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Examining the Intersection of Chemical Dependency and Mental Health Issues with the Juvenile Protection System Timelines as Related to Concurrent Planning and Termination of Parental Rights

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EXAMINING THE INTERSECTION OF CHEMICAL DEPENDENCY AND MENTAL HEALTH ISSUES WITH THE JUVENILE PROTECTION SYSTEM TIMELINES AS RELATED TO CONCURRENT PLANNING AND TERMINATION OF PARENTAL RIGHTS*

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* *Authors' Note*: Many of the resources cited in this article have independent citations to vast amounts of material and analysis well beyond the substance of this piece. Additionally, the authors of this article have over fifty-five years' worth of practice in the juvenile court. This includes hundreds of cases involving CHIPS, TPR, and adoption issues. As a result, many of the observations and comments are based on the totality of the authors' extensive experience and not cited or footnoted to any other original sources. We are in fact the original source for these comments. See http://WBDLaw.com for more background on the authors. Readers are encouraged to review the totality of these resources in exploring the complexities of these issues.

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I. INTRODUCTION

Issues dealing with children who have been neglected, abused, or otherwise harmed and have been through the social welfare system and placed in foster care, continue to be baffling for both social services and the courts. Yet, the question continues to be, *what do we do with them now?* It has been agreed for years that, historically, "[n]umerous transfers from one caregiver to another can have a negative impact on the child's development and sense of belonging,"[1] and within that context, the failure of the court system to provide for children during child protection proceedings and after termination of parental rights (TPR) of the biological parents has caused significant and ongoing conflict. In many cases these proceedings have been detrimental to the child, poorly thought out by social services, unsupported by the courts, and unsuccessful in alleviating the problems of providing stability for these children.

In addressing this problem, concepts of "concurrent planning" were developed with the original thought that a permanent placement of a child after the TPR of the biological parents was, in

1. Jane Ranum, *Minnesota's Permanency and Concurrent Planning Child Welfare System*, 26 WM. MITCHELL L. REV. 687, 688 (2000). "The hallmark of good child welfare social work is the ability to rapidly secure a child's physical and emotional well-being in the context of her family of origin or in another permanent family." *Id.* (quoting MARY FORD, THREE CONCURRENT PLANNING PROGRAMS: HOW THEY BENEFIT CHILDREN AND SUPPORT PERMANENCY PLANNING FAMILIES 2 (1998)).

fact, in the child's best interests.[2] In addition, it was assumed that permanent placement was, in fact, permanent placement.[3] It is in this context that changes in the attitudes of the courts and social services were first confronted, and it is within this context that children have been circulated and returned back into the system after an original "permanent placement" has failed.[4] Thus, social welfare systems were directed to not only begin preparing case plans to try to reunify children with their parents upon their initial entry into the system, but at the same time to make plans "concurrently," assuming that if reunification of the child was unsuccessful, then some permanent placement would end the journey.[5]

"Concurrent planning is a form of permanent planning that seeks to limit the amount of time a child, in the child welfare system, waits for a permanent home. The focus of concurrent planning is on those children for whom reunification with a parent is not likely."[6] As a result of this shift in attitude, various statutory changes were implemented to give assistance to persons providing permanent placement for children, and, simultaneously, time limits were placed upon the welfare system and the courts, during which they were required to move forward towards permanency even if the original case plan for reunification had not been completed.[7] It was noted:

> [T]he goal of concurrent planning is to abridge this process so that reunification efforts occur simultaneously with other efforts to establish a permanent home for the child. Contrary to conceptual simplicity, . . . concurrent planning is the product of a decade long effort to promote permanency. These efforts were propelled, to a great extent, by federal government actions.[8]

2. For further background, see Wright S. Walling & Stacia W. Driver, *Celebrating 100 Years of Juvenile Court in Minnesota—a Historical Overview and Perspective*, 32 WM. MITCHELL L. REV. 883 (2006).

3. *See id.* at 915–16.

4. For further background, see Wright S. Walling & Gary A. Debele, *Private CHIPS Petitions in Minnesota: The Historical and Contemporary Treatment of Children in Need of Protection or Services*, 20 WM. MITCHELL L. REV. 781 (1994).

5. Ranum, *supra* note 1, at 688.

6. *Id.*

7. *See id.* at 696.

8. *Id.* at 689.

As pressure mounted to place children in "permanent homes" more quickly, social welfare systems and courts began to reach out to prospective adoptive parents, including relatives, to provide permanent and, in most cases, adoptive homes for these children.[9] At the time they were being recruited, adoptive parents received almost no education and little information regarding the children was given to them.[10] In fact, often the information coming out of a child protection or court file was not given to the social workers handling the adoption, and it was most definitely not given to the adoptive parents. The foundation for success was often severely lacking.

As a process of concurrent planning was developed and implemented in an effort at reunification, the expected and obvious conflict between effective development of case plans on behalf of families and the timelines pushing toward the permanency of a placement for a child became more and more obvious. Furthermore, when a parent's chemical dependency or mental health was at issue, treatment often could not be completed before the statutory deadline to complete the case plan, inevitably leading to TPR.[11] The result has often been a mishmash of

9. *See* Patrick Yagle, *When Adoption Goes Wrong: Giving Up Custody to Get Kids the Mental Help They Need*, ILL. TIMES (Aug. 11, 2011, 2:40 PM), http://illinoistimes.com/article-8964-when-adoption-goes-wrong.html; *see also* Kelli Kennedy, *Experts Push Disclosure of Failed Foster Adoptions*, READING EAGLE (Aug. 22, 2011, 4:53 AM), http://www2.readingeagle.com/article.aspx?id=327803 (discussing the difficulties of adopting foster children and the lack of services available to adoptive families).

10. "Overall statistical reports reveal very few dissolutions and disruptions." CYNTHIA R. MABRY & LISA KELLY, ADOPTION LAW: THEORY, POLICY, AND PRACTICE 705 (2006). One report indicates that after an adoption is finalized, only 0.4% to 5.4% of adoptions are dissolved. *Id.* Some have been critical of such studies:

> Some reports are criticized, however, because they are limited to small populations of children or one geographical area. Also, all studies use the same subjects—children who are adopted from public agencies—so no information is available for rates of dissolutions and disruptions in private adoptions. States either do not collect the information, inaccurately record the information, utilize different definitions for dissolution and disruption, or are reluctant to disclose the data.

Id. In addition, however, "the disruption rate for adoptions ranges from ten to twenty-five percent of adoptions depending upon how an empirical study is conducted (i.e., older adoptees are isolated from the study or the study encompasses children from only one state)." *Id.* For older children, the disruption rate is much higher at twenty-five percent. *Id.* "The highest rate of disruption occurs within the first twelve to eighteen months of the placement." *Id.* at 705–06.

11. *See* MINN. STAT. § 260C.301, subdiv. 1 (2012).

confusing standards applied by courts, social services, and individuals based on personalities and work ethics rather than treatment needs, goals, or recognition of family.

This crisis has resulted from the lack of training and understanding of the issues by social workers and therapists, as well as the lack of creative statutory criteria designed to deal with these issues and provide the support and stability needed by the children and the parents.[12] It is, in fact, a failure of an essentially self-created system, which uses a short-term model that does not account for the long-term needs of children and families.

II. EARLY MINNESOTA EXPERIENCE

From a historical perspective, Minnesota developed its statutory history and background in a similar manner to other states around the country. These changes reflected the social movements occurring on a national level, and Minnesota, as did other states, began early in the twentieth century to specifically address the needs of "dependent and neglected" children.[13] From that point to today, the manner in which the courts and mental health social services deal with such children has been hotly debated as the social movement and philosophical decisions have shifted back and forth.[14] More specifically, the early Minnesota "neglect" statute, enacted in 1905, reflects the broad and sweeping powers similar to those found in other states and enacted at the turn of the century.[15] Often the child could be removed for undetermined reasons of parental unfitness, including poverty in a variety of forms.

As noted in other articles detailing the issue's historical background, even these early statutes reflect the debate that exists today over whether it is the responsibility of the state or the family to protect and punish "dependent or neglected" children.[16] While recognizing the authority and control of the state through its

12. *See* Walling & Debele, *supra* note 4, at 808–26.

13. *Id.* at 794–815.

14. *See id.*

15. *See* Act approved Apr. 19, 1905, ch. 285, § 7, 1905 Minn. Laws 418, 418; ELIZABETH PLECK, DOMESTIC TYRANNY: THE MAKING OF SOCIAL POLICY AGAINST FAMILY VIOLENCE FROM COLONIAL TIMES TO THE PRESENT 4 (1987); Walling & Debele, *supra* note 4, at 802–08.

16. *See* Walling & Debele, *supra* note 4, at 798–815 (exploring the historical background of the Minnesota statutes).

course, the statutes began to look at other options and other persons to file petitions alleging that children were neglected or dependent, as long as such persons resided in the county and knew of the child who appeared to be neglected or dependent.[17]

Yet, as often noted, these hundred-year-old statutes provided few procedural protections for children. They nevertheless recognized the interrelationship between the authority and discussions with the court system, the general responsibility of families to police their own members, and the bringing of appropriate matters to the attention of the court system to work with social services mental health professionals.[18]

As with statutes passed in other states at the turn of the century, early dependency and neglect statutes in Minnesota struggled to define exactly what a "dependent" or "neglected" child was, or should be. These statutes define circumstances under which nondelinquent behavior by children should be brought before the court and, more specifically, how these children should be dealt with.[19]

Comments by courts and professionals in the early twentieth century reflect the ongoing and continuing attempts at dealing with individualized issues for specific children through the development of ongoing programs.[20] Writing in the first issue of the *Minnesota Law Review*, Judge Edward F. Waite of the Hennepin County Juvenile Court stated, "We live in what has been aptly

17. Walling & Driver, *supra* note 2, at 898.

18. *See id.* at 904–13.

19. Walling & Debele, *supra* note 4, at 803. The 1905 statute defined "dependent child" and "neglected child" as follows:

> [A]ny child who for any reason is destitute or homeless or abandoned; or dependent upon the public for support; or has not proper parental care or guardianship; or who habitually begs or receives alms; or who is found living in any house of ill fame or with any vicious or disreputable persons, or whose home, by reason of neglect, cruelty or depravity on the part of its parents, guardian or other person in whose care it may be, is an unfit place for such a child; and any child under the age of ten (10) years who is found begging, peddling or selling any articles or singing or playing any musical instrument upon the street, or giving any public entertainment, or who accompanies or is used in aid of any person so doing.

Act approved Apr. 19, 1905, § 7, 1905 Minn. Laws at 418 ("An act to regulate the treatment and control of dependent, neglected and delinquent children.").

20. *See, e.g.*, Edward F. Waite, *New Laws for Minnesota Children*, 1 MINN. L. REV. 48 (1917).

termed the 'century of the child.' Never before have the obligations of society to its more helpless members been so generally recognized; and of all forms of helpless that of childhood makes the strongest and most universal appeal."[21] In describing the approach taken by the court, Judge Waite listed what he believed to be the specific and significant accomplishments that the State of Minnesota had achieved in addressing the needs of dependent and neglected children, including the creation of reform schools for youthful offenders, schools for the deaf and blind, juvenile courts, state hospitals for crippled children, and "Mother's Pensions," which were, in his opinion, a significant movement toward helping these children who find themselves in the category of neglected and dependent children.[22] The programs largely reflected the developments occurring in other states and, from a needs standpoint, are reflective of the considerations existing in the twenty-first century in attempting to deal with the specific individualized needs of children.[23]

III. HISTORICAL BACKGROUND OF THE PROBLEM

During the 1970s the number of children entering the public care system increased significantly.[24] This increase resulted in children staying in the system much longer than in previous years.[25] As lawmakers became increasingly concerned by the number of children in the protection system, coupled with the lack of standard procedures, Congress initially enacted the Adoption Assistance of Child Welfare Act of 1980.[26]

While "[t]he Act's laudatory goals were to discourage excessive reliance on foster care placement and to permit greater use of

21. *Id.* at 48.

22. *Id.* at 48–49.

23. *See id.*

24. *See* Kay P. Kindred, *Of Child Welfare and Welfare Reform: The Implications for Children When Contradictory Policies Collide*, 9 WM. & MARY J. WOMEN & L. 413, 445 (2003).

25. *Id.* at 446 ("The numbers of children placed in foster care has grown in part due to limited availability of resources for other forms of familial support and in part due to state laws and regulations that created a process for removing a child from the home but were less clear on how to help the families . . . . Stays in foster care turned out to be long for many children . . . ."). For a general discussion of the issues, see Walling & Debele, *supra* note 4.

26. Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, 94 Stat. 500.

services assisting in family reunification,"[27] it also resulted in slowing the process of placing children in permanent homes.[28] More specifically:

> [T]he legislative goals were not realized by thousands of children, and disproportionately for children of color. [Data showed] that while children of color [made] up 35% of the general population, [those] children [made] up 64% of the children in foster care. Furthermore, children of color [were] more likely than white children to be placed in foster care and once placed, generally [stayed] in foster care longer and wait[ed] to be adopted longer than white children.[29]

Despite the intent of the adoption assistance program's initial federal legislation, statutes and rules were created in an effort to move children more swiftly into permanency both on the state and federal level.[30] In addition, the process became more complicated because states now had to determine if a child was eligible for adoption assistance and, if so, how much. They were required to inform potential placement resources of the availability of adoption assistance funds as well.[31] Since states had limited funds from which to draw adoption assistance, these inquiries and new eligibilities became a lengthy ordeal, again, slowing down the entire permanency process. Action was necessary to avoid this slow down.

IV. SWIFT MOVEMENT TO PERMANENCY

Pressure began to build to provide quicker permanent placements for special needs children.

> In December 1996, President Clinton directed the Secretary of the Department of Health and Human Services, Donna Shalala, to conduct consultations and provide specific strategies to move children more quickly from foster care to permanent homes. His goal was to double the number of adoptions or permanent placements in five years.[32]

27. Ranum, *supra* note 1, at 689.
28. *See id.*
29. *Id.*
30. *See infra* Parts IV, V.
31. MINN. STAT. § 259A.05, subdiv. 4(b) (2012).
32. Ranum, *supra* note 1, at 689–90.

The result was the creation of the Adoption 2000 Blueprint in February 1997.[33] Among other things, the Blueprint, reflecting the attitude of social services and of the courts at the time, was based on the following eight assumptions:

(1) Every child deserves a safe and permanent family;
(2) Children's health and safety is a paramount concern that must guide all child welfare services;
(3) Children deserve prompt and timely decision-making as to who their permanent caregivers will be;
(4) Permanency planning begins when a child enters foster care; foster care is a temporary setting;
(5) Adoption is one of the pathways to a permanent family;
(6) Adoptive families require support after the child's adoption is legalized;
(7) The diversity and strengths of all communities must be tapped; and
(8) Quality services must be provided as quickly as possible to enable families in crisis to address problems.[34]

Based on these assumptions, the federal government passed the Adoption of Safe Families Act of 1997 (ASFA)[35] to address critical issues in the child welfare system. This legislation incorporated the assumptions of the Adoption 2000 Blueprint and laid the groundwork for major child welfare reform—and in particular resulted in a shorter foster care period for children and a faster path to "permanent" homes.[36] The five key principles of ASFA are:

(1) Safety is a paramount concern that must guide all child welfare services;
(2) Foster care is temporary;
(3) Child welfare system[s] must focus on results and accountability;
(4) Innovative approaches are needed to achieve the goals of safety, permanency, and well-being; and

33. *Id.* at 690.
34. *Id.*
35. Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, 111 Stat. 2115.
36. Ranum, *supra* note 1, at 690.

(5) Permanency planning efforts should begin as soon as the child enters care.[37]

It is this last principle that really puts the emphasis and importance on "concurrent planning" by the states. "While ASFA did not require . . . concurrent planning, the Act [allowed for and] opened the door for states . . . to establish concurrent planning programs."[38] In addition, the federal statute assisted states by providing that "'reasonable efforts to place a child for adoption or with a legal guardian may be made concurrently with reasonable efforts' to preserve and reunify families."[39] Technical assistance was also provided.[40]

The incentive was now set for legislative and rulemaking action to move children through foster care systems more quickly. Moving children more quickly through the system resulted in less emphasis on reunification and more emphasis on recruitment of adoptive families to provide for the permanency needs of these special-needs children.

V. STATES' REACTIONS

Due to extended delays in the foster care placement process, Adoption 2000's stress on moving the process quicker, and the ASFA legislation, states began to enact statutes and rules regarding necessary timelines in order to move children out of foster care quickly.[41] "Concurrent planning" through the court system began

37. *Id.* at 690–91.

38. *Id.*; *see* 42 U.S.C. § 671 (2012).

39. Ranum, *supra* note 1, at 691 (quoting 42 U.S.C. § 671(a)(15)(F)).

40. *Id.*

41. By way of example, and as a result of extended delays in the placement process described herein, states like Minnesota enacted legislation. *See* Act of May 11, 1999, ch. 139, art. 3, § 23, 1999 Minn. Laws 567, 661. These rules set rigid timelines for permanency in order to facilitate quick placement. Minnesota Rule of Juvenile Protection Procedure 42.01 states:

> [A] child who is under eight (8) years of age at the time a petition is filed alleging the child to be in need of protection or services, the court shall conduct a permanency progress review hearing . . . not later than six (6) months after the child is placed in foster care or in the home of a noncustodial parent.

MINN. R. JUV. PROT. P. 42.01, subdiv. 5(a). The purpose of these time requirements is clear. They are meant to speed along the placement process which, presumably, is in the child's best interests. The issue, however, is that requiring placement within a said period of time often has the effect of rushing placement

to dominate over case plans and reunification of children with parents.[42] Once federal law allowed changes in statutory movements towards permanency, states began to enact the appropriate legislation.[43]

In implementing the conceptual "concurrent planning" with permanency issues in general, a confluence of two dominant themes in child welfare emerged: the "attachment theory" and "foster care drift."[44] The attacking of and the interrelationship between these two themes led to dramatic movement by legislatures to set permanency guidelines. People in the system were concerned about the impact of the law and the impact that multiple placements had on children—specifically how they affected a child's development of healthy and permanent attachments to permanent caregivers.[45]

Most states began to set short time limits, anywhere from six months to one year of out-of-home placement.[46] By that time, social welfare systems and courts were required to move toward TPR or some other sort of permanency. In most cases, this involved recruitment of adoptive parents and the placement of children who were maltreated, suffering unhealthy attachments, or otherwise abused into "permanent" adoptive homes.[47] Standard rules in many states require movement towards permanency for a child under the age of eight within six months of the filing of a dependency, neglect, abuse, or protective services petition; or within one year for any child eight years of age or older at the time of removal from the home.[48] By the end of that time period the court is required in most states to conduct a permanency progress review hearing requiring movement towards permanency.[49] Reunification is only allowed if all of the family, chemical dependency, and mental illness issues have been significantly resolved.

Factors to consider when conducting concurrent permanency planning are: the age of the child, the child's special needs, the

considerations, ultimately leading to a higher disruption rate.

42. Ranum, *supra* note 1, at 691–92.

43. *See, e.g.*, Act approved Apr. 26, 1988, ch. 673, §§ 1–3, 1988 Minn. Laws 1031, 1031–33.

44. Ranum, *supra* note 1, at 693 (footnotes omitted).

45. *Id.*

46. *See, e.g.*, MINN. STAT. § 260C.204(a) (2012); MINN. R. JUV. PROT. P. 42.01.

47. *See* MINN. STAT. § 260C.201; MINN. R. JUV. PROT. P. 42.

48. *See, e.g.*, MINN. R. JUV. PROT. P. 42.01, subdiv. 5.

49. *See id.*

duration of the out-of-home placement, the prognosis for successful reunification with the parents, the availability of relatives or other concerned individuals that provide support or permanent placement for the child, and other factors affecting the child's interests.[50]

The system has sped up; children are being placed for permanency and adoptive homes more quickly. Simultaneously, however, there is a lack of time and funding to train the people who determine and assess case plans for parents to work to have their children return home. Thus, the path is set for a breakdown in coordinating timelines in the system between permanency for children and necessary mental health and chemical dependency treatment plans for parents.

VI. MINNESOTA'S CURRENT STATUTORY STRUCTURE

As practitioners, scholars, and politicians throughout the country debated philosophical attitudes and attempted to implement various approaches to dealing with neglected and dependent children, significant concern began to arise as to whether the labeling of a child as "neglected," a family as having "neglected," or a child as "dependent" provided some stigmatization of the child and the family.[51] Throughout the country, and particularly in Minnesota, this resulted in language changes eliminating the words "neglect" and "dependent" in the provisions of the statute.[52]

In 1988, the Minnesota Legislature created the category of the "Child in Need of Protection or Services" (CHIPS).[53] This largely consisted of a consolidation of the previously delegated categories of "dependent" and "neglected," but shifted from the previous categorization to a new category of a CHIPS child.[54] It is debatable whether or not the resulting shift to a new categorization and terminology has reduced the stigmatization of being involved in a court system and having families' lives directed by social services.

50. Ranum, *supra* note 1, at 696.

51. *See* Walling & Debele, *supra* note 4, at 782.

52. Act approved Apr. 26, 1988, ch. 673, §§ 1–2, 1988 Minn. Laws 1031, 1032; Walling & Debele, *supra* note 4, at 809–10.

53. *See* Act approved Apr. 26, 1988, §§ 1–3, 1988 Minn. Laws at 1031–33.

54. Walling & Debele, *supra* note 4, at 810.

Nevertheless, Minnesota no longer has "dependent" or "neglected" children but rather has "CHIPS" children.[55]

Additionally, the court proceedings are now referred to as "juvenile protection proceedings" wherein the adjudication determining that a child is a CHIPS child are handled, and Minnesota statutory criteria have very specific direction and philosophical goals with respect to those children.[56] As reflected in Minnesota Statutes section 260C.001, subdivision 2, the direction to the courts and social services by the statute state in part:

> (a) The paramount consideration in all juvenile protection proceedings is the health, safety, and best interest of the child. . . .
>
> (b) The purpose of the laws relating to juvenile protection proceedings is:
>
> (1) to secure for each child under the jurisdiction of the Court, the care and guidance, preferably in the child's own home, as will best serve the spiritual, emotional, mental, and physical welfare of the child;
>
> (2) to provide judicial procedures that protect the welfare of the child;
>
> (3) to preserve and strengthen the child's family ties whenever possible and in the child's best interests, removing the child from the custody of parents only when the child's welfare or safety cannot be adequately safeguarded without removal;
>
> . . . .
>
> (5) to ensure that when placement is pursuant to court order, the court order removing the child or continuing the child in foster care contains an individualized determination that placement is in the best interests of the child that coincides with the actual removal of the child;
>
> (6) to ensure that when the child is removed, the child's care and discipline is, as nearly as possible, equivalent to that which should have been given by the parents . . . .[57]

Minnesota statutes here, and in other places within this part of the juvenile code, also describe in detail the requirements of the

55. *Id.*
56. *See* MINN. STAT. § 260C.001, subdiv. 2 (2012).
57. *Id.*

creation of a case plan after a child is removed from the home or deemed to be a CHIPS child, the requirements and timing with respect to looking at permanent placement, the available services through a "disposition plan" in the juvenile court for a CHIPS child, and the requirement of pursuing "concurrent planning" any time a child is removed from the home.[58] The concurrent planning aspect discussed below provides the inherent conflict between statutory comments and mental health, chemical dependency, and other family-centered and individualized case plans.

VII. MINNESOTA'S DEFINITION OF CHIPS CHILDREN: HOW FAMILIES ENTER THE COURT AND SOCIAL SERVICES MAZE

As the legislature struggled through the years with how to define those children and families who should come within the purview of required intervention by the state and social services personnel into their families, the legislature has similarly struggled to define a CHIPS child, providing an ever-increasing number of circumstances.[59] Minnesota Statutes section 260C.007, subdivision 6 provides detailed statutory criteria for defining a Child in Need of Protection or Services.[60] More specifically, it states that a child may be found to be a Child in Need of Protection or Services if:

(1) the child is abandoned;
(2) the child is a victim of physical or sexual abuse or emotional maltreatment, resides with a victim of child abuse, or resides with a perpetrator of child abuse;
(3) the child lacks "necessary food, clothing, shelter, education, or other required care";
(4) the child lacks "special care made necessary by a physical, mental, or emotional condition";
(5) the child is medically neglected;
(6) the child's "parent, guardian, or other custodian for good cause desires to be relieved of the child's care and custody";
(7) the child was placed for adoption or care in violation of law;
(8) the child lacks proper parental care;

58. *Id.* §§ 260C.001, subdiv. 2, 260C.201, subdiv. 1, 6.

59. *See id.* § 260C.007, subdiv. 6 (Supp. 2013); *see also* Act of May 23, 2013, ch. 108, art. 3, § 39, 2013 Minn. Laws 765, 765–66 (codified as amended at MINN. STAT. § 260C.007, subdiv. 6) (amending certain definitions).

60. MINN. STAT. § 260C.007, subdiv. 6.

(9) the child's "behavior, condition, or environment is such as to be injurious or dangerous to the child or others";
(10) the child is "experiencing growth delays, which may be referred to as failure to thrive, that have been diagnosed by a physician and are due to parental neglect";
(11) the child is exploited sexually;
(12) the child "has committed a delinquent act or a juvenile petty offense before becoming ten years old";
(13) the child is a runaway;
(14) the child is a habitual truant;
(15) the child "has been found incompetent to proceed or has been found not guilty by reason of mental illness or mental deficiency in connection with a delinquency proceeding"; or
(16) the child "has a parent whose parental rights to one or more other children were involuntarily terminated or whose custodial rights to another child have been involuntarily transferred to a relative and . . . the responsible social services agency document[ed] a compelling reason why filing the termination of parental rights petition . . . is not in the best interests of the child."[61]

Once a child and a family have been determined to fit within one of these broad categories, two things of significance happen. First, the court considers what disposition or treatment plan should be ordered and imposed upon the family and the child.[62] Second, despite the definition and direction to work toward reunification of the child with the parents, the statutory criteria require immediate commencement of work to find a permanent placement for the child in a place other than his original home.[63]

Minnesota Statutes section 260C.001 provides dispositions available to the court and social services.[64] These possible alternatives run the gamut from providing in-home services to the family by the responsible social services agency to removal of the child and the transfer of legal custody to the responsible social services agency.[65] When an out-of-home placement is required, the responsible social services agency is required to prepare an out-of-

61. *Id.*
62. *Id.* § 260C.001, subdiv. 2(b)(7) (2012).
63. *Id.*
64. *Id.* § 260C.001.
65. *Id.* § 260C.212.

home placement plan within thirty days.[66] The plan is supposed to be prepared jointly with a parent or guardian in consultation with the child's guardian ad litem, foster parent, or representative foster parent where appropriate.[67] The plan is intended to provide a mechanism for return and reunification of the child with his parents upon completion of the plan.[68] This plan is required to provide specific reasons for the placement of the child and a description of the problems or conditions in the home of the parent or parents that necessitate a removal of the child from the home in the first place.[69] It also must specify the changes a parent or parents must make in order for the child to safely return home.[70] The responsible social services agency is then required to make "reasonable efforts" to assist the family in accomplishing the goals set for them in the case plan that resulted from the original need to have the child removed.[71]

However, as a limitation to the "reasonable efforts" requirement, the statutes also support concurrent planning. For every child in foster care, the court must commence proceedings to determine permanent status of the child by holding an admit/deny hearing on a permanency petition, usually a TPR petition, no later than twelve months after the child is placed in foster care or in the care of noncustodial or nonresident parents.[72]

Thus, the statutes insist on "concurrent planning" where the responsible social services agency is both theoretically providing a case plan for reunification and making reasonable efforts to reunify the family while at the same time planning exactly the opposite by looking at TPR or other permanency petition within a maximum of a twelve-month period.[73]

VIII. CONCURRENT PLANNING AS THE MINNESOTA APPROACH

As noted, the essence of concurrent planning evolved historically from the actions taken on the national level as well as the state level. Problems in looking at long-term foster care

66. *Id.* § 260.212, subdiv. 1.
67. *Id.* § 260.212, subdiv. 1(b).
68. *See id.* § 260.212, subdiv. 1(c).
69. *Id.* § 260.212, subdiv. 1(c)(2).
70. *Id.*
71. *Id.* § 260.212, subdiv. 1(c)(3)(ii).
72. *Id.* § 260C.503, subdiv. 1.
73. *See id.*

placements, jumping of foster homes, and little work by the county to actually try to reunify families have prompted a commitment across the country for fairly swift movement from reunification planning to permanency planning. Such movement is based on the assumption that a permanent placement of the child away from his or her parents is in fact in the child's best interests in all circumstances if that child cannot return home.

More specifically, Minnesota has codified the issues of concurrent permanency planning at Minnesota Statutes section 260C.223. Within that statute, it is indicated that

> concurrent permanency planning involves a planning process for children who are placed out of the home of their parents pursuant to court order, or were voluntarily placed out of the home for 60 days or more who are developmentally disabled or emotionally disabled . . . . The responsible social services agency shall develop an alternate permanency plan while making reasonable efforts for reunification of the child with family if required by section 260.012.[74]

In what almost seems to be contradictory on its face, the statute goes on to say that:

> [T]he goals of concurrent planning are to:
>
> (1) achieve early permanency for children;
>
> (2) decrease children's length of stay in foster care and reduce the number of children experiencing foster care; and
>
> (3) develop a group of families who will work toward reunification and also serve as permanent families for children.[75]

The thought is that social services workers, many of whom are often working on both sides of the concurrent planning at the same time, can be neutral and objective in providing all of the reasonable services, particularly when they may not be trained in the actual treatment as is necessary to accomplish development of a healthy family.

Subdivision 5 only requires the development of guidelines and protocols if there is available funding,[76] something that in recent times has not been as forthcoming as necessary.

74. *Id.* § 260C.223, subdiv. 1 (citations omitted).
75. *Id.*
76. *Id.* § 260C.223, subdiv. 5.

IX. PERMANENCY CONSIDERATION AND TERMINATION OF PARENTAL RIGHTS: A BLOCKADE TO EFFECTIVE TREATMENT OUTCOMES

At this point in the system, we have a child who is out of the home. A treatment plan has been developed, supposedly dealing with the individualized needs of each child and family. As a more practical reality, however, case plans and treatment plans become a litany of checklists applicable in most cases to all families. They virtually always include a complete psychological evaluation, complete chemical dependency evaluation, complete parenting evaluation, and in every case a requirement that whatever is found in those evaluations, and whatever recommendations are made, be communicated to the parents or the child. This is often true regardless of whether or not any of these issues were the primary reason for the child being removed from the home.

Treatment plans also disregard whether or not it is logical to believe that someone with a character disorder, schizophrenia, or other behavioral mental illness can be successfully "cured" in the time limits required by statute. That consideration, however, is not part of the statutory scheme. Rather, as noted, the statutory scheme focuses on how much time has run since the removal of the child rather than the steps taken toward reunification.[77] At the outset, some permanency petition, usually the TPR petition, must be heard in court at an admit/deny hearing within twelve months of the date of the removal of the child.[78] Once the concurrent planning track dealing with permanency has taken control, the effectiveness of any ongoing attempts at reunification is virtually eliminated.[79] We now move into categories for proving that an involuntary TPR is appropriate.

It is at that point we also then turn to Minnesota Statutes section 260C.301, which gives us a list of the categories of children and situations where TPR is allowed.[80] Once again, there is a broad, sweeping scope of those children where TPR is going to be granted. More specifically, Minnesota Statutes section 260C.301, subdivision 1 states as follows:

77. *Id.* § 260C.204.
78. *Id.* § 260C.503, subdiv. 1.
79. *See id.* § 260C.212, subdiv. 1–2.
80. *Id.* § 260C.301, subdiv. 1(b).

> Subdivision 1. *Voluntary and involuntary*. The juvenile court may upon petition, terminate all rights of a parent to a child:
>
> (a) with the written consent of a parent who for good cause desires to terminate parental rights; or
>
> (b) if it finds that one or more of the following conditions exist:
>
> (1) that the parent has abandoned the child;
>
> (2) that the parent has substantially, continuously, or repeatedly refused or neglected to comply with the duties imposed upon that parent by the parent and child relationship;
>
> (3) that a parent has [failed to pay child support] . . . . ;
>
> (4) that a parent is palpably unfit to be a party to the parent and child relationship . . . . ;
>
> (5) that following the child's placement out of the home, reasonable efforts . . . have failed to correct the conditions leading to the child's placement. It is presumed that reasonable efforts . . . have failed upon a showing that:
>
> (i) a child has resided out of the parental home under court order for a cumulative period of 12 months within the preceding 22 months. In the case of a child under age eight . . . , the presumption arises when the child has resided out of the parental home . . . for six months unless the parent has maintained regular contact with the child and the parent is complying with the out-of-home placement plan;
>
> (ii) the court has approved the out-of-home placement plan . . . and filed with the court under section 260C.178;
>
> (iii) conditions leading to the out-of-home placement have not been corrected. . . . ; and
>
> (iv) reasonable efforts have been made by the social services agency to rehabilitate the parent and reunite the family.
>
> This clause does not prohibit the termination of parental rights prior to one year, or in the case of a child under age eight, prior to six months after a child has been placed out of the home.

> It is also presumed that reasonable efforts have failed under this clause upon a showing that:
>
> (A) the parent has been diagnosed as chemically dependent . . . ;
>
> (B) the parent has been required by a case plan to participate in a chemical dependency treatment program;
>
> (C) the treatment programs offered to the parent were culturally, linguistically, and clinically appropriate;
>
> (D) the parent has either failed two or more times to successfully complete a treatment program or has refused at two or more separate meetings with a caseworker to participate in a treatment program; and
>
> (E) the parent continues to abuse chemicals.
>
> (6) that a child has experienced egregious harm in the parent's care . . . ;
>
> (7) that in the case of a child born to a mother who was not married to the child's father when the child was conceived nor when the child was born the person is not entitled to notice of an adoption hearing . . . and the person has not registered with the fathers' adoption registry . . . ;
>
> (8) that the child is neglected and in foster care; or
>
> (9) that the parent has been convicted of a crime listed in section 260.012, paragraph (g), clauses (1) to (5).[81]

Critically, section 260C.301, subdivision 1, paragraph b, clause 5 states that parental rights may be terminated if, after the child is placed out of the home, reasonable efforts have failed to correct the conditions leading to the child's placement.[82] There are then specific circumstances under which reasonable efforts are presumed, but the reality is that the burden appears to shift to the parent to show that reasonable efforts have not existed or been offered by the responsible social services agency.[83]

81. *Id.* § 260C.301, subdiv. 1.
82. *Id.* § 260C.301, subdiv. 1(b)(5).
83. *See id.*

X. CHEMICAL DEPENDENCY AND MENTAL HEALTH—A GENERAL OVERVIEW

As described in previous sections of this article, there is a continuing disconnect between the worlds of law and mental health. We see this in child protection cases, specifically confronted when the timeline for a permanency petition runs into the ongoing treatment of a mental health or chemical dependency issue for the parent or child. Therapies, diagnostics and approaches to treatment must be considered in determining how the disconnect between the law and mental health arose and why it continues today.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is a series of manuals designed to categorize and organize mental disorders.[84] The American Psychiatric Association published the fifth edition in 2013. The DSM-5 "is a classification of mental disorders with associated criteria designed to facilitate more reliable diagnoses of these disorders."[85] Historically, "it has become a standard reference for clinical practice in the mental health field."[86] This manual is technically designed for clinical practice. However, it has been increasingly used in other fields.[87] As specifically stated in the DSM-5, the information is useful and may be valuable to "all professionals associated with various aspects of mental health care, including psychiatrists, other physicians, psychologists, social workers, nurses, counselors, forensic and legal specialists, occupational and rehabilitation therapists, and other health professionals."[88] From this definitional information we see the very players we also see in the child protection system: social workers and legal specialists (lawyers). It is essential that social workers and lawyers have an understanding of what tools are being used by the diagnosticians.

Often a child protection social worker has a background in social science, social work, or psychology. More often though, judges, lawyers, and legislators, who assist in drafting and passing

84. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (Susan K. Schultz & Emily A. Kuhl eds., 5th ed. 2013) [hereinafter DSM-5].

85. *Id.* at xli.

86. *Id.*

87. *Id.*

88. *Id.*

and applying these laws, do not. This becomes problematic when the basic tenets and tools for success in the arena of mental health concerns do not work with permanency timelines and what we, as society and legal specialists, have deemed best for children.

As would be expected, there is a significant amount of expertise that goes into developing and constructing the DSM-5. It "is intended to serve as a practical, functional, and flexible guide for organizing information that can aid in the accurate diagnosis and treatment of mental disorders."[89] The DSM-5 is broken down into a variety of categories, and working groups of psychologists, PhDs, MDs, and consultants worked in conjunction on each group for over twelve years.[90] The major classifications are as follows:

(1) Neurodevelopmental Disorders;
(2) Schizophrenia Spectrum and Other Psychotic Disorders;
(3) Bipolar and Related Disorders;
(4) Depressive Disorders;
(5) Anxiety Disorders;
(6) Obsessive-Compulsive and Related Disorders;
(7) Trauma- and Stressor-Related Disorders;
(8) Dissociative Disorders;
(9) Somatic Symptom and Related Disorders;
(10) Feeding and Eating Disorders;
(11) Elimination Disorders;
(12) Sleep-Wake Disorders;
(13) Sexual Dysfunctions;
(14) Gender Dysphoria;
(15) Disruptive, Impulse-Control, and Conduct Disorders;
(16) Substance-Related and Addictive Disorders;
(17) Neurocognitive Disorders;
(18) Personality Disorders;
(19) Paraphilic Disorders;
(20) Other Mental Disorders;
(21) Medication-Induced Movement Disorders and Other Adverse Effects of Medication; and
(22) Other Conditions That May Be a Focus of Clinical Attention.[91]

89. *Id.*
90. *Id.* at xliii, 5.
91. *Id.* at 27.

In the CHIPS and TPR legal systems, many classifications do not often arise, or at least are not commonly diagnosed in a way that is seen by the legal practitioners who practice in juvenile court. It certainly does not mean that they cannot arise; they are just not as commonly seen or diagnosed. Also, it is difficult to miss, in looking at this list, the practical ramification of this list itself. Perhaps it is longer than one might anticipate; it is certainly clear that it involves a spectrum of disorders and diagnoses that many people, including lawyers and legislators, have never heard of. "As a result, it is important to note that the definition of mental disorder included in DSM-5 was developed to meet the needs of clinicians, public health professionals, and research investigators rather than all of the technical needs of the courts and legal professionals."[92] However, to appropriately function in the legal aspects of child protection, a practitioner must have at least a basic understanding and education of the metal health issues that are often an underlying component of the parents' or child's functioning.

It is also essential to remember that mental illness alone and the possibility of chemical dependency issues do not result in children automatically being removed from a parent.[93] Ultimately, in many situations there is an underlying mental health or chemical dependency issue for the parents of children who may end up in the child protection system.[94] Oftentimes this is seen as alcohol abuse, a variety of drug use, or mental health disorders that result in a parent being unable to care for a child due to that disorder.[95] Again, many parents with underlying mental health issues do not find their way into the child protection system.[96] But oftentimes the ones who are in the child protection system are there due to a mental health or chemical dependency issue that

92. *Id.* at 25.

93. Interview with Monica Seidel, Psychotherapist, Univ. of Minn. Cmty. Univ. Health Care Ctr. (CUHCC), in Minneapolis, Minn. (Sept. 7, 2013). Prior to the last three years at CUHCC, Ms. Seidel worked for the Wilder Foundation for ten years, serving as both a school social worker and then a residential therapist in Wilder's inpatient residential treatment program. Her areas of expertise include children's mental health, childhood trauma, PTSD, integrative therapists, family systems, and attachment disorders. She received her Master of Social Work from the University of Minnesota and her Bachelor of Arts from the University of Notre Dame.

94. *Id.*

95. *Id.*

96. *Id.*

has resulted in their lack of ability to parent.[97] Mental illness alone is not a barrier to parenting.

XI. HOW DO MENTAL HEALTH AND CHEMICAL DEPENDENCY ISSUES INTERSECT WITH CHILD PROTECTION AND WHAT IS THE RESULT

As previously discussed, at the beginning of a CHIPS action and once a child protection social worker gets involved, the parent is almost routinely sent to a therapist for diagnostic testing or assessment and often receives a chemical dependency evaluation.[98] This is done to determine what issues, concerns, or struggles the parent may have that is leading to or resulting in parenting issues.[99] Ultimately, if one cannot care for his or her child, that child will be removed prior to any diagnosis because in this system the child's needs are considered the primary needs to be met.[100] However, this removal of a child from his or her home in and of itself commences a mindset for most parents—that is, "What do I have to do to get my child back?" Even at the beginning, it is about the end goal of regaining that child, not about the possibly much-needed therapy plan for the parent.

Often one issue pervasively leads to another. This becomes very relevant in case planning and indicates there should not be a one-size-fits-all mentality for children or parents when it comes to mental illness therapies and chemical dependency treatments. For instance, sometimes the root cause of the functioning issues for the parent can be addiction to cocaine, methamphetamines, or other drugs; sometimes the parent suffers from alcohol addiction and related issues; sometimes the parent is, in fact, dealing with chemical dependency issues only secondarily to significant mental health issues such as bipolar disorder or another significant personality or mood disorder. It is routine for a parent who has entered the system to suffer from these illnesses and, as a case plan is being developed, for a child protection social worker to look into whether a chemical dependency or mental health evaluation and therapy are necessary. This is where the variety of diagnostic tools as outlined in the DSM-5 and treatment options come into play.

97. *Id.*

98. *Id.*

99. *Id.*

100. *See, e.g.*, MINN. STAT. § 260C.301, subdiv. 7 (2012) ("[T]he best interests of the child must be the paramount consideration. . . .").

Once a referral has been made by a social worker as part of a case plan to a diagnostician and/or therapist, a parent is required to work with these professionals as outlined in the case plan. However, the treatment is outlined and driven by what is required by the law in the child protection system. It is not governed as much by the mental health or chemical dependency professionals, which would be best for the ultimate treatment goals of the parent. But, as mentioned, parents are often willing to do whatever they can to get their children returned to their home because they only have a certain amount of time to "get better" as designed by law.

XII. REALITIES OF TREATMENT AND THERAPIES

Once a parent receives the case plan, one typical requirement of the plan is to receive individual therapy services, many times regardless of a diagnoses or what a therapist may recommend.[101] A parent establishes services, and typically on his or her own begins therapy and receives a diagnostic assessment as outlined in the criteria in the DSM-5.[102] At that point, a therapy treatment plan is put into play that governs how the individual therapy sessions will work.[103] When a child protection worker learns that a parent has established a therapist as directed, the worker asks a parent to sign a release of information so there is communication between the worker and therapist. This is to ensure that the parent is complying with therapy attendance and to seek recommendations from the therapist on future service needs. This is one area where the goals of therapy and goals of child protection simply do not match up. Ultimately the parent's goal with child protection is to be as compliant and upstanding as possible in an effort to reunify with his or her child.

Yet, the goal of the parent-client in therapy, from a therapist's perspective, is to establish a trusting relationship in order to expose mental health symptoms and behavioral concerns that are festering and in need of resolution.[104] As stated above, there is a specific timeline as designed by child protection services and the statutes of the State of Minnesota for completion of a successful child

101. *See* Interview with Monica Seidel, *supra* note 93.
102. *See* DSM-5, *supra* note 84, at sec. II.
103. *Id.* at 19–21.
104. *See id.*

protection plan.[105] The therapy and the child protection plan are often not in sync. For instance, some therapy issues are long-term issues that simply cannot be resolved in a six-month window and require ongoing therapy even if the parent was to be successful in the completion of the child protection plan. A client who is participating in therapy pursuant to the direction of child protection, if answering and working truthfully with the therapist, can use the therapy as intended but often does not look "better," as is needed for a successful child protection case plan.[106] Often there is reluctance for parents ordered through child protection into therapy to make good use of the therapeutic relationship—hence a cycle of a family being in and out of child protection over time may be set in motion.[107] But, in the end, if serious mental health and chemical dependency issues are not truly dealt with as designed by mental health professionals, the parent is likely to fail in continued and future case plans. Therefore, concurrent planning is made that much more necessary.

XIII. CONCLUSION—WHAT NOW?[108]

The history of the development of the timelines for moving toward "permanency" in a child's life after removal from the parents' home and the development of "concurrent planning" both in fact have some basis in rational and sociological thought. The fact that children are often moved from foster home to foster home, not having an opportunity to attach or have stability and security within someone's home, and the realization that in most cases, placement of a child on a permanent basis with a relative was in the child's best interests, have led to a reexamination of the manner in which children are removed from the home and under

105. *See supra* notes 45–51 and accompanying text.

106. *See* Interview with Monica Seidel, *supra* note 93.

107. *See id.*

108. The comments and opinions expressed in the "Conclusion" section of this article are those of the authors based on their years of experience and observations of the interaction between the often conflicting goals of reunification and permanency. This is particularly true as noted in the other parts of the article in the overlay of attempts at reunification within the context of actually providing substantial and effective mental health and chemical dependency services. Thus, the expressed opinions are based upon the information provided in the early part of the article, the authors' experience, and the conflicts reflected in the main body of the article.

what circumstances and under what timelines they are returned home or placed permanently somewhere else.

The problem is that the legal requirements often do not have any relationship to the likelihood of success in dealing with the underlying causes of family trauma or family issues. While the courts look to the social workers and the psychologists for recommendations regarding treatment, they rarely are allowed to give the parents sufficient time in that therapy or in the chemical dependency program to fully deal with the issues underlying the initial removal.

The courts are forced to move toward permanency on a fast track, where the items they look at in concluding that permanency is necessary rarely refer directly to the success of treatment or other therapy and programs. Rather, they look to the "success" of the therapy in the short time allowed by the timeline requirement, as presented by the social workers and the counties. They look to how long the child has been out of the home, what the parent has done, and whether the parent has been "compliant" with the requirements of the "case plan."

Since the case plans rarely deal initially with the actual issues, but rather are a sweeping generalization of significant testing and obligations through various programs as applied to all cases, the courts rarely have significant information to avoid the strict requirements of the statutory movement toward permanency.

Additionally, since the "concurrent planners" have, throughout the course of the case, assumed and planned for the failure of the parents to meet the "case plan goals," there is the constant pressure to move toward permanency and to get the case closed and done. The situation where a parent has been compliant and has worked hard in therapy, but is not ready to have the child returned, poses a dilemma for the courts and the counties that the law does not allow them to contemplate. Rather, the courts are pushed against the wall to make permanency decisions along with strict timelines, sometimes regardless of the recommendations of the treating psychologist.

How courts deal with mental health issues in the juvenile protection system remains a problem. Even when they rely upon an initial evaluation, courts are often unable to rely on the ongoing recommendations of the psychologists. Additionally, parents are often unable to create a significant trust relationship with treating psychologists or social workers as a result of knowing that anything

they say can and will be used in order to prevent their children from returning home, which causes deep divisions in a system designed to help children and at least theoretically return them to the parents.

Since the courts are hamstrung in many cases in their effort to assist children and families based on the recommendations of the therapists and the mental health professionals, and since all assistance, therapy, and program resolutions are an open book not only to the county workers but the court, and in most cases, the general public, the flexibility of the court system is severely hampered.

What is necessary is that the laws be amended in order to give the courts and the professionals the flexibility to deal with the treatment issues beyond the scope of the requirements of moving to a permanency decision and the undermining of treatment systems by concurrent planning. The failure to integrate mental health flexibility into the rigidity of the statutory scheme, as we have seen, rarely meets the "individualized needs" of children, thus thwarting the original goals of the system to protect children and families.

The concern about children moving in foster care and not having permanency has resulted in an unbending system which often is not able to do what is, in fact, in a child's best interests and what will, in fact, reunite the family unit.