides a comprehensive array of services to 17–21 year-old pregnant and parenting young women with mental health challenges who are referred by the Illinois DCFS or the Department of Juvenile Justice. The TLP includes 24-hour staffed residences. Residents receive case management, individual and group therapy, Dialectical Behavior Therapy skills training, psychiatry and medication management support, parent education, certain employment and education services, and crisis intervention when needed. The Mothers' Project also maintains an Early Learning Center for children six weeks to five years old. Although this program seems to align with best practices, it is unfortunately unique.

To prevent discrimination against parents with mental illness, the authors of *Walking with Them* recommend: (1) educating all professionals in the child welfare system about parents with mental illness, (2) advocating for knowledgeable, intensive case managers that will manage a variety of services for the family and (3) identifying models of integrated services systems to meet the needs of the parents in the context of their families. Furthermore, the authors note three ways in which advocacy can take place: First, advocates for parents should contact child welfare and mental health agencies to encourage them to engage in coordinated service evaluation; it is key to have all involved become more knowledgeable about the nature of mental illnesses, the types of treatments available, and the ways in which agencies can support parents and children during treatment, recovery, or maintenance of functionality despite a chronic condition. Second, advocates should utilize the ADA to advocate for parents with mental illnesses in child welfare proceedings and, throughout the advocacy process, proactively and reactively address the negative stereotypes that most persons involved in the system have about mental illness. Finally, advocates should recognize when litigation may be required because child welfare agency mental health system personnel, as well as judges, are unsympathetic to ADA claims.⁴²

In the resource "Families with multiple and complex needs," one "complex problem" identified is mental illness of the parent. This article presents best interests case practice models and specialist practice resources. In the section on "Approaching Work with Families with Multiple and Complex Needs," the article states it is important to adopt a child-focused, whole family approach that (1) acknowledges family strengths and (2) works collaboratively with

³⁹ See Section III(1) "Manner of Assessment," *supra* for discussion of the "reasonable accommodation" standard.

⁴⁰ Glennan, *supra* note 5.

⁴¹ See <http://www.thresholds.org/our-work/youth-services/mothers-project/>.

⁴² Glennan, *supra* note 5.

multiple services. Three important parts of this approach are family group meetings, professionals' meetings, and care teams that build relationships between and across services.⁴³

In the section on "Information Gathering," the article discusses gathering information to be able to undertake a family assessment, and emphasizes engaging parents and building a relationship with the family. The goal of an assessment is to develop a sophisticated understanding of the family's functioning, gain an understanding of the factors affecting the family and its needs, develop partnerships, and prepare for intervention if necessary. The perspectives of all family members should be sought, and information from multiple sources (e.g., extended family, other professionals, and services involved with the family) should be analyzed. The comprehensive family assessment should involve gradual and sensitive exploration with the family about: (1) history and prior experience; (2) current circumstances and needs; and (3) future protective and risk factors. The article suggests constructing a genogram⁴⁴ and an eco-map to provide visual representations of the family life and key social and community links, respectively. Information about the following is particularly important to gather:

- Each parent's family of origin, experience growing up, the way they were parented, and the nature of family relationships (including the presence of violence or abuse, mental illness, or other trauma or disadvantage that is likely to affect parenting and the parent's well-being and functioning).
- Family history and current circumstances (health, employment, education, support systems, extended family, status of relationships, dynamics of the couple relationship, substance abuse, violence, mental health concerns, and other factors that could impact parenting or family functioning).
- Developmental stages of children; the parents' understanding of children's needs and ability to prioritize those needs; relationship between the parent and each child; relationship between siblings; children's health and development (emotional, behavioral, social, educational); children's connection to primary caregiver, extended family, school, community and culture; and potential sources of harm to the child.
- Parents' attitude to the children and capacity to meet children's needs and to ensure safety, stability, and opportunities for optimal development, any history of abuse, neglect or patterns of harm, parental family of origin experience.

A comprehensive family assessment should reveal why the parents are struggling to meet their children's needs. The article provides a page-long list of additional questions that should be answered by the family assessment.⁴⁵ In addition, a critical component of the assessment that can inadvertently be overlooked is gathering information on the effects of parental and family

⁴³ Bromfield et al., *supra* note 26, at 24-25. This resource is intended to be used as a supplement to the online child protection manual at <http://www.cpmanual.vic.gov.au/>. The specialist practice resources were developed to provide additional guidance on information gathering, analysis and planning, action, and reviewing outcomes in cases where specific problems or complex issues exist.

⁴⁴ See the child and family snapshot practitioner field tool for more information on genograms at: <http://www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection/specialist-practice-resources-for-child-protection-workers>.

⁴⁵ See Glennan, *supra* note 5, at 32.

problems on the child. Note that naming the problems experienced by the family is not a parenting assessment. An assessment of parenting capacity requires the caseworker to analyze and articulate how the problems and strengths in the family affect the parent-child relationship and result in children's parenting and safety needs being met or unmet.⁴⁶

In the section on "Analysis and Planning," the article begins by describing characteristics to consider when assessing risk. Attention should be given (1) to the balance of risk of harm and protective factors and (2) to strengths and difficulties in the family. Based on an examination of records relating to over 1,500 children, one study identified three important organizing principles consistently associated with occurrences and recurrences of child abuse or neglect:

1. Caregivers' prior pattern with respect to the treatment of children is the most important characteristic to consider. Behavior patterns would be expected to continue in the future in the absence of effective intervention.
2. If an individual believes he/she is correct in his/her opinions about children, he/she will attempt to continue his/her behavior so long as he/she is not prevented from doing so.
3. Complicating factors such as mental illness can be relevant to the extent they diminish the capacity to provide sufficient care and protection to the child.

A strengths-based approach is recommended that assesses the risks while building on the protective factors to increase the child's safety.

1. Both the potential for harm and for safety must be considered to achieve balanced risk assessment and risk management.
2. Strengths that increase the potential for safety are evident in even the worst case scenarios, and these are fundamental building blocks for change.
3. A constructive approach to building safety can be taken that may be different from efforts to minimize harm.
4. A strengths perspective can be actively (and safely) incorporated into what may otherwise become a "problem saturated" approach to risk assessment and risk management.

While planning intervention, the article highlights ten considerations for service providers: 1) importance of practitioner/family relationship; 2) communicating respectfully and clearly; 3) managing yourself and others; 4) role clarity; 5) planning with the family; 6) planning informed by professionals; 7) specifying "SMART"⁴⁷ goals; 8) identifying resources and supports; 9) documenting the plan; and 10) formal planning mechanisms for child practitioners. The next section, "Action," discusses how to support families and methods of effective intervention, such as partnering *with* (rather than *for*) families to plan the intervention and working in partnership with other services, such as mental health services. Lastly, the article discusses "Reviewing Outcomes" and notes that effectiveness of the plan must be constantly monitored and reviewed,

⁴⁶ See *id.* at 36.

⁴⁷ Specific, Measurable, Achievable, Related to the concerns and Timely.

and that trying several strategies or interventions will generally be required before developing an approach that works.⁴⁸

Several articles note that focusing on the family, versus treating the individual in isolation, is difficult. For one thing, interventions that focus on individual level change, or first order change, are informed by well-established evidence-based⁴⁹ practice; however, the way in which change at a system level is best achieved is less understood.⁵⁰ In addition, adult mental health workers can appear to child care workers to focus solely on their adult patients and to be overly concerned about issues of client confidentiality, which, in turn, precludes discussion of the situation with partners and other family members.⁵¹ Furthermore, adult mental health workers' lack of time and resources may play a role in their failure to create opportunities for regular discussion with families about children's needs. Moreover, adult mental health workers may hesitate to do this, because they feel unskilled in child and family work, or because they seek to protect their patients from discussing issues that might shake their confidence and add to their anxiety.⁵²

Professionals suggest a joint collaboration approach and services that have a family focus.

Professionals suggest a joint collaboration approach and services that have a family focus. During assessment, caseworkers should “think family.” Parents need to build family cohesion, services need to support the strengthening and supporting of family networkers, and, in the very long-term, there needs to be a policy shift that takes the focus *off* of “crisis, acute mental illness and child rescue” and puts the focus *on* “prevention, early intervention and family support.”⁵³

As another component of a family-centered approach, experts note that all families have strengths and weaknesses, and effective intervention should focus on the families' strengths. Focus should be on how to *help* families with issues of parental mental illness.⁵⁴ A strengths-based approach looks for what parents and children do despite problems, how they have tried to overcome their problems, and what they do well.⁵⁵ One way to do this is to identify the family's naturally occurring support systems (e.g., friends, family, church community members). The family's current support system can be built on by connecting the family with the mental health community for additional support from others dealing with similar issues.⁵⁶ A strengths-based approach explores the family's aspirations and hopes.⁵⁷ Of course, practitioners should not ignore risks or vulnerabilities in the family environment, especially where children's safety is at stake.

⁴⁸ Bromfield et al., *supra* note 26.

⁴⁹ “The rationale for achieving the goal of evidence-based practices for parents with mental illness and their families has been documented in previous work,” Hinden et al., *supra* note 33, at 13 (citing the authors' 2001 article *Critical issues for parents with mental illness and their families*).

⁵⁰ Coates & Howe, *supra* note 36.

⁵¹ Tunnard, *supra* note 38, at 45.

⁵² *Id.*

⁵³ *Id.*

⁵⁴ Discussion with Ella Callow.

⁵⁵ Bromfield et al., *supra* note 26, at 23.

⁵⁶ Discussion with Ella Callow.

⁵⁷ Bromfield et al., *supra* note 26, at 23.

Risk factors and deficits will need to be addressed at the same time that strengths, capabilities, and resources are acknowledged and built upon.⁵⁸

B. Interagency Collaboration

To achieve desirable results for children, a shift from a compartmentalized focus on risk to a more holistic view of family experience is necessary.

Another main theme that emerged in the research is the importance of interagency collaboration, where agencies and groups of professionals focus on and draw on their expertise.⁵⁹ Mental health workers and child protective workers are encouraged to collaborate to the extent possible, such as through joint trainings, information exchange processes, and implementation of structures and policies to facilitate collaboration.⁶⁰ To achieve desirable results for children, a shift from a compartmentalized focus on risk to a more holistic view of family experience is necessary.⁶¹

Interagency collaboration is valuable because it increases the capacity of service providers to respond appropriately by bridging knowledge, skills, and values across professions and departments. Barriers to collaboration can include: challenges with communication and information sharing, issues around confidentiality, inconsistency in terms of the level and style of collaboration, role ambiguity, tensions between the different theoretical paradigms that underpin practice for mental health, drug, and alcohol clinicians versus child protection workers, unrealistic expectations, and insufficient clarity around processes and expectations.⁶²

Open communication is one of the most critical aspects of effective collaboration, but the tension between clients' rights to privacy and the need for workers to have a thorough understanding of the family situation can impede the communication process. One suggestion to overcome this barrier is to formalize the consent process and establish clear protocols for information exchange.⁶³

A pilot program in Australia was conducted in which families with mental health/drug and alcohol ("MH/D&A") problems and child protection concerns participated in a collaborative partnership between child protection workers and MH/D&A clinicians (the "MH/D&A Program"). Key recommendations to improve collaboration among child protection and mental health clinicians that came from that research include: improve collaboration to improve information sharing, overcome silo ways of thinking, manage risk together and more consistently, and develop

⁵⁸ Rhys Price-Robertson, Gemma Olsen, Helen Francis, Angela Obradovic and Brad Morgan, *Supporting recovery in families affected by parental mental illness*, Australian Government, Australian Institute of Family Studies, Child Family Community Australia Practitioner Resource—August 2016, at 10.

⁵⁹ Cowling, *supra* note 34; Yvonne Darlington, Judith A. Feeney, Kylie Rixon, *Interagency collaboration between child protection and mental health services: Practices, attitudes and barriers*, Child Abuse & Neglect 29 (2005) 1085-98 (National Health and Medical Research Council of Australia).

⁶⁰ Darlington et al., *supra* note 59.

⁶¹ Bromfield et al., *supra* note 26, at 24.

⁶² Coates, *supra* note 34; Darlington et al., *supra* note 59.

⁶³ Darlington et al., *supra* note 59.

consistent processes and expectations. Further expanding on how to overcome these barriers, the article makes the following points:

- Information on what reports are being made about the families, by service providers or child protection, needs to be communicated to the families so that everyone is on the same page about what the concerns are. Regular interagency roundtable discussions, with the family present at least some of the time, are recommended.
- Because Australian mental health services and child protection services fall within different government departments with different professional views and organizational goals, silo ways of thinking can result. One suggestion is for service providers to stop viewing themselves as “experts” (which can create a “me versus you” atmosphere and lead to defensiveness of one’s viewpoints) and, instead, shift their focus from providing “expert intervention” to developing partnerships and working collaboratively.
- The article also highlights that service providers who cast child protection in a negative light, by making comments such as “we are not child protection, you can trust us,” pose a risk of underreporting out of fear of breaking trust; if it ultimately becomes necessary for the clinician to make a mandatory report, the fragile trust with families becomes broken and is difficult to regain. In addition, the language may inadvertently “stigmatize” child protection and further increase the divide between families and child protection. Using language that highlights the separation between child protection and mental health inhibits effective collaboration between those services.
- Enhanced clarity and consistency around the role of service providers and child protection can help reduce role ambiguity and enhance collaboration.⁶⁴

In addition to collaboration between child protection services and clinicians, one expert noted that open lines of communication between child protection workers and the public defenders’ office is critical.⁶⁵ Public and family defenders need to be fully informed of a family’s circumstances and the issues—mental health and otherwise—being faced by the parent.

As part of interagency collaboration, caseworkers should be skilled in identifying needs of the families and helping to connect them with appropriate service providers. Experts note that caseworkers need to observe how parents and children actually interact, and need to consider the actual disability at issue with the parent and offer tailored services. Such services could include, for example, supportive housing, supported employment, and assistance with activities such as meal planning, shopping, and managing finances.⁶⁶

C. Ongoing Availability of Services

A third theme that intersects with a family-centered approach and interagency collaboration is that families need consistent access to services. The model reunification statute developed by

⁶⁴ Coates, *supra* note 34.

⁶⁵ Discussion with Ella Callow.

⁶⁶ Jennifer Mathis, *Keeping Families Together: Preserving the Rights of Parents with Psychiatric Disabilities*, The Judge David L. Bazelon Center for Mental Health Law, <http://www.bazelon.org/LinkClick.aspx?fileticket=gsoVqDAbIUo%3D&tabid=640>.

the Bazelon Center suggests that preventative services should be provided to prevent or eliminate the need for removal of a child from the child's home due to abuse or neglect. These services should be designed specifically to address the particular needs of the parent, including, for a parent with a disability, any needs related to that disability that may affect parenting abilities, and to maximize the chance of the child remaining at home safely.⁶⁷

In that regard, it is important that, following a report of suspected abuse or neglect, Illinois DCFS investigators determine whether there is enough evidence of behavior leading to a real, significant, and imminent likelihood of harm to a child to accept a report of abuse or neglect. If it is determined that there is enough evidence, the next question should be whether there is enough for DCFS to come in and take the child. Notably, the diagnosis of a mental illness may or may not be relevant to this question. As discussed further in Section III(2) of this report, the relevant inquiry is whether there is behavior that constitutes abuse or neglect, and the presence of a mental illness alone does not inform this inquiry. Caseworkers must assess the presence of a mental illness in context. Allegation 60 in Illinois provides that mental illness may, though not by itself, create a real, significant, and imminent risk of harm “if an incident or *behavior that is symptomatic of the mental illness* creates real, significant and imminent risk of moderate to severe harm to the child's health, physical well-being or welfare, *and if the parent or caregiver has failed to exercise reasonable precautionary measures to prevent or mitigate the risk of harm to the child.*”⁶⁸ Thus, the inquiry should focus on (i) whether the mental illness causes a behavior that creates a risk of harm and (ii) whether the parent or caregiver has failed to exercise reasonable precautionary measures to prevent or mitigate the risk of harm. It is within these guidelines that investigators should assess whether the presence of the mental illness justifies action, such as removal of the child.⁶⁹

Preventative services to be considered should include a comprehensive array of services, including services that may be necessary to address a psychiatric disability, such as supportive housing, assertive community treatment, crisis services, peer supports, household management training, homemaker services, substance abuse services, and/or parenting skills training tailored to address the parent's specific needs. Preventative services might also include services provided to the child or other family members when necessary.⁷⁰ Related to the availability of services, programs are needed with counselors skilled in helping children express their feelings. In addition, peer support programs are needed for parents.⁷¹

Note, however, that the model reunification statute makes clear that preventative services should be provided to any parent whose child is at risk of removal from the home due to abuse or neglect, *unless* it is not possible, through the provision of services, to protect the child from imminent, serious harm.⁷²

Minnesota appears to be one state that offers services to parents with mental illness. In a fact sheet directed to parents with mental illnesses, the National Alliance on Mental Illnesses in

⁶⁷ Scott, *supra* note 8.

⁶⁸ 89 Ill. Adm. Code, Ch. III(1), Subch. A, Part 300, Allegation # 60 (emphasis added).

⁶⁹ Discussion with Ella Callow.

⁷⁰ Scott, *supra* note 8.

⁷¹ Cowling, *supra* note 34.

⁷² Scott, *supra* note 8.

Minnesota describes a potential intervention by the Minnesota child protection system.⁷³ The fact sheet explains that the first step after the child protection agency has been contacted regarding possible abuse or neglect of a child is an assessment. An assessment is conducted when less serious types of abuse and neglect are reported. If the information gathered by child protection indicates signs of abuse or neglect, services are offered to the family based on its needs. The family is required to participate in the assessment, but it can choose not to participate in the services. If the family chooses to participate in services, the family and the caseworker together develop a “case plan” that will help the family obtain health care, transportation, housing, parenting classes, skill building classes, services to address barriers or stressors in the parent’s life, and support from relatives. The fact sheet notes that parents can get the help they need without their child being removed, as long as the child remains safe. If the family chooses not to participate in the services, another report may be made by child protection, which could result in an investigation. A caseworker will do an investigation if there is a report of very serious abuse or neglect and a belief that the child is not safe. The fact sheet contains a section on “telling child protection about your mental illness” and highlights the pros and cons of telling the caseworker about the parent’s mental illness. Pros include that the worker gains a better understanding of the parent’s situation and can connect them to mental health treatment or services. Cons are that the worker may not have training on mental illness and may not understand the needs of a family that has a parent with mental illness.

D. Education

Caseworkers should have a background of working with mental health issues to ensure they have the appropriate skills to handle these complex cases.⁷⁴ In addition, to ensure the family is connected with appropriate service providers, professionals need to be educated and provided with appropriate resources so they feel more confident working with parents with mental illness and speaking with children.⁷⁵

For example, caseworkers should understand that a range of factors can trigger the onset and continuation of the mental illness, that a vast majority of parents do not neglect or harm children simply as a consequence of mental illness, and that mental health problems may result in fluctuations in parenting that can be accommodated by flexible service responses.⁷⁶ If caseworkers aren’t educated about mental illness, they may draw on negative perceptions of individuals with mental illnesses and, as a consequence, may be more apt to focus on developing cases for termination than aiding the efforts of parents with mental illnesses to retain or regain custody of their children.⁷⁷ In one survey, service providers identified their own need for information and increased understanding about mental illness, particularly in relation to the implications for child protection.⁷⁸

Working with highly complex families can lead to constant crisis management rather than working to achieve attainable, specific, prioritized goals.

⁷³ *Parenting with Mental Illness in the Minnesota Child Protection System*, Fact Sheet, National Alliance on Mental Illness-Minnesota, available at www.namihelps.org/Parents-with-MI-Factsheet-Revised.pdf (April 2015) (“Minnesota Fact Sheet”).

⁷⁴ Discussion with Ella Callow.

⁷⁵ Cowling, *supra* note 34.

⁷⁶ Tunnard, *supra* note 38, at 44.

⁷⁷ Glennan, *supra* note 5.

⁷⁸ Cowling, *supra* note 34.

Related to the education of caseworkers is understanding and addressing the challenges faced by case workers. Working with highly complex families can lead to constant crisis management rather than working to achieve attainable, specific, prioritized goals. Working under these conditions can be emotionally exhausting for caseworkers, and it can lead to burn-out.⁷⁹ Although the emotional exhaustion and sense of burn-out are primarily due to the complexity of the client group, caseworkers in the MH/D&A Program identified that changes could be made to better support staff well-being and protect staff from burnout.⁸⁰ Recall that the MH/D&A Program is a collaborate program where child protection workers and MH/D&A clinicians work together with families dealing with mental health issues. Although the context of this program is different from an Illinois DCFS investigation, the challenges faced by the caseworkers and clinicians, and their suggestions for improvement, may be equally applicable to Illinois DCFS or other states' child welfare agency caseworkers.

The staff identified four factors that could protect staff from burnout: consistency and direction from management, a sense of achievement, using professional skills and strengths, and more success stories. First, regular supervision that promotes self-reflective practice, enhances therapeutic outcomes, and supports staff well-being are essential. Effective supervision equips workers with the self-awareness needed to recognize the push and pull of opposing family members and to avoid possible emotional alliances. Job clarity and clear direction are also key to staff well-being. Second, workers needed a sense of achievement. The staff suggested a service model that is not driven by crisis but is goal-focused, with achievable outcomes. Processes are needed that assist workers in identifying key priorities and realistic treatment goals. Third, workers want the opportunity to draw on specific skills and strengths rather than having to be "everything for everyone." They argued that a number of clinicians should be allocated to each family based on skills and experience. Allocating based on strengths and skills supports workers' professional identities, and enhances their capacity to work with the family to meet identified priorities and goals.⁸¹ The last suggestion to protect staff from burnout is to find ways to measure successes in a tangible way so that workers achieve a greater sense of having made a "win." The lack of tangible wins can be demoralizing for workers.

Regarding educating parents, parents with mental illnesses may need parenting classes and other services that are specifically geared toward their needs and abilities.⁸² Most parenting classes are not geared toward the needs of parents with mental illnesses, which can lead parents to become disengaged and drop out.⁸³ Parenting classes are only one tool; they should be integrated with other services that parents and family members are receiving. Although parents with mental illness, like other parents, may benefit from seeking help, parents with mental illness may avoid seeking help and support because they fear that by asking for help they will be seen as not coping and that their children will be removed by child protection authorities.⁸⁴ There is also a prevailing view that asking for help seems like failure and indicates the parent is not independent and in control.⁸⁵ Caseworkers should collaborate with mental health agencies to offer appropriate services to

⁷⁹ Coates & Howe, *supra* note 36 ("working with such complex and crisis prone clients impacts negatively on staff wellbeing and leads to emotional exhaustion and burnout").

⁸⁰ Coates & Howe, *supra* note 36, at 329.

⁸¹ Coates & Howe, *supra* note 36.

⁸² Glennan, *supra* note 5, at 297.

⁸³ *Id.*

⁸⁴ Cowling, *supra* note 34, at 23.

⁸⁵ *Id.*

parents for parenting and working with children.⁸⁶ By supporting parents through partnerships with programs like the Mothers' Project at Thresholds, discussed in Section III(3)(A), the Illinois DCFS could put itself in a position to be a trusted partner to parents.

Many of the resources we reviewed emphasized the importance of involving and educating children who have a parent with a mental illness and/or are involved in a child welfare investigation. For example, Australia has developed a web site for "Children and Parents with a Mental Illness."⁸⁷ The web site is designed with children-friendly navigation, Q&A for "kids and young people," and age-appropriate resources. In addition, several articles promoted programs that educate children and help them express feelings.⁸⁸ Children who lack information about their parent's mental illness may interpret their parent's behavior through their own limited, often-inaccurate understanding, which may be far worse than what is actually the case. This can lead to the child experiencing distress or confusion.⁸⁹ Research shows that children can benefit from understanding their parent's mental health problems, particularly the causes, symptoms, and treatments.⁹⁰ Helping children to understand the nature of their parent's illness can provide reassurance and allay fears.⁹¹ Moreover, studies have reported that children have fewer emotional and behavioral problems if they use strategies to accept or adapt to the stress of parental depression.⁹²

E. Long-Term Plan

Parenting Directives

Another approach to working with families where there is a parent with a mental health concern is to implement a "parenting directive," if and when appropriate.⁹³ In creating a parenting directive, the caseworker would work with the family to develop a written plan for what to do when a parent's mental illness leads to a serious deficit in the parent's performance. The parenting directive would outline who should care for the child when the parent cannot do so. That person should sign the directive and agree to the plan. The plan would provide very specific and comprehensive information about the child (name, social security number, teacher, school, doctor, coaches' names/phone numbers, pets, etc.). The plan might also include signs that the parent, child, or others can identify that, when present, mean the child should be put in the previously determined alternate setting.

Indeed, the Minnesota Child Protection System ("MCPS") currently suggests to parents with a mental illness that one strategy for keeping your child at home is to prepare something similar, which the MCPA calls a "Crisis Plan" or an "Advance Psychiatric Healthcare Directive."⁹⁴ The MCPS states that a "mental health crisis plan" is a written plan to handle symptoms and help

⁸⁶ Mathis, *Keeping Families Together: Preserving the Rights of Parents with Psychiatric Disabilities*.

⁸⁷ copmi.net.au.

⁸⁸ Cowling, *supra* note 34.

⁸⁹ Parent Psychiatric Disorder, *Distressed Parents and their Families*, Third Edition 2015, Chapter 19 "Helping children understand their parent's mental illness," at 105.

⁹⁰ Tunnard, *supra* note 38.

⁹¹ *Id.* at 60.

⁹² *Id.* at 49.

⁹³ Discussion with Ella Callow.

⁹⁴ Minnesota Fact Sheet, *supra* note 73.

prepare for a crisis. They suggest that this shows the caseworker that the parent is prepared for a mental health emergency.⁹⁵ In addition, the MCPS has prepared an Advance Psychiatric Directive and Healthcare Directive Form, complete with instructions and Q&A on why to use the form.⁹⁶

Therapy

In one expert's opinion, anyone dealing with child custody would benefit from voluntarily seeking therapy, because involvement with child custody proceedings is one of the most traumatic experiences a parent can encounter.⁹⁷ If therapy is mandated, it should be goal-oriented and designed to address a specific problem. The professionals and the family should consider parent-child therapy. As noted above, communication within the family and the child's understanding of the mental illness are important building blocks in a successful plan.

State Data Collection and Practice Reforms

Another suggestion for long-term action is that the Illinois DCFS should begin to screen the population, and collect and store information on mental health illness or disability in a state data collection system. For example, how many investigations are based on Illinois Allegation 60, and what are the details of such investigations and their outcomes? These characteristics should be collected and provided to a third party to determine how many parents need services related to a mental health condition. With this information, the State would be able to provide appropriate resources to address the needs of parents with mental health issues. In addition, as noted above, the first step in providing the required "reasonable accommodations" that would allow the parent to retain custody of the child while protecting the welfare of the child is to understand the service needs of parents with a mental health condition.⁹⁸ If the Illinois DCFS began to systematically gather and assess this information, it could begin to put these services in place to provide reasonable accommodations to families dealing with a parent who has a mental health condition.

* * * *

⁹⁵ The Crisis Plan would include (1) signs and symptoms of a mental health crisis, (2) phone numbers of primary doctors, therapists and psychiatrists, (3) a list of current medications and (4) a list of friends and family members who can temporarily care for your child. Minnesota Fact Sheet, *supra* note 73.

⁹⁶ A link to the form can be found here under the heading "Advanced Psychiatric & Health Care Directives (Minnesota)": <http://www.namihelps.org/support/supportive-links.html>.

⁹⁷ Discussion with Ella Callow; *see also* Tunnard, *supra* note 38, at 47 ("Therapy may be needed, as well as opportunities to develop confidence and self-esteem, and the practical and emotional support that can help [the parent] cope better.").

⁹⁸ Discussion with Ella Callow.

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