

Running head: PARENTS WITH MENTAL ILLNESS

Parents with Mental Illness and the
Child Protection System
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Mental illness poses a significant problem in this country. The surgeon general estimates that 21% of all adults suffer from some form of mental illness (Oyserman, Bybee, Mowbray & MacFarlane, 1998). However, only one-third of those with mental illness has a diagnosis and receives treatment. The remaining two-thirds go undiagnosed and untreated (Oyserman, Bybee, Mowbray & MacFarlane, 1998). Stigma, lack of education and medical access all contribute to individuals not seeking help (Ackerson, 2003).

In the past, the majority of adults with diagnoses of significant mental illness were institutionalized and in many ways forgotten by the rest of society. After the deinstitutionalization movement of the 1970's, most of these adults were returned to their communities. Though this proved a great advance for recognizing the ability of those with mental illness to function and live full lives outside of institutions, it also led to several adjustment problems. New programs and treatment modalities had to be established to offer these people the needed support to succeed in the community setting (Cogan, 1998).

Psychosocial rehabilitation programs provided this needed community-based support. Researchers and those treating mental illness have spent a significant amount of time and resources to address vocational issues and familial stress for mentally ill adults and their families of origin (Oyserman & Mowbray, 1994). They did not, however, spend the same time and resources addressing issues around parenting for these individuals. They assumed that taking a "one size fits all" approach focusing on the needs for employment and dealing with siblings and parents would suffice. They did

little to address parenting needs, cultural issues or socioeconomic status of the mentally ill (Ackerson, 2003; Nicholson and Biebel, 2002; Oyserman & Mowbray; 1994; Nicholson & Branch, 1994). Many with mental illness are not receiving treatment at all; those receiving treatment do not often get their needs addressed holistically in the system. This lack of sufficient services also contributes to more parents with mental illness being involved in the child protection system. Once part of that system, parents with mental illness may not have access to service plans addressing the unique needs associated with their illnesses. This could lead to some parents losing custody of their children (Ackerson, 2003).

This study attempts to address gaps in the research regarding parents with mental illness for one specific agency- the child protection unit of St. Louis County, Minnesota. It will assess the prevalence of mental illness for parents in child protection cases. It will also look at the types of assessment used to ascertain the needs and strengths of parents with mental illness. The study will ask what specific services these parents receive for their mental illnesses and assess if these services also meet their unique parenting issues. Finally, it will look at the level of coordination between child protection services and mental health services in the community.

Literature Review

Parents with mental illness. In reality, women with mental illness are equally as likely to have children as women without mental illness (Ackerson, 2003; Nicholson and Biebel, 2002; Oyserman & Mowbray, 1994; Nicholson & Branch, 1994 and Oyserman et al, 2002). They identify parenting as giving meaning and a sense of normalcy to their lives (Bassett, Lampe & Lloyd, 1999). Many women choose to be parents and do not see

their mental illnesses as blocking that ability. Mentally ill women who parent function better than women who do not parent but receive the same level of mental health care. However, very little research has addressed the parenting needs and development of parenting competencies for mentally ill parents. They are also at greater risk for losing custody of their children (Ackerson, 2003).

When in treatment, mentally ill mothers are expected to fit into the male focused treatment paradigms of non-parents described above (Cogan, 1998). The system does not treat them as parents and ignores this aspect of their lives and personhood. A national survey by Nicholson and Branch (1994) found that only two states included parenting needs in their assessments of adults with mental illness. Though this may have improved some over the last ten years, no current research is available to check for progress in this area. Nicholson and Branch (1994) also identified a huge gap in programming for mentally ill mothers. They are not given education on development or reproductive issues. Some treatment programs go so far as to discourage mentally ill women from having children due the misconception they cannot possibly parent adequately (Sands, 1995). Only one-third of states monitor parenting status of mentally ill patients in their care (Blanch, Nicholson & Purcell, 1994). These findings provide evidence that the system has not accepted mentally ill people's rights and desires to become parents.

The qualitative research with mentally ill mothers also suggests gaps in available services from the perspective of the mothers. In Bassett, Lampe and Lloyd's (1999) study of mentally ill mothers, the mothers indicated they wished the mental health system would acknowledge their status as parents. Only 20% of respondents felt their treatment addressed their parenting needs. They also felt they needed assistance with the trauma

for them and their children around hospitalization, parenting programs specifically geared to their unique needs, links with community agencies and added support in the community. These mothers also identified the lack of education for their family members and the greater community about their illnesses. Another qualitative study by Sands (1995) elicited similar concerns with mentally ill mothers strongly echoing the need for the mental health system to acknowledge their parent status.

Effects of parental mental illness on children. Despite the lack of research and treatment options for mothers with mental illness, several past studies have looked at how parental mental illness might lead to child pathology. Some studies suggest mental illness can and does have a profound effect on children. Generally, children of parents with mental illness may have more behavior problems and lessened cognitive, social and attentional performance (Sands, 1995). They also have a greater risk for mental health problems (Oyserman, Bybee, Mowbray & MacFarlane, 1998). Abusive parents tend to have greater psychopathology, and researchers have found a link between mood disorders and child maltreatment. In a study of child abuse cases, 52.4% listed mental illness of one or both parents as a risk factor (Walsh, MacMillan & Jamieson, 2002). All of these findings indicate the presence of psychopathology provides a better predictor of problems than a simple diagnosis (Lee and Gotlib, 1989).

The parenting problems of mentally ill parents also differ by both the diagnosis and severity and chronicity of the illness. Depressed mothers have a higher rate of filicide and neonaticide. They also tend “to be more negative, less encouraging and more punitive in their parenting.” (Oyserman, Bybee, Mowbray & MacFarlane, 1998). Anxiety disorders, antisocial behavior, personality disorder and dissociative

symptomatology are more common among parents who abuse their children. Children of bipolar parents tend to have greater incidence of affective disturbance than parents without or with other mental illnesses. In all cases, the negative effects vary by the severity and chronicity of the illness, with increased relapses and severity of symptoms correlated with greater problems for the children (Lee & Gotlib, 1989).

However, more recent studies claim the effects of parental mental illness on children are less definitive and mitigated by several other factors. Oyserman, Bybee, Mowbray and MacFarlane (1998) found many women with mental illness are able to parent their children effectively. However, in this study, they did identify mental illness as a significant risk factor for children. There is an increased risk for sexual and physical abuse for children with mentally ill parents. However, it remains unclear whether this risk is due to parents committing such abuse or due to the increased vulnerability of a child whose parents are not as attentive to his or her needs. Several factors mediate this risk including the presence of a caregiver without mental illness, the severity of the illness and/or presence of a support network. In fact, the majority of children of parents with mental illness in this study (52.5%) did not have any issues with abuse or neglect. The risk of parenting for mentally ill parents may be attributable to other factors such as poverty, low educational attainment and lack of social supports. No causal links have been established, though all of these factors are linked to maternal mental illness in general.

One cannot make an automatic assumption that mental illness leads to poor parenting or children at risk (Azar, Lauretti & Loding, 1998). Previous research suggests a particular diagnosis or the presence of psychopathology may predict outcomes for the

health and well-being of children. However, Sands (1995) suggests that quality of parenting (regardless of the presence of mental illness) provides a better predictor of outcome than either of these conditions. The interaction between parenting and a particular diagnosis proves complex. One cannot make cause and effect hypothesis of how one does or not affect the other (Azar, Lauretti & Loding, 1998). Mental illness and parenting must be seen from a multifactorial perspective analyzing both additional risk and protective factors that add or detract from a mentally ill parent's quality of parenting (Jacobsen, Miller & Kirkwood, 1997). If most children of a parent with mental illness do not suffer from abuse or pathology, then a diagnosis or psychopathology alone cannot be seen as leading to problems for children. Research needs to expand its scope to focus more on what those additional protective and risk factors are and how to best increase those protective factors and decrease the risk to best meet the needs of these parents.

Parents with mental illness and the child protection system. Unfortunately, the child protection system does not operate from the perspective described above. In many states, a diagnosis of parental mental illness in a child protection matter puts the case on a faster track for the termination of parental rights (Ackerson, 2003; Nicholson & Biebel, 2002). Incompetent parenting attributed to mental illness proves one of the most common grounds for termination of parental rights (Sackett, 1991 in Ackerson, 2003). Those involved in the child protection system tend to have biases assuming the lack of parenting competency and potential for change with parents who have a mental illness despite ample research suggesting otherwise (Azar, Lauretti & Loding, 1998; Jacobsen, Miller & Kirkwood, 1997). Child protection workers tend to be under trained in the area of mental health and thus seek guidance elsewhere (Jacobsen, Miller & Kirkwood, 1997; Ackerson,

2003). They send parents to mental health professionals who have little or no training in the area of child protection (Budd, Poindexter, Felix & Naik-Polan, 2001). The lack of coordination and understanding between mental health professionals and child protection personnel can have dire consequences for parents with mental illness. They may not be assessed appropriately for the risk factors that got them into the system. They may lose their children due to treatment plans not meeting their actual needs or a treatment system not set-up to address their parenting issues (Budd, Poindexter, Felix & Naik-Polan, 2001).

The safety of children and family preservation provide the two main goals of the child protection system. Research suggests children fare best when they can be raised with their biological families. When that is not possible, the guidelines of the adoption and Safe Families Act require children have permanent homes within six months to a year depending on their ages (Pecora, Whittaker, Maluccio & Barth, 2000). Children of parents with mental illnesses are at risk on several levels. Some may experience the negative consequences described above due to the effects of their parent's mental illness. Others may end up in out-of-placement due to maltreatment or neglect issues with their caregiver's mental illness as a contributing factor. The lack of effective assessments, treatment and coordination of services may block the children's return to their homes. The primary goal is safety of the child. In cases where the factors leading to the maltreatment cannot be rectified, they should have alternative placements. However, the system should be better equipped to meet the needs of mentally ill parents to preserve their families and best meet the needs of these children.

The child protection system often refers parents to the mental health system for assessments of their parenting competency. However, the assessments done in the mental health system rarely address actual parenting ability (Ackerson, 2003). Instead, they focus on personality, intelligence and academic functioning (Budd, Poindexter, Felix & Naik-Polan, 2001). Research does not indicate any of these factors actually affect quality of parenting for a mentally ill parent. When specific parenting needs are addressed, they are compared with optimal parental functioning rather than a competent or minimally acceptable level of skill (Ackerson, 2003; Budd, Poindexter, Felix & Naik-Polan, 2001; Azar, Lauretti & Loding, 1998; Jacobsen, Miller & Kirkwood, 1997). Few parents operate at an optimal level most of the time, and a more reasonable measure would assess for minimum parent functioning. Existing assessments have been developed according to white, middle class standards and do not allow for cultural or community differences in parenting standards and practices (Azar, Lauretti & Loding, 1998; Jacobsen, Miller & Kirkwood, 1997). Current assessments ignore the research suggesting the importance of contextual factors in parenting (Ackerson, 2003; Azar, Lauretti & Loding, 1998; Ackerson, 2003). Most importantly, none of these assessments are designed to address the specific issues that led to these parents getting into the child protection system (Budd, Poindexter, Felix & Naik-Polan, 2001; Azar, Lauretti & Loding, 1998).

Required changes in the child protection and mental health systems. Mental health and parenting assessments of parents in the child protection system need to change significantly to best meet the needs of the process and of parents. Foremost, they need to address the legal issues pertinent to the case (Budd, Poindexter, Felix & Naik-Polan, 2001). They should address what parenting skills were compromised in the past and

assess the risk for parenting problems associated with those skills continuing in the future (Azar, Lauretti & Loding, 1998). They should also indicate any treatment needs around alleviating those risks. Parenting assessments should include additional risk factors in the family and surrounding system as well as strengths and current parenting competencies (Budd, Poindexter, Felix & Naik-Polan, 2001; Nicholson & Branch, 1994). Contextual factors identified in the research must be added to the assessment process including social supports, severity of illness, frequency of relapses, economic issues, parenting modeled for parent during their youth (Ackerson, 2003), needs of a particular child in a particular context, history of previous child protection concerns (Azar, Lauretti & Loding, 1998) and an ability to handle interpersonal demands of parenting (Ackerson, 2003). Those completing the assessment should be independent of the court process and not use the unethical, one-size fits all strategy for a parenting competency assessment (Jacobsen, Miller & Kirkwood, 1997). Unfortunately, as described above, the system may not be prepared to meet the unique treatment needs of mentally ill adults when such a comprehensive assessment is available.

These changes in assessments and treatment planning will start to alleviate the undo burden on mentally ill mothers and their children in the child protection system. However, it requires much better coordination and education for all members of the child protection process (judges, social workers, guardian ad litem, attorneys, etc.) and the mental health system (Blanch, Nicholson & Purcell, 1994). Much work must be done to remove the stigma and assumptions around mental illness and parenting. Laws in states fast-tracking these cases must be changed. The mental health system must do more to address parenting needs. The child protection system must view mental illness as simply

a risk factor among other risk factors and focus on strengths and competencies that alleviate such risk. Without such changes, some parents might not seek needed treatment for fear of coming to the attention of the child welfare system and losing their children (Ackerson, 2003). Equally troubling, some may lose their children (and the children their biological parents) despite their potential for adequate parenting with the appropriate support.

There are progressive programs and researchers attempting to better meet the needs of mothers with mental illness and their children. These programs and supporting research recognize the unique needs of mentally ill mothers as well as their potential for being competent parents. Ackerson, (2003) indicates that mentally ill parents need early intervention to help divert potential parenting problems before they start. This should include comprehensive, integrated home-based services. One hospital in England had a specific unit for mothers with mental illness and their children. This allows for coordinated services as well as preserving the important early bonding of mother and child (Oyserman & Mowbray, 1994).

Other needed services include education for mothers on the specific developmental needs of their children as they grow. This gets back to assessments determining whether a parent can adequately parent a particular child at a particular time. Children's needs change and parents may need support and education in recognizing and attending to those changing needs. They also need basic assistance with skill development for both parenting and managing the symptoms of their particular illness (Nicholson & Branch, 1994). They may also require assistance for meeting basic needs like housing and child-care. Social services could provide respite care for these parents

when their illnesses become more acute or they simply need a break. Finally, adequate support networks provide powerful positive mitigating factors for mental illness and services should assist with building and maintaining those connections (Nicholson and Biebel, 2002; Bassett, Lampe & Lloyd, 1999).

In addition to programmatic changes, research should assess more specifically how decisions are being made in the child protection system around mental illness and how treatment plans address the mental health needs of parents. Research should focus on child protection workers' competencies for dealing with mental health issues and how they view mental illness in relation to child protection needs.

Agency context. This study will take place at the St. Louis County Social Services Department. St. Louis County is a large county in Minnesota covering 457,395 square miles and stretching from the city of Duluth north to the Canada border. The social services are divided into the southern and northern portions of the county. This study will look at the southern, more metropolitan portion. This area has more available services for serving mental health needs. The St. Louis County Social Services Children and Families division employs 19 on-going child protection workers as well as an initial intervention unit and prevention services. This study will survey a sample of the on-going protection workers regarding their caseloads and the prevalence of mental illness as well as the services available to those clients.

Significance of Topic to the Social Work Profession

The Social Work Code of Ethics dictates that social workers should promote “human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and

living in poverty.” (Social Work Code of Ethics, 1999). Two of the core values for social work include the dignity and worth of the person and the promotion of social justice. This study will address those key issues for social workers serving people with mental illness. They may be vulnerable to losing their rights as parents or may simply need assistance in building their parenting capacities. Social workers must recognize the worth of potential of parents with mental illness to parent their children effectively and promote a system that improves their chances of doing so. The Code also dictates a client’s right to self-determination. The systems and social workers within them must recognize and acknowledge a person with mental illness has the right to become a parent. This study will assess how common mental illness is as a risk factor for parents in the child protection system and how well the child protection and mental health systems are meeting the needs of parents with mental illness and their families.

Pecora, Whittaker, Maluccio and Barth (2000) discuss multiple general problems for workers in the child protection system including lack of training, excessive caseloads and lack of supervision. Many people holding these positions do not hold social work degrees. Many do not have adequate training to address the myriad of needs their clients may have. These issues require workers be able to adequately coordinate with other professionals to meet the needs of their clients. This study will examine how well workers and their clients are able to access mental health services.

Research Questions

- 1- What is the prevalence of parental mental illness in child protection cases for St. Louis County?

- 2- To what extent are parents with mental illness involved in the child protection system receiving mental health treatment and/or case management addressing their parenting needs?
- 3- To what extent do child protection workers feel they are able to coordinate with the mental health system to best meet parenting needs?

Methods

Population and Sample

The population for this study includes all case records for active child protection cases at St. Louis County Social Services during the second quarter (April, May and June of 2004) and all workers employed in the agency as on-going child protection workers. From those case records, we will take a random sample of 50 cases. The workers assigned to those cases will be surveyed about the selected cases and their personal knowledge of the topic.

Research Design

This is an exploratory study of the prevalence of mental health issues for caregivers in child protection cases, the types and extent of services they receive and the perceived level of coordination between the child protection and mental health systems. These issues will be investigated using both quantitative and qualitative methods. The quantitative portion will include a questionnaire of four items assessing the prevalence and perceived prevalence of mental illness in a sample of child protection cases. It will also assess the prevalence and kind of treatment received by those parents who do have mental illness. Finally, it will have a series of ten questions with Likert type scales

asking child protection workers to rate how effective/useful the services for clients are and how confident they are coordinating with the mental health system.

The second section of the study will involve a qualitative portion including interviews of child protection workers. They will be asked questions according to an interview schedule asking them to elaborate on the issues described above.

Operational Definitions

Diagnosis of mental illness: Mental illness includes any diagnosis determined by a mental health professional according to the criteria of the American Psychological Association's Diagnostic and Statistical Manual.

On-going child protection worker: A practitioner employed to provide case management to families in the child protection system. These services include efforts to reunite families with children in foster care or to find permanent alternative homes for those children through the provision of case planning, services and permanency planning for those families. Permanency planning includes finding alternative permanent homes for the children who are able to meet the children's needs or permanently reunifying children with their families.

On-going child protection case: A case involving a family where maltreatment (abuse or neglect) has been determined and the need for on-going services has been determined.

Primary caregivers: A mother, father, stepparent, other relative or guardian who has the majority of responsibility of meeting the needs of a child/children in a child protection case. The primary caregivers will be pre-determined by the social workers involved in the case.

Child protection system: The system used to address issues of maltreatment and neglect of children through assessment and case management services.

Rule 79 case management: Client has been assigned an adult mental health case manager by social services to provide on-going support for the needs of a person with mental illness.

Mental health treatment: Includes individual and group counseling, psychiatric services including medication management

Data Collection

The data was collected from questionnaires (see appendix A) distributed to the selected on-going child protection workers. It includes demographic information for the primary caregiver of each selected case with mostly nominal level data such as age of caregiver, number of children and ethnic background. The questionnaires provide nominal data about the diagnoses, symptoms and treatment received for caregivers of selected cases. They will also provide interval level data through a series of likert-type scales. Finally, the qualitative data will be narrative responses from brief interviews with the selected child protection workers (see appendix B for interview schedule).

Data Analysis

The qualitative data was be coded and reported according to the themes that emerge from the data coding and analysis process. The quantitative data will be analyzed with a series of descriptive statistics calculated using SPSS. The overall prevalence was calculated for percentage of cases with an actual diagnosis of caregiver mental illness, percentage of cases with no diagnosis but a worker suspected mental health issue and a total percentage of cases with either a diagnosis or a worker suspected mental health

problem. Similar percentages were calculated for the number of parents receiving either Rule 79 case management through the county and other mental health services. The likert type scales will be analyzed with frequencies, percentages and means of responses. The qualitative portion will be analyzed by looking for themes that emerge from responses.

Ethical Considerations

The researcher will follow all NASW guidelines for ethical research with this study. This study does not directly survey any clients. However, it will involve looking at their personal diagnoses of mental illness and services received. This writer will have that information and that could be an intrusion. However, no one but this researcher will have access to the names associated with cases and will keep all data confidential.

This study only assesses workers at one agency at one particular time. It is an exploratory study designed to being the investigation of these issues. It should not be generalized to the greater population. Until further research is conducted to elaborate on these findings, it should not be used to inform policy decisions.

Results

Sampled child protection cases

Of the 48 cases in the sample, 24 had a diagnosis of mental illness for the primary caregiver. Child protection workers suspected mental illness in an additional seven cases. Of the all cases sampled, 31 of 48 or 67% had a diagnosis or suspected mental illness. Four of the cases had both a diagnosis of mental illness and the worker further suspected additional mental health issues existed. (see Table A?).

Of the 24 cases with a diagnosis of mental illness, five receive Rule 79 case management (21%) through the county system. Seventeen of the 24 receive other mental health services in the community. Three cases received both mental health services in the community and Rule 79 case management. In total, 21 of the 24 cases with a diagnosis of mental illness or 79% received mental health services of some kind. Of the additional seven cases where there was suspected mental illness, none receive Rule 79 case management and four (57%) receive other mental health services. In total, of the 31 cases with either a diagnosis or suspected mental illness, 25 or 81% receive some kind of mental health services.

Workers also indicated what kind of community mental health services the client received. Three of the 25 indicated they specifically received parenting services (either a mom's group or family services). An additional seven received unspecified services through the two agencies in town that offer parenting services. They did not specify if they were in fact receiving parenting services. The other fifteen did not receive services specific to their parenting needs.

25 of the 47 cases had a white primary caregiver. Twelve of those 25 had a diagnosis of mental illness. An additional three had suspected mental illness. In total, 28 or 60% of white primary caregivers had either a diagnosis or suspected mental illness. Sixteen of the 48 cases had an American Indian primary caregiver. Ten of those sixteen had a diagnosis of mental illness. Three of the remaining six had suspected mental illness. In total, 13 of 16 or 81% of American Indian primary caregivers had either a diagnosis or suspected mental illness.

Child protection worker survey

The following table shows the results of the child protection worker survey. Workers rated the degree to which they agreed or disagreed with the statement listed on a scale including five options: strongly disagree, disagree, undecided, agree and strongly agree. The table lists what percentage of the 16 workers disagreed (includes both strongly disagreed and disagreed responses), were undecided and agreed (includes both agreed and strongly agreed responses) with the statement. Due to the small sample size, the results were simplified into these three categories.

Table 1: Worker Survey Results

Statement	Responses N=16		
	% disagree	%undecided	%Agree
I am confident that the mental health system can address parenting needs in mental health assessments of caregivers for families on my caseload.	56%	31%	13%
I am satisfied with the level of coordination between my case management and Rule 79 case management services to meet the needs of parents in child protection cases.	44%	25%	31%
I am satisfied with the level of coordination between my case management and mental health services in the community to meet the needs of parents in child protection cases.	62%	13%	25%
I am confident that the level of coordination between my case management and Rule 79 case management best meets the needs of children of parents with mental illness on my caseload.	31%	50%	19%
I am confident that the level of coordination between my case management and mental health services in the community best meets the needs of children of parents with mental illness on my caseload.	56%	25%	19%
I am confident in my ability to meet the parenting needs of parents with mental illness on my caseload.	31%	31%	38%
I am confident in my ability to meet the needs of children of parents with mental illness on my caseload.	19%	6%	75%
I believe there are specific protective factors that increase the capacity of a person with mental illness to parent.	75%	13%	13%
I believe our child protection system adequately addresses			

the needs of mentally ill parents.	75%	13%	13%
I believe I have adequate training to deal with the needs of parents with mental illness on my caseload.	44%		56%

Qualitative results

Eight child protection workers were asked to respond to eleven statements on an interview schedule (see Appendix). The responses to these questions varied greatly but certain themes emerged from the interviews. The following lists the questions with a description of the themes that emerged from the responses for each

1. What unique needs do you feel parents with mental illness have?

The most often mentioned need for parents with mental illness in the child protection system is the failure of those parents to understand the dynamics of that system. The child protection workers cited struggles to understand the court process, timelines and their complicated case plans. They recommended that parents have and mental health advocate focused on the needs of parents there to explain things adequately. One worker indicated this does happen much of the time. Two others indicated it does not. One suggested parents have their own guardian ad litem. In addition to the struggles to understand the details of the court and child protection process, one worker indicated the need to make lists and provide frequent reminders for parents. Two workers indicated that mental illness is one additional complicating factor in already complex cases. Two also felt that parents with mental illness complicate their illnesses by using drugs or not being compliant with their medications. One specified that the needs of the parents were dependent on the specific diagnosis. Two suggested that mental illness is on a continuum and the unique needs are dependent on the severity and chronicity of the illness.

2. Please describe for me the positive aspects of the available mental health services for parents in St. Louis County. In other words, how well do the available services specifically address parenting needs for parents with mental illness?

Several responses indicated that HDC (Human Development Center) provides the majority of mental health services. Two workers specifically mentioned the benefits of the mom's group offered for mothers with mental illness at HDC. Most felt HDC provided good services. One worker indicated that HDC case management and mom's group allows parents to, "feel supported and have door opened for examining how mental illness might impact ability to provide care they want to provide their children." The Center for American Indian also provides family centered services but no workers mentioned services specific to parenting.

3. Please describe for me the negative aspects of the available mental health services for parents in St. Louis County. In other words, how well do the available services specifically fail to address parenting needs for parents with mental illness?

Workers in general had much more to say about the negative aspects of available mental health services. Two were not aware of any services that specifically addressed parenting needs. Other felt that there were not enough services for parenting needs- specifically group services, services designed to help parents understand the developmental needs of their children, available mentors for the children and services to provide an advocate for parents in the court process. Half the workers felt that it takes too long (two to three months) for parents to get into the Human Development Center for an assessment or to see a psychiatrist. They indicated this proves problematic for parents

facing a timeline of six months to a year to improve their parenting and regain the custody of their children.

4. Please describe for me the types of assessments you use to assess parenting needs.

The child protection workers indicated they do not always order full assessments of parenting capacity. When they do, most elect to have those assessments done in conjunction with a psychological evaluation by a professional in the community. These assessments tend to include an office visit with the parent and professional and no direct observation of parental interactions with the children. One worker described these assessments as, “cookie cutter printouts” that do not provide useful information. Workers typically base parenting needs on their own observations, knowledge and experience rather than a formal assessment. One indicated that parenting assessments done by the Center for American Indian Resources did include six visits including observations of parent and child interactions and a visit with the parent in the office.

5. Please describe how well you think these assessments address the unique needs of parents with mental illness.

Two workers indicated that the assessments did not add anything specific to the needs of parents with mental illness. One did not have any thoughts on the issues. Several workers indicated the assessments done outside the agency need to be based more on observations and not on one office visit without the children present. One specified, “The assessment tools available do not assess at all the fluctuations of parenting abilities of parents with mental illness.” One mentioned that there is simply not enough time with all the other issues that have to be addressed to do adequate assessments.

6. Please describe the positive aspects of coordination between your services and the available mental health services to meet the needs of mentally ill parents in child protection cases.

In general, the child protection workers indicated that there was sometimes very good communication and coordination between their work and that of the other professionals in the community. The Human Development Center, the Center for American Indian Resources and the Crisis Response Team (a collaborative team of county, state and Human Development Center workers responding to immediate crises of people with mental illness) were all mentioned as promoting good communication. As will be noted in the next question, good communication is not always the norm. One worker was on occasion able to hold meeting with the therapist, parents, guardian ad litem and the worker present. She found these very productive. However, she indicated in the following question that this rarely happens due to time and ego issues among the participants.

7. Please describe the negative aspects of coordination between your services and the available mental health services to meet the needs of mentally ill parents in child protection cases.

There were more varied and extensive responses to the negative aspects of coordination between mental health and child protection services. One worker noted that mental health workers do not understand the child protection system. Often the mental health advocate or a therapist does not understand the child protection issues. One worker indicated that the therapist need to build rapport with the parents prohibits them from instructing on needed parenting changes and puts them at odds with the child

protection worker. Again, the issue of how long it takes to get into the Human Development Center for services was brought up as barrier to coordination.

8. What suggestions do you have for improving coordination of services?

Two workers indicated that the mental professionals need to have a better understanding of the child protection system. One added that mental health professionals should regularly attend court hearings to provide, “more realistic and sophisticated services to clients.” One advocated for more systematic change embracing mediation and family group conferencing over the more adversarial court proceedings. Again, the need for more hands on parenting groups and in home services was reiterated. One also stated that child protection workers and therapists need to work to get on the “same page” with case planning.

9. In your experience, what are some protective factors that decrease risk to children and improve a mentally ill person’s ability to parent effectively?

Six workers indicated the primary protective factor was a support system. This includes family support, friends, community services and a positive relationship with a social worker or other professional. The relationship with a professional works best if it is voluntary and includes access to the professional beyond regular business hours. They also cited the ability to access help in a crisis and respite care.

10. In your experience, what are some risk factors that increase risk to children and improve a mentally ill person’s ability to parent effectively?

Half the workers indicated that chemical use provides additional risk. They also cited isolation or the lack of a support system. Lack of medication compliance, not accessing services and lack of insight into their own mental illness also proved common

risk factors. One worker indicated having a child with special needs added to problems in parenting as does not understanding a child's developmental needs. One indicated the severity and persistence of the mental illness could provide additional risk along with fear of professionals and seeking help.

11. What training or educational needs do you feel you have for working with parents with mental illness?

Most the workers indicated the available training offered through the county was sufficient. However, most also offered suggestions for additional training. They include: more training on how to better persuade parents to willingly get help, training on available services for parents with mental illness in the community, training with practitioners from the mom's group at the Human Development Center, holding a roundtable "chat" with mental health system providers and child protection workers to talk about issues, how to avoid "advocacy at expense of responsibility" with mental health advocates, how to avoid the "win/lose dialogue" inherent in court action, education on dealing with personality disorders and other severe and persistent mental illness and a system for knowing who in the agency has skills for dealing with different mental health issues along with better coordination with other units in the county system.

Discussion

Research question one: What is the prevalence of parental mental illness in child protection cases for St. Louis County?

According the results, mental illness was present in half of all child protection cases and suspected in an additional 17%. A previous study indicated that mental illness was listed as a risk factor in just over half of the cases sampled. This study provides

similar results but adds that it may be present in more cases but undiagnosed. Several workers indicated the difficulty of accessing services in the community in a timely manner. Others indicated parents are afraid to access services due to fear of losing their children or stigma associated with mental illness. These factors may contribute to parental mental illness going undiagnosed. With mental illness a factor in well over half the cases, it is important to investigate how well the child protection and mental health systems address the parenting needs.

Research question two: To what extent are parents with mental illness involved in the child protection system receiving mental health treatment and/or case management addressing their parenting needs?

According to the quantitative data provided by the survey of child protection cases, 81% of those with mental illness are receiving some kind of services. However, only three of the 24 are receiving services that specifically address treatment of their parenting needs. Another half of the 24 are receiving services from agencies that provide parenting services. However, the data does not specify whether or not their parenting needs are met or addressed through those services. Half are not receiving parenting assistance of any kind. The mental health system does not seem to be focusing on or providing enough specific services for parenting. This finding is supported by the survey of worker opinions. Only twelve percent of workers felt that that mental health system adequately addresses parenting needs in its services.

Similarly, only twelve percent of workers felt that the child protection system adequately addresses the needs of parents. Workers seemed slightly more confident in their own ability to meet those parents need. One third were confident in their ability to

meet the parenting needs of parents with mental illness on their caseloads. Another third were undecided while the final third were not confident in their abilities to meet these parents' needs. In contrast, 75% felt they could adequately meet the needs of children of parents with mental illness. With 67% of their cases including a primary caregiver with mental illness, it will be important for the system to address how to better prepare these workers to meet the needs of parents.

Though just over half the workers indicated they had sufficient training to address the needs of parents with mental illness, all but one had suggestion in the qualitative portion of the study for further training needs. One suggestion included bringing together professionals from both systems to discuss issues. This could include training on the child protection system as well as mental health professionals explicating their roles to child protection workers. As will be discussed in the next question, it would also improve coordination between the two systems.

Research question three: To what extent do child protection workers feel they are able to coordinate with the mental health system to best meet parenting needs?

Limitations of the Study

This study does not directly assess the feelings and opinions of actual parents with mental illness involved in the child protection system. Future research should examine parents' perceptions of the effectiveness of the child protection system to address their

unique needs and how well they felt the mental health and child protection systems coordinated on their cases. This study does not correlate actual case outcomes with the level and types of services and assessments received by parents.

The measure of prevalence including workers subjective perceptions of mental illness does not provide a reliable and valid method of accounting for undiagnosed mental illness. Different workers might have differing views on what constitutes mental illness. Finally, those questions pertaining to the level of coordination among the two systems may result in a social desirability bias as workers might want to portray the system within which they work in a positive light. Similarly, the workers may exhibit a self-reporting bias when reporting on their own ability to case plan according to the unique needs of caregivers with mental illness. Finally, the instruments do not have established reliability and validity.

References

- Ackerson, B.J. (2003). Coping with the dual demands of severe mental illness and parenting: The parents' perspective. *Families in Society*, 84(1), 109-118.
- Ackerson, B.J. (2003). Parents with serious and persistent mental illness: Issues in assessment and services. *Social Work*, 48(2), 187-194.
- Azar, S.T., Lauretti, A.E., & Loding, B.V. (1998). The evaluation of parental fitness in termination of parental rights cases: A functional-contextual perspective. *Clinical Child and Family Psychology Review*, 1(2), 77-100.
- Bassett, H., Lampe, J., & Lloyd, C. (1999). Parenting: Experiences and feelings of parents with mental illness. *Journal of Mental Health*, 8(6), 597-604.
- Blanch, A.K., Nicholson, J. & Purcell, J. (1994). Parents with severe mental illness and their children: The need for human services integration. *Journal of Mental Health Administration*, 21(4), 388-396.
- Budd, K.S., Poindexter, L.M., Felix, E.D., & Naik-Polan, A.T. (2001). Clinical assessment of parents in child protection cases: An empirical analysis. *Law and Human Behavior*, 23(1), 93-108.
- Cogan, J.C. (1998). The consumer as expert: Women with severe mental illness and their relationship based needs. *Psychiatric Rehabilitation Journal*, 22(2), 142-154.
- Goodman, S.H. & Brumley, H.E. (1990). Schizophrenic and depressed mothers relational deficits in parenting. *Developmental Psychology*, 26(1), 31-39.
- Jacobsen, T., Miller, L.J., & Pesek Kirkwood, K. (1997). Assessing parenting competency in individuals with severe mental illness: A comprehensive service. *Journal of Mental Health Administration*, 24(2), 189-214.

- Lee, C.M. & Gotlib, I.H. (1989). Maternal depression and child adjustment: A longitudinal Analysis. *Journal of Abnormal Psychology*, 98(1), 78-85.
- Nicholson, J., & Biebel, K. (2002). Commentary on community mental health care for women with severe mental illness who are parents- the tragedy of missed opportunities: What can providers do. *Community Mental Health Journal*, 38(2), 167-172.
- Nicholson, J. & Blanch, A. (1994). Rehabilitation of parenting roles for people with serious mental illness. *Psychosocial Rehabilitation Journal*, 18(1), 109-119.
- Oyserman, D., Bybee, D., Mowbray, C.T., & MacFarlane, P. (2002). Positive parenting among African American mothers with a serious mental illness. *Journal of Marriage and the Family*, 64(1), 65-77.
- Oyserman, D., & Mowbray, C.T. (1994). Resources and supports for mothers with severe mental illness. *Health & Social Work*, 19(2), 132-142.
- Sands, R. (1995). The parenting experience of low-income single women with serious mental disorders. *Families in society*, 76(2), 86-96.
- Walsh, C., MacMillan, H., & Jamieson, E. (2002). The relationship between psychiatric disorder and child physical and sexual abuse: Findings from the Ontario Health Supplement. *Child Abuse & Neglect*, 26, 11-22.

