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# Victimized Twice: The Reasonable Efforts Requirement in Child Protection Cases When Parents Have a Mental Illness

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# VICTIMIZED TWICE: THE REASONABLE EFFORTS REQUIREMENT IN CHILD PROTECTION CASES WHEN PARENTS HAVE A MENTAL ILLNESS

JEANNE M. KAISER

*Abstract: State child protection agencies are required by federal law to exert reasonable efforts to keep families together before seeking termination of parental rights. Some states, however, have created an exception to this requirement when the parent involved suffers from a chronic mental illness. Moreover, even in those states that enforce the requirement, the reunification services provided to parents with a mental illness often do not meet the needs of those parents.*

*This article argues that although parents with a mental illness face serious challenges in caring for their children, they should not be categorically excluded from reunification efforts by means of a state statute. It further contends that in order to be "reasonable" reunification services must be reasonably calculated to address the specific issues faced by parents with a mental illness. The article concludes with several suggestions on how this goal can be accomplished even in the face of scarce resources.*

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## I. INTRODUCTION

Child protective services first became involved with Mary R.<sup>1</sup> after the police responded to an anonymous call from a shopper who saw Mary slapping her nine-year-old son Brian while she screamed uncontrollably at him outside a local Wal-Mart. The police contacted the child protection hotline because they remained concerned about Mary's mental state even after they resolved the immediate emergency outside the store. The social worker assigned to investigate visited Mary and Brian at their apartment on several occasions in the ensuing months.

The social worker determined that Mary's outburst outside the Wal-Mart was an isolated incident. Nonetheless, she remained deeply concerned about Mary's treatment of Brian for a number of reasons. First, the apartment she shared with Brian was very messy, with piles of papers covering almost every surface in each room and toppling onto the floor. More worrisome to the social worker was that when she met with Mary, she talked rapidly and incessantly about people who were breaking into her apartment in the middle of the night and rifling through her papers. She reported that every night she barricaded the doors, but still "her enemies" broke into the apartment. Mary freely conveyed her fear of these enemies to Brian; in fact she enlisted him in her efforts to keep them out of her apartment. She expressed great frustration with Brian for not understanding the seriousness of their plight. Nothing the social worker said could disabuse Mary of her belief that she was subject to nightly invasions by her enemies.

The child welfare agency ("CWA") drew up a service plan for Mary. The plan recognized that Mary exhibited symptoms of mental illness and thus the plan required Mary to obtain a psychological evaluation and a medication evaluation, and to see a therapist. The plan further required Mary to accept the services of a parent aide to help her clean-up her home and to attend parenting classes.

Mary rebuffed the suggestion for a psychiatric evaluation, but did agree to see a counselor to provide emotional support. Mary met with the counselor for six sessions before discontinuing therapy, telling the social worker that the counselor and she agreed that she no longer needed any help. Mary also allowed a parent aide to visit her in her home, but refused to let her touch any of the papers cluttering her

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1. The facts set out here are based on a case in which the author represented a mother on appeal.

apartment, claiming that they were all necessary to prosecute her case against the enemies that invaded the apartment. The parent aide ultimately told the social worker that Mary was “impossible” to deal with and that she was not benefiting from the services being provided; consequently the service was discontinued. As for the parenting classes, Mary attended once and then made a series of excuses for not attending further classes, including transportation difficulties and her belief that other parents in the group were ridiculing her.

In the meantime, Brian was showing signs of severe stress. He fell asleep at school because Mary kept him up at night to try to ward off the invaders. Even when awake, he appeared inattentive and worried all of the time. Often, he went to school looking dirty and disheveled and without appropriate clothing for the cold weather. The family was also facing possible eviction because Mary made no progress in cleaning up the apartment. Throughout, Mary insisted her only real problem was that her enemies were sabotaging her every move.

After several months, seeing no cooperation with services or improvement in Mary’s ability to function, the CWA took temporary custody of Brian. When Mary’s condition deteriorated even further, the CWA brought a court action to terminate Mary’s parental rights. Ultimately the CWA prevailed and Mary’s legal relationship with Brian was permanently severed.

There is little question in a case like Mary’s that the significant deficits that led to the termination of her parental rights were related to mental illness. What is debatable, however, is whether the steps taken by the CWA before acting to terminate Mary’s parental rights satisfied its obligation to use reasonable efforts to keep her family together.<sup>2</sup> Although the agency offered referrals to mental health services and parenting classes, it is questionable whether this constitutes a reasonable effort with a parent like Mary who suffers from a serious mental illness and as a consequence is likely to either reject the referral out of hand or receive minimal benefits from participation in services.

The reasonable efforts requirement presents a complicated set of questions in any child protection case but these questions are particularly difficult when a parent suffers from a serious mental illness. In such cases, there must be an assessment of whether it is enough for the CWA to do as the agency did here and simply provide a

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2. See *infra* notes 66-114 and accompanying text.

referral for evaluation and counseling and a set of generic services. Or, conversely, does the law require the CWA to engage in more proactive efforts to link a resistant parent, whose judgment is clouded by the very illness that needs to be treated, with the services that are appropriate and helpful? Alternatively, is mental illness such an intractable disorder that the state should be excused from exercising any efforts whatsoever, on the grounds that such efforts would be futile?

This article addresses the ways in which state child protection systems fulfill their obligation to exercise reasonable efforts when a parent suffers from a serious mental illness. Part I of the article describes the difficulties faced by parents with a serious mental illness, including the impact these illnesses have on parenting. Part II discusses the federally mandated reasonable efforts requirement and the ways in which states have interpreted that requirement with regard to services for mentally ill parents. It explains that a minority of states have excused the state from making reasonable efforts altogether when a parent has a severe mental illness projected to last indefinitely. It argues that this practice both subverts the purpose of the reasonable efforts requirement and is unnecessary to protect the welfare of children. Part III looks at those states that enforce the reasonable efforts requirement in cases of parental mental illness. It explores whether the efforts employed in those states are useful in keeping families together. The article concludes that in order to truly fulfill the reasonable efforts requirement, state CWAs must more closely tailor the services they offer to mentally ill parents so as to increase the possibility that families can stay together. This section acknowledges the significant difficulties CWAs face because of lack of resources, lack of effective programs, and the innumerable challenges faced by families afflicted by mental illness. It nonetheless contends that there are steps that CWAs can take, and in fact should take, to assure they are fulfilling the reasonable efforts requirement.

## II. SERIOUS MENTAL ILLNESS AND PARENTING

### A. Parents with Mental Illness

The term serious mental illness encompasses a wide range of diagnoses.<sup>3</sup> Generally, serious mental illness is generally characterized

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3. Christina Risley-Curtiss et al., *Identifying and Reducing Barriers to Reunification for Seriously Mentally Ill Parents Involved in Child Welfare Cases*, 85 FAM. SOC'Y: J. CONTEMP. SOC. SERV. 107, 108 (2004).

by “psychological symptoms that persist over time and are functionally disabling in daily living skills and in abilities involving social interactions, family relations and jobs or education.”<sup>4</sup> Although serious mental illness takes many forms, this section describes schizophrenia in detail to illustrate the difficulties faced by parents with a serious mental illness. Schizophrenia is an apt example because this disorder is common,<sup>5</sup> disruptive to daily living<sup>6</sup> and difficult to treat.<sup>7</sup> Nonetheless, other mental illnesses, including affective disorders such as major depression<sup>8</sup> and bipolar disorder<sup>9</sup> can create equally difficult challenges in the child protection setting.

Schizophrenia manifests itself by both positive and negative symptoms. Positive symptoms of schizophrenia include hallucinations (seeing or hearing phenomena not present), delusions, disordered thinking, and bizarre behavior.<sup>10</sup> Hallucinations can take the form of hearing voices that are both distressing and distracting. For instance, a person with active hallucinations may hear voices criticizing or talking about them.<sup>11</sup> Delusions, or false beliefs, can be similarly disruptive to

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4. *Id.* (quoting from Dale L. Johnson, *Overview of Severe Mental Illness*, 17 CLINICAL PSYCHOL. REV. 247, 247 (1997). The Substance Abuse and Mental Health Services Administration has a similar definition. It defines serious mental illness as “a diagnosable mental, behavioral, or emotional disorder . . . that substantially interferes with or limits one of more life activities, such as employment, self-care, and social relationships.” Diane T. Marsh, *Parental Mental Illness: Issues in Custody Determinations*, 23 AM. J. FAM. L. 28, 28 (2009).

5. Two to three million persons (up to one percent of the population) in the United States suffer from schizophrenia. Schizophrenia accounts for more hospital admissions in the United States than any other mental illness. KIM T. MUESER & SUSAN GINGERICH, *THE COMPLETE FAMILY GUIDE TO SCHIZOPHRENIA* 7 (2006)

6. *See infra* notes 11-17.

7. *See infra* notes 30-36.

8. Major depression is a serious mood disorder marked by persistent sadness, difficulty concentrating, serious sleep and appetite disturbances, social withdrawal and risk of suicide. Some people have recurrent episodes of major depression throughout their lifetime. Riseley-Curtiss et al., *supra* note 3, at 109. Parents suffering from major depression can encounter serious difficulties in caring for their children such as failing to provide meals, fulfill obligations, and becoming convinced that the children are better off without them. *Id.* at 109-10.

9. Bipolar disorder is a mood disorder in which there has been at least one episode of depression and one episode of mania. Manic behavior includes rapid speech, inability to sleep, heightened and sometimes irrational activity and reckless or impulsive behavior. *Id.* at 110.

10. *Id.* at 108.

11. MUESER & GINGERICH, *supra* note 5, at 22.

a person's daily functioning.<sup>12</sup> One person described the experience as "dreaming when you're wide awake."<sup>13</sup> In other words, someone with schizophrenia is forced to navigate the waking world while simultaneously experiencing the bizarre events of a dream as if they were real.

While the presence of positive symptoms of schizophrenia fluctuates over time,<sup>14</sup> individuals with schizophrenia more consistently demonstrate the "negative" manifestations of the disorder.<sup>15</sup> These symptoms include flat affect, lack of motivation, and cognitive difficulties, such as problems with attention and concentration.<sup>16</sup> Negative symptoms can be as disruptive and upsetting as the positive ones because they result in social isolation and lack of enjoyment. One person with schizophrenia provided this example: "I loved going to the beach. Now the beach is just a few blocks away, but I can't get the motivation to go there."<sup>17</sup>

Not surprisingly, the symptoms of schizophrenia can interfere significantly with parenting duties. Hallucinations, when perceived as real, can impair daily care of children. For instance, a parent reported hearing voices that told her that her son's peanut butter sandwich was poisoned, so she threw it away.<sup>18</sup> Delusions are also disruptive; a father who believed he was a special agent of the FBI and that his children were spies felt tense and suspicious around his children.<sup>19</sup> Even more problematic is the disordered behavior typical of a full-blown psychotic break, which at times can be dangerous to children. One mother reported thinking that her child was possessed by the devil and that the only way to cure the problem was to bring him to the lake and baptize him.<sup>20</sup> Fortunately, the child suffered only a sunburn and hunger during the hike to the lake, but the mother reported lasting guilt over her behavior and presumably her child was quite frightened and

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12. *Id.*

13. *Id.* at 6-7.

14. Positive symptoms can be intense at times, leading to hospitalization. However, twenty-five to fifty percent of individuals experience chronic psychotic symptoms. *Id.* at 21.

15. *Id.* at 24.

16. Risley-Curtiss et al., *supra* note 3, at 108; MUESER & GINGERICH, *supra* note 5, at 24-25.

17. MUESER & GINGERICH, *supra* note 5, at 7.

18. *Id.* at 125.

19. *Id.* at 125.

20. *Id.* at 127.

confused.<sup>21</sup> Disordered behavior such as this often leads to hospitalization, which in turn creates more problems because it necessitates separations from children.<sup>22</sup>

The negative symptoms of schizophrenia also affect parenting. The low energy and lack of motivation characteristic of the disorder make it difficult for parents to keep up with energetic and physically needy young children. Difficulty with concentration and attention can cause problems with keeping track of school events and holidays, doctors' appointments and other scheduled events.<sup>23</sup> A parent's poor social skills or isolation can cause embarrassment to children in social settings.<sup>24</sup>

The statistics on the prognosis for schizophrenia can be disheartening, at least in terms of full recovery. Indeed, recovery from schizophrenia is probably best looked at as a process, rather than an event.<sup>25</sup> Essentially, many persons who receive a diagnosis of schizophrenia can expect to struggle with the disorder throughout their lives, although the symptoms may wax and wane.<sup>26</sup> About sixty percent of people with schizophrenia improve significantly with treatment.<sup>27</sup> Of these, about twenty-five percent return to a high level of functioning.<sup>28</sup> About ten to fifteen percent of persons with schizophrenia continue to exhibit symptoms and function poorly, even when they adhere to treatment.<sup>29</sup>

The prescribed treatment for schizophrenia can create its own difficulties. The typical treatment for schizophrenia is antipsychotic medication. Patients are prescribed either one of the conventional antipsychotic drugs used routinely from the 1960s through the 1990s or

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21. *Id.*

22. *Id.* at 126-27.

23. *Id.* at 126; Marsh, *supra* note 4, at 30.

24. Marsh, *supra* note 4, at 30.

25. MUESER & GINGERICH, *supra* note 5, at 35.

26. *Id.* at 35-39. The authors explore the "themes" of recovery, emphasizing the need for acceptance, coping and finding meaning in life. *Id.* The prognosis for other serious mental illnesses is more favorable. Major depression, for instance, is quite treatable, although episodes can reoccur throughout a lifetime. Risley-Curtiss et al., *supra* note 3, at 109.

27. Risley-Curtiss et al., *supra* note 3, at 108. Statistics vary somewhat in this regard. One source, drawing from a variety of countries, estimated that forty-two to sixty-eight percent of people with schizophrenia either show full recovery or substantial improvement. MUESER & GINGERICH, *supra* note 5, at 33.

28. Risley-Curtiss et al., *supra* note 3, at 108.

29. *Id.*



with one of the more recently developed drugs.<sup>30</sup> The older medications used to treat schizophrenia are very sedating, leading to extreme lethargy, fuzzy thinking and difficulty waking up.<sup>31</sup> One patient described “feeling like a zombie” when on this type of medication.<sup>32</sup> These side effects obviously can make it difficult to care for active young children. The newer antipsychotic medications have less of a sedating effect, but can have side effects that make the use inadvisable for some people.<sup>33</sup> For example, individuals using the newer drugs experience weight gain, sometimes at a rate of up to one pound a week.<sup>34</sup> In addition, the drugs carry the risk of very serious medical conditions and require consistent monitoring in some instances.<sup>35</sup> As a consequence, some individuals cannot take the new antipsychotic medications, despite their considerable advantages in controlling symptoms.<sup>36</sup>

In short, even when persons with schizophrenia comply with medication regimes, they often do not experience a complete return to their previous level of functioning. Moreover, they must cope with the negative side effects of the medications. These effects alone make compliance with treatment difficult but patients must cope with other issues such as the stigma associated with serious mental illness. Given this, treatment compliance with schizophrenia is often poor.

## B. Effects on children

Statistically, children of parents with a serious mental illness have more problems than children raised by parents without such an illness.<sup>37</sup> Indeed, “[t]wo decades of research have unequivocally indicated that children who have a parent with mental illness are at significantly greater risk for multiple psychosocial problems.”<sup>38</sup>

30. MUESER & GINGERICH, *supra* note 5, at 150-51.

31. Risley-Curtiss et al., *supra* note 3, at 109; MUESER & GINGERICH, *supra* note 5, at 150-51.

32. Risley-Curtiss et al., *supra* note 3, at 109.

33. *Id.*

34. *Id.*

35. MUESER & GINGERICH, *supra* note 5 at 151-52.

36. *Id.*

37. Marsh, *supra* note 4, at 30.

38. *Id.*; Joanne Nicholson et al., *Critical Issues for Parents with Mental Illness and their Families*, MENTAL HEALTH AM., 18 (July 30, 2001), available at [www.nmha.org/download.cfm?DownloadFile=A04D60B2-1372-4D20-C8DFC0CBF51ACF9C](http://www.nmha.org/download.cfm?DownloadFile=A04D60B2-1372-4D20-C8DFC0CBF51ACF9C).

Children with a mentally ill parent are significantly more likely to have a psychiatric diagnosis of their own during childhood.<sup>39</sup> In addition, these children tend to suffer from developmental delays, problems with academic performance and difficulties in social relationships.<sup>40</sup>

Multiple factors explain these statistics. First, there is a clear genetic component to many mental illnesses, which means some children of mentally ill parents are at risk of developing a psychiatric disorder no matter their environment.<sup>41</sup> Nonetheless, a child's family environment can make a crucial difference in whether he or she will eventually develop a psychiatric diagnosis.<sup>42</sup>

In part, this is because the symptoms of mental illness have a negative impact on the ability to parent. "Numerous studies suggest that parenting behavior is affected by the presence of mental illness, and that parenting has a strong influence on child outcomes."<sup>43</sup> For example, mothers with affective disorders such as depression and bipolar disorder, as well as mothers with schizophrenia, often exhibit blunted emotional expressiveness.<sup>44</sup> This can lead to difficulties in attachment with their children.<sup>45</sup>

But even apart from genetics and parenting problems, children of the mentally ill face a difficult upbringing. Families in which a parent is mentally ill often feature poor communication and disordered behavior, which can lead to emotional and behavioral problems in children.<sup>46</sup> Children with mentally ill parents also must cope with embarrassment, stigma and isolation due to a parent's symptoms.<sup>47</sup>

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39. Nicholson et al., *supra* note 38, at 18.

40. *Id.*

41. *Id.* at 19. The existence of a genetic component to mental illness has been established by twin studies. Identical (monozygotic) twins are more likely to share a diagnosis of schizophrenia or anxiety than fraternal (dizygotic) twins. *Id.* Moreover, children of parents with schizophrenia and anti-social personality disorder who have been adopted are more likely to develop these disorders than adopted children whose natural parents did not have a mental illness. *Id.*

42. *Id.* (citing a study involving adopted children, which showed that schizophrenia may develop as a result of a genetic predisposition along with a difficult family environment).

43. *Id.* at 21.

44. *Id.*

45. *Id.*

46. *Id.* at 22.

47. Marsh, *supra* note 4, at 30. The descriptions of children of parents with a serious mental illness can be heartbreaking. One adult child said:

I was always embarrassed by my mother. I wanted her to look like everyone

Young children can be prematurely placed in a caretaking role.<sup>48</sup> These children can be intimately involved in tasks as crucial as providing emotional support during a mental health crisis that culminates in self-harm or psychosis; or more mundane tasks, such as monitoring the parent's medications; or simply being physically present when a parent has downturns.<sup>49</sup> This level of responsibility can place a great deal of stress on a child.<sup>50</sup> Added to the mix, children witnessing the behavior of a mentally ill parent may worry about their own vulnerability to mental illness.<sup>51</sup>

In short, childhood can be quite difficult for children with mentally ill parents. Adult children of mentally ill parents report considerable struggles, including feelings of grief and loss. One adult child of a mother with schizophrenia said: "I feel like I lost my whole childhood. I lost my family, I lost birthdays and holidays, trips to the beach and all the family stuff people take for granted."<sup>52</sup> Adult children also speak of feeling abandoned by an ill parent and not having their own needs attended to.<sup>53</sup>

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else's mother, but she might wear an overcoat in the summer, and her clothes were always mismatched. . . . She just didn't look sane. My sister and I could never bring kids home because we never knew how she was going to be. One time she came screaming out of the kitchen that she knew that all of my friends' parents were in a plot against her, and another time she ran through the house naked. I never brought anybody home after that.

MARGARET J. BROWN & DORIS PARKER ROBERTS, *GROWING UP WITH A SCHIZOPHRENIC MOTHER* 21 (2000).

48. Marsh, *supra* note 4, at 30.

49. Jo Aldridge, *The Experiences of Children Living with and Caring for Parents with Mental Illness*, 15 *CHILD ABUSE REV.* 79, 81 (2006).

50. *Id.* Aldridge quotes a parent who said her son's presence "saved me quite a few times." *Id.*

51. Marsh, *supra* note 4, at 30.

52. BROWN & ROBERTS, *supra* note 47, at 97.

53. Marsh, *supra* note 4, at 30. See also Debbie Hindle, *Growing Up with a Parent Who Has a Chronic Mental Illness: One Child's Perspective*, 3 *CHILD & FAM. SOC. WORK* 259, 260-263 (1998). The author of this article worked intensively with Kennie, an adolescent boy who grew up with a chronically mentally ill mother. Kennie described the complicated emotional burden of coping with an ill mother to the author:

Kennie described himself as being close to his mother. He spent a lot of time with her, was mindful of her preoccupations, and worried about leaving her in case anything happened to her. It was clear that Kennie had not only been afraid of his mother but had also been inextricably involved with her in what Kennie and I came to call 'The Knot.' . . . Kennie's fears of madness, openly expressed in his sessions, can be seen as both an identification with his ill mother and the consequence of his enmeshment with her. He literally did not know his own mind.

A few caveats must be added to the negative picture painted here. First, while there is a relationship between parental mental illness and children's developmental problems, the correlation is by no means perfect. The range of skills for parents in all diagnostic categories ranges from excellent to abusive.<sup>54</sup> Many children of mentally ill parents are quite resilient and function as well as children of non-affected parents.<sup>55</sup> Moreover, despite the problems faced by children of the mentally ill, most adult children report positive aspects of their experience.<sup>56</sup> These include a sense that they developed greater compassion and tolerance as a result of their experience; feel greater satisfaction in overcoming problems; and eventually establish stronger family bonds.<sup>57</sup> Importantly, the most serious problems associated with parental mental illness are not a function of a particular diagnosis, but rather related to severity and chronicity of the disorder.<sup>58</sup>

In addition, many of the negative statistics on children of the mentally ill date from an era when treatment of mental illness was quite different than it is today. In the past, persons with a mental illness were often institutionalized for lengthy periods of time, which meant their children could spend almost their entire childhood without significant contact with their parent.<sup>59</sup> And the sense of secrecy and stigma surrounding mental illness, while it still exists today, has been substantially reduced as knowledge and understanding of mental illness reaches the general public.<sup>60</sup> Finally, the better medications currently being used to treat mental illness likely will have a significant impact

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*Id.* at 262.

54. Risley-Curtis et al., *supra* note 3, at 110.

55. Nicholson et al., *supra* note 38, at 18; Marsh, *supra* note 4, at 30 (noting that not all children of mentally ill parents suffer adverse consequences and many are quite successful across a broad spectrum of adult functioning); Aldridge, *supra* note 49, at 83 (stating that the evidence does not show that the children of mentally ill parents are at "inevitable" risk of harm).

56. Marsh, *supra* note 4, at 30.

57. *Id.*

58. Nicholson et al., *supra* note 38, at 20.

59. *Id.* at 13.

60. There is some evidence that the public perception of mental illness has changed for the better; nonetheless there is still a stigma attached to mental disorders and many people incorrectly associate mental illness with violence. See Theresa Glennon, *Walking with Them: Advocating for Parents with Mental Illnesses in the Child Welfare System*, 12 TEMP. POL. & CIV. RTS. L. REV. 273, 292 (2003). Glennon notes that the connection between mental illness and violence is inflated in the public's mind when highly publicized incidents of child abuse by a mentally ill parents occur. *Id.* at 293.

on both individual functioning and family life.<sup>61</sup>

Nonetheless, “while the prognosis for persons with major mental illness has never been better, parents with mental illness still fear the automatic removal of their children from their homes by social services.”<sup>62</sup> This fear is not unfounded: mental illness of a parent is one of the most common grounds for termination of parental rights.<sup>63</sup> Up to eighty percent of parents with a serious mental illness lose custody of their children.<sup>64</sup> These parents report that losing custody creates a lifelong pain.<sup>65</sup> Thus, for a parent with mental illness, what happens when child welfare agencies enter their lives is of crucial importance. In particular, parents with a mental illness will be affected by the types of “reasonable efforts” that the child welfare agency involved makes to preserve their family.

### III. THE REASONABLE EFFORTS REQUIREMENT

#### A. Mental Illness and the Reasonable Efforts Requirement

Under the federal Adoption and Safe Families Act (“ASFA”), state child protection agencies must exert “reasonable efforts,” first, to avoid removing children from their homes, and then to reunite them with their families if they have been removed.<sup>66</sup> The stated goal of the reasonable efforts requirement is to preserve families when at all possible, while at the same time protecting the child’s health and safety.<sup>67</sup> State CWAs must comply with the reasonable efforts requirement in order to receive federal matching funds for their programs.<sup>68</sup> The phrase “reasonable efforts” is not defined in the

61. See *supra* notes 30-36.

62. Joanne Nicholson, Jeffrey L. Geller & William H. Fisher, “*Sylvia Frunkin*” *Has a Baby: A Case Study for Policymakers*, 47 PSYCHIATRIC SERVS. 497, 500 (1996).

63. Bary J. Ackerson, *Parents with Serious and Persistent Mental Illness: Issues in Assessment and Services*, 48 SOC. WORK 187, 187 (2003).

64. Nicholson et. al., *supra* note 38, at 10. Mothers with affective disorders tend to be more successful at maintaining custody; however, children of women with schizophrenia are likely to be raised by someone other than their mother. *Id.*

65. *Id.*

66. Adoption and Safe Families Act, 42 U.S.C.A. § 671(a)(15)(B) (West 2011).

67. See 42 U.S.C.A. § 671(a)(15)(B) (enumerating preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing breakup of the family where the prevention of child removal is desirable and possible, as one of the purposes of child welfare programs).

68. 42 U.S.C.A. § 671(a)(15) (West 2011). As a practical matter, the federal

federal statute, so states have been left to define the term on their own. State interpretations of the requirement vary and enforcement has been uneven from state to state.<sup>69</sup>

ASFA excuses reasonable efforts under certain circumstances. States agencies need not exercise reasonable efforts if there is a judicial determination that the parent has engaged in particularly egregious behavior, including murder or manslaughter of another child, or a felony assault that has resulted in serious bodily injury to a child.<sup>70</sup> Reasonable efforts are also excused when a parent has previously lost parental rights to a sibling of the child.<sup>71</sup> Notably, each of these exceptions to the reasonable efforts requirement focuses on serious acts committed by the parent and not the existence of some form of disability, such as mental illness or substance abuse.

Thus, it would appear at first glance, that state child welfare agencies are required to take proactive steps to help parents with a mental illness retain custody of their children or reunite the family if the children have been removed. The picture is more complicated, however. A few states explicitly allow their child welfare agencies to forego reasonable efforts when a family has a parent with a mental illness. Other states implicitly provide this same exception. And, even

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government has rarely exercised its power to withhold funds because of failure to comply with the reasonable efforts requirement. *See* Shawn L. Raymond, Note, *Where Are the Reasonable Efforts to Enforce the Reasonable Efforts Requirement?: Monitoring State Compliance Under the Adoption Assistance and Child Welfare Act of 1980*, 77 TEX. L. REV. 1235, 1236 (1999). Moreover, parents who believe the state has not exercised reasonable efforts do not have a private right of action to enforce the requirement. *Suter v. Artist M.*, 503 U.S. 347, 363 (1992).

69. *See generally* Jeanne M. Kaiser, *Current Issues in Public Policy: Finding a Reasonable Way to Enforce the Reasonable Efforts Requirement in Child Protection Cases*, 7 RUTGERS J.L. & PUB. POL'Y, 100, 111-125 (2009); Kathleen S. Bean, *Reasonable Efforts: What State Courts Think*, 36 U. TOL. L. REV. 321, 325 (2005).

70. 42 U.S.C.A. § 671(a)(1)(15)(D). These exceptions to the reasonable efforts requirement did not exist when Congress first legislated on the matter by enacting the Adoption Assistance and Child Welfare Act of 1980 ("AACWA"), Pub. L. No. 96-272, § 101 (a)(1), 94 Stat. 500. However, following the enactment of the AACWA, a perception developed that caseworkers' hand were tied by the reasonable efforts requirement when they sought to remove children from their parents' home. The reasonable efforts requirement was blamed for a number of high profile child abuse cases, which one author went so far as to call "reunification murders." *See* Kaiser, *supra* note 69, at 108. In response, Congress provided exceptions to the need to make reasonable efforts when it amended the AACWA in the Adoption and Safe Families Act ("ASFA") in 1997. Adoption and Safe Families Act of 1997, Pub. L. 105-89, 111 Stat. 2115 (codified at various section of United States Code Title 42).

71. 42 U.S.C.A. § 671(a)(15)(D)(iii).

in states which require reasonable efforts to preserve families when a parent has a mental illness, there is often a very poor fit between the services the agency provides and the needs of the family. Thus, despite the existence of the reasonable efforts requirement, parents with a mental illness often are left without services that might help their families remain united and functional. These inadequate approaches to the reasonable efforts requirement subvert its very purpose and should be substantially modified.

### 1. Explicit Exclusions from Reasonable Efforts Requirement Based on Mental Illness

A number of states excuse their child welfare agencies from providing reunification services when a parent suffers from a mental illness that cannot be projected to improve within a predictable period of time. New York State provides an extreme example in this regard. New York permits termination of parental rights (“TPR”) when the parent’s mental illness makes them “presently and for the foreseeable future unable ... to provide proper and adequate care for a child who has been in the care of an authorized agency for ... one year.”<sup>72</sup> This provision of the child protection statute, unlike the provisions governing cases of neglect or abuse unrelated to parental mental illness, does not explicitly require the state to exert reasonable efforts to reunite the family before seeking TPR.<sup>73</sup> New York courts have consistently decided not to read the reasonable efforts requirement into the part of the statute governing cases of mental illness.<sup>74</sup> Consequently, parental rights can be terminated without any showing that the states made reasonable efforts to reunite the family when the state provides mental illness, as opposed to some form of neglect or abuse, as the grounds for termination.<sup>75</sup> Moreover, although New York State requires judicial dispensation to dispose of the reasonable efforts requirement when grounds other than mental illness are asserted as the

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72. N.Y. SOC. SERV. LAW § 384-b(4)(c) (McKinney 2010).

73. Compare *id.*, with N.Y. SOC. SERV. LAW § 384-b(7)(a) (McKinney 2010).

74. See, e.g., *In re Harris AA.*, 727 N.Y.S.2d 769, 771 (App. Div. 2001); *In re Jammie CC.*, 540 N.Y.S.2d 27, 28 (App. Div. 1989).

75. *In re Jammie CC.*, 540 N.Y.S.2d at 28. See Dale Margolin, Abstract, *No Chance to Prove Themselves: The Rights of Mentally Disabled Parents Under the Americans with Disabilities Act and State Law*, 15 VA. J. SOC. POL’Y & L. 112, 150 (2007). Margolin argues that New York’s law violates the Americans with Disabilities Act because it discriminates against persons with mental health disorders because of their membership in a particular group. *Id.* at 155-56.

reason for termination, no judicial dispensation is required when the TPR request is based on parental mental illness.<sup>76</sup>

South Carolina has a similar statute excusing reasonable efforts when the state proceeds to TPR on the grounds of a “diagnosable” mental disability likely to prevent the parent from providing minimally acceptable care to the child.<sup>77</sup> It too, does not require a judicial determination that the disability exists.<sup>78</sup> However, when evidence exists that despite the presence of a diagnosable disorder, reunification services could help the parent provide minimally acceptable care, the state must provide those services before obtaining TPR.<sup>79</sup>

Several other states have similar statutes providing for termination of parental rights based on the grounds of a parent’s mental illness, but provide stronger procedural protections. For instance, Utah excuses the state from providing reunification services when a court finds clear and convincing evidence that a parent has a mental illness so severe that he or she is incapable of utilizing them.<sup>80</sup> Similarly,

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76. The exemptions from the reasonable efforts requirement included in ASFA have been incorporated into New York law. *See supra* note 74 and accompanying text; Margolin, *supra* note 75, at 150-51. However, before efforts are excused based on one of these exemptions, a court must determine that one of the enumerated grounds exists. *In re Custody and Guardianship of Marino S. Jr.*, 693 N.Y.S.2d 822, 832 (Fam. Ct. 1999).

77. Under South Carolina law, mental illness, along with other “diagnosable” disorders including drug or alcohol addiction, mental retardation and extreme physical incapacity can serve as grounds for TPR. S.C. CODE ANN. § 63-7-2570(6) (2010). When the state proceeds under this section of the law, it need not prove it made reasonable efforts to reunite the family before TPR. Orangeburg Cnty. Dept. of Soc. Servs. v. Harley, 393 S.E.2d 597, 598 (S.C. Ct. App. 1990) (finding reasonable efforts requirement “irrelevant” when TPR is based on diagnosable disorder).

78. S.C. CODE ANN. § 63-7-2570(6); *Harley*, 393 S.E.2d at 598.

79. S.C. Dep’t of Soc. Servs. v. Smith, 429 S.E.2d 807, 809 (S.C. 1993) (reversing judgment of termination when evidence showed that parenting programs might help mildly mentally retarded parents successfully parent their child).

80. UTAH CODE ANN. § 78A-6-312(3)(d)(i)(B) (LexisNexis 2011) (corresponds to Utah Code § 78A-6-312(21)(b) (1996)). The Utah statute provides for a presumption against reunification services on eleven separate grounds. *Id.* §§ 78A-6-312(3)(d)(i)(A)-(K). All of these grounds, except for the one governing mental illness, relate to prior behavior of the parent as opposed to the parent’s status as a person with a mental illness. *Id.* In order to deny reunification services under this subsection, the state must provide testimony from two licensed experts that the parent will be unable to capably care for their child within twelve months. *Id.* § 78A-6-312(3)(d)(ii). The provisions denying reunification services to mentally ill parents survived a challenge on equal protection grounds. *In re N.R.*, 967 P. 2d 951, 957 (Utah Ct. App. 1998). The court held that there was no suspect class and no fundamental right implicated by the statute. *Id.* at 954-56.



California has a reunification “by-pass” provision, excusing reasonable efforts when two licensed mental health experts provide clear and convincing evidence of the parent’s ongoing mental disability and that reunification services would be fruitless.<sup>81</sup> Colorado’s statute allows its child welfare agencies to forego reunification services when parents suffer from an emotional or mental disability and the state provides clear and convincing evidence that no appropriate treatment plan can be devised to address the unfitness of the parent.<sup>82</sup> In essence, these state statutes excuse reasonable efforts on the assumption that some mental illnesses are incurable and nothing can be done to improve the parent’s ability to care for their child.

## 2. Implicit Exclusion from the Reasonable Efforts Requirement Based on Mental Illness

Most states do not single out parents with mental illness in determining whether to offer reunification services to a family. Nonetheless, a fair number of states interpret the reasonable efforts requirement in a way that makes it permissible for child welfare agencies to forego reunification services to families affected by mental illness. In these states, the child welfare agencies are not required to use reasonable efforts when such efforts are likely to be futile.<sup>83</sup>

This interpretation has served to permit TPR without any attempt at reunification when a parent suffers from a mental illness. For instance, the Nebraska Supreme Court upheld the TPR of a mother diagnosed with chronic undifferentiated schizophrenia.<sup>84</sup> Here, even though the Nebraska statute explicitly required reasonable efforts, the court ruled that no such efforts were needed because “the mother was destined by virtue of the mental condition never to be able to comply

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81. CAL. WELF. & INST. CODE § 361.5(b)(2) (Deering 2008). Like Utah, California law excuses reunification services under multiple circumstances, but other than mental disability, all of these circumstances relate to the parent’s behavior and not their status. Compare *id.* § 361.5(b), with UTAH CODE ANN. § 78A-6-312(3)(d)(i).

82. COLO. REV. STAT. § 19-3-604(1)(b)(I) (2010). The Colorado Appeals Court has interpreted this section to mean that the state does not have to provide any reunification services at all when services that might effectuate reunification are not available or would be prohibitively expensive. See *In re Interest of C.S.M.*, 805 P.2d 1129, 1131 (Colo. App. 1990) (holding that TPR was appropriate when evidence demonstrated that parent could benefit from inpatient services but only outpatient services were available).

83. See Bean, *supra* note 69, at 337-43.

84. *In re Interest of C.W.*, 414 N.W.2d 277, 279 (Neb. 1987).

with any order of rehabilitation.”<sup>85</sup> Indeed, the court appeared irritated at the suggestion that reasonable efforts should have been made, stating that the mother’s condition was “hopeless from inception,” and that there was no point to any rehabilitation plan.<sup>86</sup> The court concluded that it was merely affirming what “should have mercifully been ordered immediately.”<sup>87</sup>

In essence, reasonable efforts can be avoided for parents with a mental illness in any state that excuses the requirement because efforts are likely to be futile. Again, a court can permit a CWA to assume that a parent’s mental illness is so severe and so permanent, that it would be fruitless to even make an attempt to keep the family together.

#### B. Unsoundness of Excusing the Reasonable Efforts Requirement in Cases of Parental Mental Illness

Parents with a mental illness should not be excluded from reunification services, either explicitly by statute or implicitly through judicial interpretation of the reasonable efforts requirement. First, the practice arguably runs afoul of both the United States Constitution and the Americans with Disabilities Act (“ADA”). With regard to the constitutional implications, parents have a “fundamental liberty interest” in the “care, custody, and management of their child.”<sup>88</sup> At least two states have determined that parents’ fundamental right to the custody of their children does not permit parental rights to be terminated unless the state exercises reasonable efforts to avoid that result.<sup>89</sup> As for the ADA, a statute that categorically excludes parents with a mental illness from state-provided services on the basis of their disability appears to be in serious conflict with the language and

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85. *Id.* See NEB. REV. STAT. § 43-292(6) (2011).

86. *In re C.W.*, 414 N.W.2d at 279.

87. *Id.*

88. *Santosky v. Kramer*, 455 U.S. 745, 753 (1982).

89. See *In re Natalya C.*, 946 A.2d 198, 203 (R.I. 2008); *Mary Ellen C. v. Ariz. Dep’t of Econ. Sec.*, 971 P.2d 1046, 1053 (Ariz. Ct. App. 1999). In *Mary Ellen C.*, the court refused to follow the approach of the New York courts and allow the state to avoid reasonable efforts because it pursued TPR on the grounds of the parent’s mental illness. *Mary Ellen C.*, 971 P.2d at 1051-1053. See also *Santosky*, 455 U.S. at 747-748. Similar to the New York child protection statute, the provision of the Arizona child protection statute pertaining to mental illness did not explicitly require reasonable efforts; whereas the provisions of the statute governing other grounds for TPR did include the requirement. *Mary Ellen C.*, 971 P.2d at 1051-1053. Nonetheless, the court ruled that the parent’s fundamental liberty interest in caring for her child required the court to read the reasonable efforts requirement into the statute. *Id.* at 1053-1055.

purpose of the federal law.<sup>90</sup>

But even if the exclusion of mentally ill parents from reunification services does not violate either the constitution or the ADA, it is not a wise practice. To the contrary, it fundamentally ignores the purpose of the reasonable efforts requirement, which is to balance the protection of children with the significant benefits children receive from

being raised in their family of origin.<sup>91</sup> It also has the effect of assuming a child will inevitably be harmed by being raised by a parent with a mental illness at the same time that it minimizes the potentially devastating effects a child suffers when permanently separated from their parents.<sup>92</sup>

First, excusing reasonable efforts based on a parent's mental illness cannot be justified by the admittedly serious problems that individuals with a psychiatric diagnosis face in caring for their children.<sup>93</sup> There is no doubt that both the symptoms of, and treatment for, mental illness can significantly interfere with parenting duties.<sup>94</sup> There is also no doubt that children of parents with a mental illness frequently suffer ill effects that cannot be explained entirely by a genetics, but rather are caused in part by the consequences of being raised by a parent impaired by mental illness.<sup>95</sup> Nonetheless, allowing states to deny reunification services because of these substantial difficulties misses the point of the reasonable efforts requirement.

Presumably all parents who enter the child welfare system exhibit severe dysfunction in their personal, social, or family life. Indeed, such parents are "by definition saddled with problems: economic, physical, sociological, psychiatric or any combination thereof."<sup>96</sup> It will thus be

90. 42 U.S.C.A. § 12132 (West 2011). Title II of the ADA precludes discrimination based on disability in public services. *See* Glennon, *supra* note 60, 288-320 (discussing the relationship between reunification services and the ADA); Margolin, *supra* note 75, 115-131 (reviewing the treatment of ADA claims in TPRs in state courts).

91. Kaiser, *supra* note 69, at 105-107 nn.12-23 and accompanying text; *see also* Margolin, *supra* note 75, at 18-27.

92. *See* Nell Clement, Note, *Do "Reasonable Efforts" Require Cultural Competence? The Importance of Culturally Competent Reunification Services in the California Child Welfare System*, 5 HASTING RACE & POVERTY L.J. 397, 418-19 (2008).

93. *See supra* notes 72-87 and accompanying text.

94. *See supra* notes 37-65 and accompanying text.

95. Nicholson et al., *supra* note 38, at 21-23.

96. *In re Eden F.*, 710 A.2d 771, 783 (Conn. App. Ct. 1998) (quoting *In re Sheila G.*, 61 N.Y.2d 368, 381 (1984)).

the rare case where a high level of effort and patience is not needed to reunite a family. The reasonable efforts requirement anticipates that child welfare agencies will use their “expertise, experience, capital, manpower and prestige” to help the family try to resolve their problems.<sup>97</sup>

In view of the complex problems faced by all parents in the system, it does not make sense to categorically exclude parents with a mental illness from services meant to help the family. In fact, a parent with mental illness is arguably less culpable for their difficulties, and more deserving of assistance, than other parents in the system. Parents with a mental illness are in essence “victimized twice”: first because they have a “devastating neurobiological illness” that is no fault of their own and then because their illness is perceived as permanently impairing their ability to care for their children.<sup>98</sup>

This double victimization is not necessary to strike the proper balance between family preservation and protection of children. Parents with a mental illness certainly face many challenges, but they are not necessarily either so unsusceptible to rehabilitation, or so dangerous, that they should be treated differently than other parents in the child welfare system. Children whose parents suffer from alcoholism, for instance, tend to do more poorly than children whose parents suffer from mental illness.<sup>99</sup> Moreover, children suffer most when a parent’s mental illness coexists with substance abuse and domestic violence, factors not taken into account by the applicable statutes.<sup>100</sup>

Perhaps the commonly held belief that mental illness, particularly schizophrenia, is closely linked to violence has affected state views on reunification services for families with a mentally ill parent. If so, those states should reconsider: “mental disorders—in sharp contrast to alcohol and drug abuse—account for a minuscule portion of the violence that afflicts American society.”<sup>101</sup> In this regard, there is a

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97. *In re Eden F.*, 710 A.2d at 783.

98. Ackerson, *supra* note 63, at 188.

99. Oliver B. Williams & Patrick W. Corrigan, *The Differential Effects of Parental Alcoholism and Mental Illness on Their Adult Children*, 48 J. CLINICAL PSYCHOL. 406, 407 (1992).

100. Nicky Stanley, Bridget Penhale, Denise Riordan, Rosaline S. Barbour & Sue Holden, *Child Protection and Mental Health Services: Interprofessional Responses to the Needs of Mothers* 8 (2003).

101. John W. Parry, *Highlights and Trends*, 24 MENTAL & PHYSICAL DISABILITY L. REP. 538, 542 (2000).

need to be wary of so-called expert predictions that a mentally ill parent is likely to abuse or neglect their child. Evidence suggests that mental health experts are ill equipped to make predictions about whether such parents are likely to be physically abusive. They tend to over-predict child abuse and neglect, perhaps out of a fear of failing to adequately protect the child.<sup>102</sup> While such caution is understandable, it should not be used to exclude mentally ill parents from services based on undifferentiated fears about them as a group. In reality, most parents with a mental illness do not either abuse or neglect their children, even when symptoms are at their worst.<sup>103</sup> In this regard, mental illness is perhaps better looked at as a risk factor for child neglect or abuse instead of an indication of its presence.<sup>104</sup>

Similarly, while child welfare agencies must be concerned about the negative effects of growing up with a mentally ill parent, these concerns do not justify excluding entirely foregoing reunification services. That practice overestimates the benefits of removing children from mentally ill parents while underestimating the impact of TPRs on children.

Evidence that children with a mentally ill parent do better when they are removed from their home and placed elsewhere is sparse.<sup>105</sup> This is despite the fact that much of the research surrounding children of parents with a mental illness has focused on potential negative outcomes or the development of pathology in a child.<sup>106</sup> By contrast, not much attention has been devoted to the impact of separation of the

102. Nina Wasow, *Planned Failure: California's Denial of Reunification Services to Parents with Mental Disabilities*, 31 N.Y.U. REV. L. & SOC. CHANGE 183, 212 (2006). Wasow notes that when children are permanently removed from a parent's care, a professional's prediction of abuse or neglect can never be disproved. *Id.*

103. Aldridge, *supra* note 49, at 82. *See also* Wasow, *supra* note 102, at 209 (noting that mental illness as a predictor of child abuse and neglect has "low specificity," that is there are too many confounding factors to determine whether mental illness is directly linked to mistreatment).

104. Nicky Stanley & Bridget Penhale, *The Mental Health Problems of Mothers Experiencing the Child Protection System: Identifying Needs and Appropriate Responses*, 8 CHILD ABUSE REV. 34, 35-37 (1999).

105. One longitudinal study done in 1988 looked at the placement of 306 children with a mentally ill parent and concluded that a child's risk status was reduced when not living with their parent. Arlene Rubin Stiffman, Kenneth G. Jung & Ronald A. Feldman, *Parental Mental Illness, Family Living Arrangements, and Child Behavior*, 11 J. SOC. SERV. RES. 21, 31-33 (1988). However, this study included substance abuse as a form of mental illness, so it is difficult to tell to what degree children of non-substance abusing parents fared poorly. *Id.* at 23.

106. Nicholson et al., *supra* note 38, at 18.

child from their home.<sup>107</sup> However, there is reason to be concerned. One study of children who were adopted after TPR found that many children have tremendous difficulty accepting separation from their natural parents. The author of the study concluded that “involuntary terminations of parental rights by court order seemed to create more serious problems for the children than it solved.”<sup>108</sup>

This is particularly true when, as is often the case, TPR does not result in a permanent home through adoption, but rather prolonged foster care, often times in multiple placements.<sup>109</sup> Because children with a mentally ill parent often have behavioral or psychological problems, they are at particular risk for this fate. When a child “drifts” through foster care, they are vulnerable to numerous serious problems. For instance, children “age-out” of foster care when they reach age 18, and often are left with no remaining family ties at all. They might also have to transfer schools often, which hampers their educational achievement and disrupts social ties.<sup>110</sup>

But most disturbingly, foster children are at considerable risk of being seriously abused or neglected by their foster parents. Children with behavioral or psychological problems are at special risk.<sup>111</sup> Given that the children of the mentally ill are more likely than other children to demonstrate such problems, they are more likely to be mistreated by a substitute caregiver.<sup>112</sup>

In short, when the natural trauma of being separated from a parent is combined with the rigors of long-term foster care placement, and the risk of being harmed by a new caregiver, the decision to excuse reasonable efforts to keep the family together seems illogical. Indeed, one author has concluded that the best outcome for children is to remain with a parent whose abilities are “adequate, even if not optimal.”<sup>113</sup> In view of this, it seems that state statutes should strike the

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107. *Id.* at 4, 24-25.

108. Matthew B. Johnson, *Examining Risks to Children in the Context of Parental Rights Termination Proceedings*, 22 N.Y.U. REV. L. & SOC. CHANGE 397, 414 (quoting Robert Borgman, *Antecedents and Consequences of Parental Rights Termination for Abused and Neglected Children*, 60 CHILD WELFARE 391, 402 (1981)).

109. Orly Rachmilovitz, *Achieving Due Process Through Comprehensive Care for Mentally Disabled Parents: A Less Restrictive Alternative to Family Separation*, 12 U. PA. J. CONST. L. 785, 816 (2010).

110. *Id.*

111. Nicholson et al., *supra* note 38, at 23.

112. Rachmilovitz, *supra* note 109, at 817.

113. Marsh, *supra* note 4, at 32.

same balance that ASFA strikes—to excuse reasonable efforts on the basis of a parent’s actual past behavior, usually serious violence and abuse, as opposed to the parent’s status or diagnosis.<sup>114</sup> In this way, states can attempt to balance the benefits of preserving the family with protecting the child.

In fact, given advances in psychiatry, states that excuse reasonable efforts on the basis of mental illness risk having their laws become outdated and irrational. There is reason to be optimistic about the prognosis of individuals with a mental illness. Although schizophrenia remains a challenging disability, recent advances in medication and treatment have made the outlook brighter now than in the day when a diagnosis of schizophrenia likely resulted in long-term institutionalization. There have been similar advances in the affective disorder like bipolar disorder and depression. It is regrettable that laws in states that specifically exclude parents with a mental illness from receiving services remain in effect while progress is being made in treating these disorders.

#### IV. THE REASONABLENESS OF EFFORTS EMPLOYED IN MENTAL HEALTH CASES

The failure to provide reunification services at all is not the most serious problem faced by parents with a mental illness throughout the nation. Most states recognize a duty to exercise reasonable efforts to reunify a family, even in cases of mental illness, before seeking TPR.<sup>115</sup> Indeed, a few states view it as constitutionally required.<sup>116</sup> Other states reject<sup>117</sup> the approach taken by New York and South Carolina, where courts have interpreted the lack of an explicit reasonable efforts requirement in the portion of a statute permitting TPR on grounds of mental illness as justification for providing no efforts at all.<sup>118</sup> Indeed, in many instances, state CWAs appear to at the very least refer parents with a mental illness to a great many services.<sup>119</sup>

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114. See *supra* notes 70-87 and accompanying text.

115. See Margolin, *supra* note 75, at 152.

116. See *supra* note 89 and accompanying text.

117. See e.g., *In re Welfare of S.Z.*, 547 N.W.2d 886, 891-93 (Minn. 1996) (accepting father’s argument that TPR statutes had to be read together to avoid the “conflict of interest” that would arise if state could escape need to make reasonable efforts by pursuing TPR under particular portion of the statute).

118. See *supra* notes 72-79 and accompanying text.

119. See, e.g., *In re Amanda A.*, 755 A.2d 243, 247 (Conn. App. Ct. 2000) (holding record was “replete” with evidence of reunification services including attempts to build

Nonetheless, even in cases where numerous services are offered and/or received, the question of whether the reasonable efforts requirement is being satisfied remains. This is because often the efforts exerted are not by their nature likely to offer the family the type of help it needs. State courts are generally quick to note that reasonable efforts means that the state's obligation does not require it to engage in exhaustive efforts, only reasonable ones.<sup>120</sup> However, efforts that are not reasonably targeted at the population to be served can hardly be deemed reasonable, even if the efforts are great in number.

Therein lies the problem in reasonable efforts cases that involve a mentally ill parent. A review of the literature concerning reunification services for such parents reveals that the efforts typically made by state child welfare agencies are frequently both unsuitable and ineffective. In essence, the existing evidence shows that agencies are often simply going through the motions of providing reunification services to parents with a mental illness without providing them with any actual help. The following section of this article will address some steps that can be taken to remedy this problem so that reasonable efforts become more than pro forma efforts.

#### A. Scarcity of Programs Targeted for Parents with a Serious Mental Illness

Ideally, parents with a mental illness would have access to programs that specifically designed to meet their needs both as parents and as persons suffering from a mental illness. Parents with a serious mental illness largely share the needs of all parents involved with CWAs.<sup>121</sup> They, like other parents, need assistance with housing, transportation, vocational training, access to benefits and childcare, recreation, parenting skills and respite.<sup>122</sup> In fact, parents with a mental illness may have greater needs for these generic types of services than parents in the same socio-economic group who do not suffer from such

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a therapeutic team, in-home services and visitation); *In re Welfare of H.S.*, 973 P.2d 474, 481, n.2 (Wash. Ct. App. 1999) (enumerating services offered to parents and concluding that family was "saturated" with reunification efforts); *In re Welfare of S.Z.*, 547 N.W.2d at 889 (indicating that father with chronic schizophrenia received psychiatric services including multiple hospitalizations and crisis intervention).

120. See, e.g., *In re Anthony B.*, 735 A.2d 893, 900 (Conn. App. Ct. 1999) (holding that reasonable efforts means "doing everything reasonable, not everything possible").

121. Nicholson et al., *supra* note 38, at 14.

122. *Id.*



an illness.<sup>123</sup> However, parents with a serious mental illness face additional challenges related to the illness itself.<sup>124</sup>

In this respect, the services typically offered or suggested by CWAs are often lacking because they do not take those challenges into account. For example, a stock requirement of service plans for parents involved with CWAs is participation in a parenting group.<sup>125</sup> Parenting groups seek to educate participants about child development, managing children's behavior and overall parenting skills.<sup>126</sup> However, parents with a mental illness often find these programs to be "irrelevant, inappropriate or uncomfortable."<sup>127</sup> It is easy to see why when thinking back to the example of Mary in the introduction to this article. Mary attended a parenting group briefly, but left in part because she thought the participants were making fun of her. Mary could well have been right: given her preoccupation with her delusion that enemies were invading her home, the other participants in her group might well have ridiculed her. Even under the best circumstances, where the participants were sympathetic and tolerant, a group not specifically targeted for parents with a mental illness would have a difficult time managing Mary's idiosyncratic concerns.

Parents with a mental illness might also reject parenting groups because the programs do not address problems specific to mental illness, such as distraction and lethargy.<sup>128</sup> Parents faced with a program that ignores their most crucial problems are likely to become alienated. If, as a consequence, they cease participation in a program that was not helping them in the first place, their withdrawal might well be used against them in a TPR hearing.

Likewise, providers of a generic service may become frustrated with the behavior of a parent with a mental illness. Again, the example of Mary from the introduction of this article is instructive. Mary received assistance from a parent aide who in part was assigned to help her clean up her apartment. However, the aide became frustrated with

123. *Id.* (citing study of mothers with and without mental illness in a high poverty area in Detroit which showed "living with mental illness plays a role above and beyond that of poverty alone").

124. *Id.*

125. The author's observation is that participation in a parenting group is a stock requirement.

126. Nicholson et al., *supra* note 38, at 16.

127. *Id.*

128. *Id.* at 16. Similarly, psychosocial rehabilitation programs designed expressly for the mentally ill may not address issues related to parenting). *Id.*

Mary and determined she was “impossible” because Mary’s delusions interfered with the aide’s attempts to dispose of her litter. Here the aide, lacking understanding of the symptoms of mental illness, viewed Mary’s behavior as stubborn resistance, as opposed to a manifestation of her psychiatric disorder. In other instances, an aide may lack an understanding of the toll antipsychotic medication can take on energy and initiative and thus bring unrealistic expectations to the relationship. In short, because the parent aide program is not tailored to the needs of a parent with mental illness, the service can become counter-productive.

Another problem that often arises with parents with a mental illness occurs when the CWA simply refers the parent to mental health services without any attempt to assure that the parent follows through with the referral. The CWA might deliberately avoid intensive follow-up because it is commonly assumed that people do not benefit from therapy unless they are motivated to address problems, seek therapy out themselves and follow-through with appointments. But the conventional wisdom does not hold true for parents with a mental illness. A study in which parents with a mental illness received aggressive intervention from a child protection agency determined that personal motivation is not the key to successful linkage to therapy in cases of serious psychiatric disorders.<sup>129</sup>

An obvious solution is to provide programs that specifically address the needs and concerns of mentally ill parents and in fact, a number of programs, taking a wide variety of approaches to addressing the needs of mentally ill parents have been developed.<sup>130</sup> Although it has been difficult to acquire conclusive evidence of the efficacy of the programs, the results are promising.<sup>131</sup> In fact, in some instances the

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129. ELIZABETH P. RICE, MIRIAM C. EKDAHL & LEO MILLER, CHILDREN OF MENTALLY ILL PARENTS: PROBLEMS IN CHILD CARE 219-220 (Sheldon R. Roen ed., 1971). The study also concluded that the families of parents with a mental illness greatly appreciated the extra follow-up. *Id.*

130. See, e.g., B.C. MINISTRY OF CHILDREN & FAMILY DEV. & B.C. MINISTRY OF HEALTH SERVS., SUPPORTING FAMILIES WITH PARENTAL MENTAL ILLNESS: A COMMUNITY EDUCATION AND DEVELOPMENT WORKSHOP B.C. MINISTRY OF HEALTH 232-234 (2002), available at [http://www.health.gov.bc.ca/library/publications/year/2002/MHA\\_Parental\\_Mental\\_Illness\\_Support.pdf](http://www.health.gov.bc.ca/library/publications/year/2002/MHA_Parental_Mental_Illness_Support.pdf) (identifying ten programs in the United States directed toward parents with a mental illness, utilizing a variety of approaches).

131. Ackerson, *supra* note 63, at 191-92 (noting success for pilot programs specifically targeted for parents with mental illness). See also Nicholson et al., *supra* note 38, at 46-47 (describing a number of “high specificity” programs for parents with

outcomes are quite impressive. One program designed to assist parents with a mental illness resulted in fewer hospitalizations and an eighty-percent reduction in foster care placement.<sup>132</sup>

Nonetheless, CWAs are unlikely to link parents with a mental illness to a program specifically designed to address their problems. Quite simply, such programs are rarely available.<sup>133</sup> Instead, they have “generally been developed on a small, local scale with limited funding, and have remained largely isolated from one other.”<sup>134</sup> This fact is not surprising: programs for parents with a serious mental illness are labor-intensive, requiring many types of services along with a high degree of service coordination.<sup>135</sup> One study identified the need for a “comprehensive array of services” including housing, vocational training, early childhood education, crisis intervention, emergency rent payments, and parent education and skills training.<sup>136</sup>

Presumably the scope of the services needed and the need for coordination of those services, make the programs both expensive and difficult to implement. While the barriers of cost and complexity may be difficult to surmount in the best of times, they are particularly challenging during the current economic climate when state and federal programs for the needy are being slashed.

The scarcity and expense of programs designed for parents that are mentally ill make it quite difficult for parents to prevail on a claim that a CWA did not exercise reasonable efforts. State courts routinely hold that it is not reasonable to require CWAs to provide services that are not readily available.<sup>137</sup> In fact, court decisions addressing the

a mental illness, but noting many of these programs did not have the resources to evaluate the effectiveness of the programs). Consequently, evaluation was often limited to collecting data about client satisfaction, which was generally high. *Id.* at 47.

132. Marsh, *supra* note 4, at 32.

133. *Id.* at 33; Ackerson, *supra* note 63, at 191-92.

134. Beth Hinden et al., *Steps Toward Evidence-Based Practices for Parents with Mental Illness and Their Families*, MENTAL HEALTH AM., iii (Mar. 15, 2002), available at <http://www.nmha.org/download.cfm?DownloadFile=A04C327C-1372-4D20-C864724876AFF2E3>.

135. *See id.* at 30-32 (describing program that provided intensive services including twenty-four hour availability, behavioral modeling, skill-building, education and family support). *See also* Nicholson et al., *supra* note 38, at 45-46 (noting that a number of programs were comprehensive and required a high degree of coordination between service providers).

136. Hinden et al., *supra* note 134, at 13.

137. *See, e.g., In re Interest of C.S.M.*, 805 P. 2d at 1131 (ruling that state was not required to provide the inpatient treatment that mother’s doctors predicted was the only

reasonable efforts requirement frequently stress that CWAs are not required to exert significant energy locating a program that might actually suit a particular parent's needs.<sup>138</sup> Should this mean that unless a parent with a mental illness is fortunate enough to live in one of the few locations where a program to assist such parents exists, a CWA can meet its reasonable efforts obligation by referring the parent to services known to be ineffective and unsuited the parents' needs? The answer to this question should be no.

First, state and federal funding sources, along with CWAs and courts, should not be so quick to decide that it is cost-prohibitive and thus unreasonable to implement programs that serve the specific needs of parents with a mental illness. In this respect, it is interesting to examine work being done with patients in the health-care system who generate the most costs. Very recently, a number of programs have developed that identify the patients in a particular population who are the most expensive to treat. These patients, like parents with a mental illness, often have multiple problems, including housing, employment, income and overall stability. Once these patients are identified, they are provided with health care that involves a high degree of outreach, coordination and intervention that goes way beyond what one might usually expect from their medical provider.<sup>139</sup> For instance, one program employs coaches whose services can include helping patients make appointments, procuring medication, and tracking them down when they miss appointments.<sup>140</sup> The services even go so far as programming the health clinic's telephone number into patients' cell phones.<sup>141</sup> The last of these services was effective: it resulted in a drop of costly calls to 911.<sup>142</sup>

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program that could help her when such treatment was not available); *In re Adoption of Lenore*, 770 N.E.2d 498, 503 (Mass. App. Ct. 2002) (finding reasonable efforts requirement satisfied when parent's applications for services recommended by the child protection agency were rejected).

138. See, e.g., *In re Hanks*, 553 A.2d 1171, 1172, 1178-1179 (Del. 1989) (holding that the state had provided sufficient reunification services for mother who had been involuntarily hospitalized for psychiatric illness by providing visitation and instructing mother to attend counseling and take medication). But see, e.g., *P.A. v. Dep't of Health & Rehabilitative Servs.*, 685 So. 2d. 92, 93 (Fla. Dist. Ct. App. 1997) (reversing TPR when child protection agency did not monitor the mother's progress but simply referred her to a mental health agency).

139. Atul Gawande, *The Hot Spotters*, THE NEW YORKER, Jan. 24, 2011, at 41-51.

140. *Id.* at 48.

141. *Id.* at 49.

142. *Id.*

State and federal agencies could certainly consider intensive services like this for parents with a mental illness. Many of these parents could certainly benefit from a similar approach in which caregivers followed them closely to help assure they received the services that they need. And when weighing the expense of such programs against its benefit, the other costs associated with child protection cases should be taken into account. Very significant resources are into placing children in foster care, terminating parental rights and pursuing adoption. These costs are borne by different systems. For example, one budget line provides subsidies to foster and adoptive parents; another budget line pays for the mental health services needed by children as a result of emotional problems occasioned by their displacement; and a third pays the lawyers and judges involved in the TPR proceedings.<sup>143</sup> When all of these costs are totaled, an intensive program targeted at parents with a mental illness, which may be able to keep some families intact, does not seem nearly as costly.

Nonetheless, without a significant change in thinking, it is unlikely that the reasonable efforts requirement will compel CWAs to invent programs for parents with a serious mental illness out of whole cloth anytime soon. Despite this, the requirement should at a minimum mandate that CWAs take logical steps to ameliorate the problems faced by families affected by mental illness. Two logical steps can be taken without unduly taxing current systems. The first of these is increasing cooperation and coordination between the mental health system and the child welfare system. The second is providing better education to child welfare workers about mental illness.

#### B. Lack of Connection Between Mental Health Services and Child Welfare Agency Intervention

The most common theme running through the literature about services for parents with a mental illness is an almost complete disconnection between the actions by a child welfare system and the services provided by mental health system. While an optimal service plan for a mentally ill parent would have these systems working in tandem, it appears it is far more likely for the two systems to function more like parallel lines—proceeding along their paths, but never intersecting.

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143. Nicholson, Geller & Fisher, *supra* note 62, at 499.

CWAs by necessity must refer parents in order to psychiatric services to treat their mental illness. However, while those services may have some success in helping parents cope as individuals with psychiatric problems and controlling symptoms, they largely leave problems specifically associated with caring for children unaddressed. This is primarily because mental health professionals tend not to pay much attention to the parenting roles of the patients they serve. Studies conducted from 1946 until recent years have repeatedly shown that mental health professionals do not address parenting problems and often do not even ask their clients whether they are parents at all.<sup>144</sup> Given this tendency, the focus of treatment is on the parent as an individual as opposed to the parent's ability to function in the family environment.<sup>145</sup> In fact, clinicians treating mental illness may have very little understanding of child protection law even when the patients they are treating are entrenched in the child protection system.<sup>146</sup>

Moreover, even when mental health professionals are viewed by parents as helpful in an overall sense, they are not viewed as helpful in addressing parenting problems. As a consequence, while many parents with a mental illness find mental health professionals to be supportive in general, they do not find that they help them cope with their children.<sup>147</sup> In fact, a mental health clinician's failure to address parenting responsibilities may contribute to inappropriate service plans that ultimately lead to a parent's non-compliance. For instance, a psychiatrist might prescribe medication that has a sedating effect to be taken in the morning. A mother who must get up and get her child breakfast in the morning may decide not to take the medication so she can fulfill her parenting responsibility.<sup>148</sup>

Obviously, greater communication and cooperation between child

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144. See RICE, EKDAHL & MILLER, *supra* note 129, at 14 (citing 1946 study finding that relatively little consideration has been given to the rest of the cohabiting family); Nicholson et al., *supra* note 38, at 32 (citing study finding that only twenty-five percent of state mental health agencies identify their clients as parents and only thirty-one percent collect data on whether clients have pre-school children); Stanley & Penhale, *supra* note 104, at 41 (citing 1996 study showing that mental health professionals exhibit little awareness of a patient's parental role).

145. Nicholson et al., *supra* note 38, at 32.

146. Andrea K. Blanch, Joanne Nicholson & James Purcell, *Parents with Severe Mental Illness and Their Children: The Need for Human Services Integration*, 21 J. MENTAL HEALTH ADMIN. 388, 391 (1994).

147. Nicholson et al., *supra* note 38, at 14-15.

148. See *id.* at 15.

welfare agencies and mental health systems is in order. Indeed, some of the literature examining this issue advocates a more integrated approach.<sup>149</sup> However, even assuming that professionals on each side of the child welfare-mental health divide wanted to expend the time and energy needed to effectuate a more coordinated approach, they would face significant obstacles.

The most formidable of these is that in almost every state, patient confidentiality laws would preclude mental health professionals from sharing information with child welfare workers.<sup>150</sup> Thus, in most cases, mental health clinicians could not share information about whether a parent was attending appointments, what medications the parent was prescribed, and whether the parent was compliant with those medications and other treatments unless the parent affirmatively permitted the communication. Furthermore, although the literature suggests that the needs of mentally ill parents and their children should be treated holistically rather than compartmentally,<sup>151</sup> mental health clinicians are precluded from participating in case conferences and planning sessions without the permission of their patients.

Such permission may not be easy to come by. Parents fear that if they engage in mental health services at all, they will increase their risk of losing custody of their children.<sup>152</sup> Thus, they may recoil at the prospect of allowing a therapist or psychiatrist to share information with the agency, whose role might be to build a case for termination of parental rights against them.<sup>153</sup> This fear is not necessarily unwarranted, given the large number of mentally ill parents who ultimately have their children removed from their care.<sup>154</sup> Moreover,

149. See Stanley & Penhale, *supra* note 104, at 42 (asserting that there is a “mandate” for child welfare workers to either address mental health problems themselves or in cooperation with other professionals); Blanch, Nicholson & Purcell, *supra* note 146, at 395 (suggesting a “rigorous evaluation of services integration efforts” in New York state).

150. See, e.g., CAL. EVID. CODE, §1012 (West 2011); MASS. GEN. LAWS ANN. ch. 233, § 20B (West 2011); N.J. STAT. ANN. § 45:14B-2B (West 2011).

151. Stanley & Penhale, *supra* note 104, at 42.

152. *Id.* at 39; Nicholson et al., *supra* note 38, at 15 (noting that stigma associated with mental illness is the single biggest barrier to seeking treatment).

153. See Nicholson et al., *supra* note 38, at 15. Anecdotally, this author has observed that parents in the child protection system often refuse to sign releases of information allowing their mental health providers to share information with the child protection agency. *Id.* This decision can backfire on the parent when the refusal to sign a waiver is presented as evidence of lack of cooperation in a service plan at a TPR trial.

154. Nicholson et al., *supra* note 38, at 1.

professionals in both the child welfare and mental health systems may foster these fears. One study showed that mothers with mental health problems in the child welfare system perceived social workers as focusing on their illness and assuming that they were incapable of caring for their children.<sup>155</sup> This perception, in turn, led them to distrust the social workers.<sup>156</sup>

Despite this admittedly serious obstacle, there are steps that child welfare agencies can take to make their referrals to mental health professionals more effective. First, although the conversations between a patient and a clinician are usually protected by privilege, there is no legal obstacle preventing the clinician from hearing the concerns of a social worker for a child welfare agency. Thus, the social worker can make regular contact with a clinician and express his or her concerns about the parent's behavior as it affects the children. The child welfare worker can also suggest assertively, that the clinician focus some attention on parenting problems instead of independently pursuing a course of treatment. Such communication would be particularly important when the child welfare worker is aware of growing concerns about a parent's behavior or problems in the family that the parent might be able to hide from the clinician in the course of a one-hour therapy session or an even shorter medication evaluation.

Moreover, this communication does not have to be an entirely one-way street. While clinicians cannot disclose their communications with their clients, they can certainly help educate child welfare professionals about such matters as the symptoms of mental illness, the typical course of treatment, and the side effects of medication. In addition, a mental health professional can help a child welfare worker explore more effective approaches to working with a mentally ill parent in the child protection setting. Research shows that most agencies take a deficit-oriented approach to working with mentally ill parents, that is they focus almost entirely on the negative aspects of parenting with a mental illness.<sup>157</sup> However, it may be far more effective to work with parents to take an asset-oriented approach that helps the parent identify the strengths they possess to manage their symptoms and improve their parenting.<sup>158</sup> In fact, when professionals regularly focus on the parent's deficits, rather than his or her strengths,

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155. Stanley & Penhale, *supra* note 104, at 39-40.

156. *Id.*

157. Risley-Curtis et al., *supra* note 3, at 115.

158. *Id.* at 115-16.



they risk making the relationship so adversarial that the parent is alienated from it altogether.<sup>159</sup>

A mental health clinician may be able to be helpful here by encouraging child welfare workers to compare a parent with a serious mental illness to one with a substantial physical disability. Taking this approach, the child welfare worker may be able help the parent to learn to compensate for parenting deficits and develop strategies for circumventing problems, much like they would with a parent with physical limitations.<sup>160</sup>

First, mental health programs need to be far more cognizant of whether their patients are also parents. If such programs more routinely inquired into whether their case rolls included parents, they would likely routinely begin tailoring some of their services to meet the needs of those parents. For instance, mental health centers regularly provide therapeutic groups for their patients; one of these groups could be a parenting group. In such circumstances, a CWA could refer a parent with mental illness to that specialized group rather than a generic parenting group that the parent may find "irrelevant, inappropriate or uncomfortable."

Second, if personnel in the child protection system were more attuned to the parenting problems faced by those with a serious mental illness, they could bring this knowledge to the services they provide to those parents.

### C. Child Welfare Worker Education

A related issue that impairs delivery of effective reunification services to mentally ill parents is lack of education on the part of child welfare workers about mental illness. Just as mental health clinicians frequently know little about the child protection system, child protection workers often know little about mental illness, including its effects and its treatment.<sup>161</sup> As a consequence, child welfare workers often make little distinction between the way they treat parents with a mental illness and parents on their caseload as a whole.<sup>162</sup>

This lack of information can lead to serious misunderstandings

159. Nicholson et al., *supra* note 38, at 15.

160. Risley-Curtis et al., *supra* note 3, at 116.

161. See Blanch, Nicholson & Purcell, *supra* note 146, at 391; Risley-Curtis et al., *supra* note 3, at 115; Aldridge, *supra* note 49, at 84.

162. Aldridge, *supra* note 49, at 84.

about the problems that mentally ill parents present. For instance, the negative symptoms of schizophrenia<sup>163</sup> will appear to the untrained social worker as laziness and inertia on the part of the parent. Similarly, an untrained social worker might not recognize the developing symptoms of a bipolar disorder and view symptoms on either side of that spectrum as willful.

The obvious remedy for lack of education and training about the effects of mental illness is for child welfare agencies to provide that training to their staff. But once again, in this arena, there are no simple solutions. Social workers in child welfare agencies do not come to the job with a solid educational background in social work and human services. Many states do not require bachelor's degrees for their child welfare social workers and even when new workers do have degrees they are often not in the field of counseling or social work.<sup>164</sup> As a consequence, even when new workers are given information in training programs, they are not building on an established base of information but instead learning entirely new material at a time when they are taking on an enormously challenging job.<sup>165</sup> Thus, in order to comply with the reasonable efforts requirement, all state child welfare agencies should provide frequent and comprehensive education about mental illness, its symptoms, its treatment, and its effects on parenting.

And this training will have to be repeated with great frequency. There is enormous turnover among child welfare workers, with one agency reporting a rate of one hundred percent.<sup>166</sup> Therefore, it is crucial for child welfare agencies to provide training about mental illness at regular intervals to insure all of their workers are fully educated on each aspect of the problem.<sup>167</sup> Nonetheless, it seems that any reunification efforts that are offered without some training regarding the specific needs of parents with a mental illness are by definition unreasonable.

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163. See *supra* notes 15-17 and accompanying text.

164. Risley-Curtis et al., *supra* note 3, at 114-15.

165. See, Kaiser, *supra* note 69, at 128-29 (describing the challenges facing child protection workers).

166. Risley-Curtis et al., *supra* note 3, at 114.

167. One alternative to all of this training is to have some workers specialize in working with parents with mental illness, thus allowing them to build up expertise in this area. While this approach has its attractions, at least one report suggests that a full caseload of families with mental illness is too demanding for one worker to handle. RICE, EKDAHL & MILLER, *supra* note 129, at 214.

## V. CONCLUSION

Decisions about terminating parental rights are among the most wrenching considered by the legal system. The Adoption and Safe Families Act<sup>168</sup> attempts to balance the desirability of keeping families together with the need to protect children's safety by imposing the reasonable efforts requirement. This balance is thrown out of whack when states legislate to exclude families who have a parent with a mental illness from the chance to benefit from the reunification services other families receive. The balance is similarly upset when the state requires reasonable efforts but those efforts do not address the problems faced by parents with a mental illness.

The steps suggested in this article are modest and no doubt insufficient to solve the problem. It is certainly "reasonable" to continue developing programs designed specifically for parents with a mental illness, to create extra communication between child welfare and mental health organizations, and better training about mental illness to child protection workers. In fact, to ignore what is already known about improving the efficacy of the help offered to parents and children afflicted by serious mental illness is not just of questionable legal legitimacy; it is of questionable ethical legitimacy. Forty years ago, the forward of a book about the problems faced by children of mentally ill parents quoted an even older statement noting:

We human beings know little enough about ourselves, individually and as members of society, in all conscience, but we do know a good deal more than we practice, and we could add to the knowledge we have more rapidly if we used it and reflected upon the results. It is profoundly unethical if in dealing with people we employ methods that are less skilled, less intelligently compassionate, than they need to be. If we use hit-or-miss methods to a greater extent than we must, then we will miss more often than we need, and in so doing damage or fail to help others more often than is inevitable.<sup>169</sup>

Better enforcement of the reasonable efforts requirement with parents who have a mental illness is one way to avoid failing to help other more than is inevitable and should be done.

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168. See *supra* note 66-71 and accompanying text.

169. RICE, EKDAHL & MILLER, *supra* note 129, at viii-ix (quoting E. YOUNGHUSBAND, SOCIAL WORK AND SOCIAL CHANGE (1969)).