THE PRIVATE WORLD OF JUVENILE COURT: MOTHERS, MENTAL ILLNESS AND THE RELENTLESS MACHINERY OF THE STATE

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> Coco reread the official-looking letter. She couldn't bear the thought of losing Mercedes. . . . She slumped down, like Mercedes at her classroom desk. But instead of sleeping, like her daughter, Coco placed her heavy head in her small hands and wept.[1]

I. INTRODUCTION

Motherhood is an increasingly central life experience for mentally ill women.[2] Many are fine parents, and their children adjust well.[3] Others have difficulties related to their health, with negative outcomes for their children.[4] Most mentally ill women who raise their children themselves do so in the context of marital discord, single-parent status, social isolation and sometimes extreme poverty.[5]

Mentally ill mothers are not more likely to abuse or neglect their children;[6] whatever one's parenting deficiencies, less than optimal parenting does not by

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1. ADRIAN NICOLE LEBLANC, RANDOM FAMILY: LOVE, DRUGS, TROUBLE, AND COMING OF AGE IN THE BRONX 374 (2003).

2. Roberta G. Sands, *The Parenting Experience of Low-Income Single Women with Serious Mental Disorders*, FAM. SOC'Y 86, 90 (Feb. 1995) [hereinafter Sands, *Parenting Experience*].

3. *See, e.g.*, GARY MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS § 15.05(a) (3d ed. 2007).

4. Corina Benjet, Sandra T. Azar & Regina Keursten-Hogan, *Evaluating the Parental Fitness of Psychiatrically Diagnosed Individuals: Advocating a Functional-Contextual Analysis of Parenting*, 17 J. FAM. PSYCHOL. 238, 242 (2003).

5. Daphna Oyserman, et al., *Parenting Among Mothers With a Serious Mental Illness*, 70 AM. J. ORTHOPSYCHIATRY 296, 309 (2000).

6. *See* Jung Min Park et al., *Involvement in the Child Welfare System Among Mothers With Serious Mental Illness*, 57 PSYCHIATRIC SERVS. 493–94 (2006); MELTON, *supra* note 3, § 15.05(a).

definition fall below society's minimum standards.[7] Nevertheless, mothers with mental illness lose custody of their children disproportionately more often than do healthy mothers, often via the child welfare system, and they also experience greater difficulty regaining custody.[8] Multiple court systems may award custody to multiple caregivers, leaving mothers "bewildered" by all the complex arrangements.[9]

Some experts worry that too often diagnosis alone drives custody and termination of parental rights decisions.[10] Only when mental illness creates a direct and serious risk to the child should the state interfere with a mother's parental rights.[11] Nevertheless, individual and systemic bias against the mentally ill lowers the legal standard that the state must meet in fact to justify opening and pursuing child welfare cases.[12]

Juvenile courts in "dependency cases"[13] supervise many child welfare agency activities and enter orders removing children from mentally ill mothers' care, sometimes leading to termination of parental rights.[14] Juvenile law balances the parent's and child's fundamental interest in their relationship against a child's statutory right to a safe, permanent home.[15] Juvenile courts perform this function in dependency cases: they decide whether a child has been abused or neglected; if state agencies have made "reasonable efforts" to preserve or reunify a family; and whether a parent has made sufficient efforts and progress to provide a safe and permanent home.[16]

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7. Benjet, *supra* note 4, at 242 (explaining that most studies only attempt to determine whether mentally ill mothers have optimal parenting skills, not whether their parenting skills are unacceptably substandard).

8. *See generally* Park, *supra* note 6; Sands, *Parenting Experience*, *supra* note 2, at 90.

9. *See, e.g.*, Roberta G. Sands, et al., *Maternal Custody Status and Living Arrangements of Children of Women With Severe Mental Illness*, 4 HEALTH & SOC. WORK 317, 318, 321–23 (2004) [hereinafter Sands, *Maternal Custody Status*].

10. *See* MELTON, *supra* note 3, at § 15.05(a).

11. Santosky v. Kramer, 455 U.S. 745, 760 n.11 (1982); *see also* J.E.H. v. Dep't for Human Res., 642 S.W.2d 600 (Ky. Ct. App. 1982).

12. George J. Alexander, *Big Mother: The State's Use of Mental Health Experts in Dependency Cases*, 24 PAC. L.J. 1465, 1487-88 (1993) (noting tendency of state-hired mental health experts to adopt social workers' views); Sudha Nair & Mary F. Morrison, *The Evaluation of Maternal Competency*, 41 PSYCHOSOMATICS 523, 527 (2000) (noting "expectation . . . that the patient will be found incompetent").

13. A "dependency" case is one brought pursuant to a juvenile court's jurisdiction to decide if a child is neglected or abused and to protect that child from harm. *See generally* Mark Hardin, *Responsibilities and Effectiveness of the Juvenile Court in Handling Dependency Cases*, 6 FUTURE CHILD. 111, 111 (1996).

14. *See* Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, § 103(a)(3), 111 Stat. 2115.

15. *See* 16 LOUISE E. GRAHAM & JAMES E. KELLER, KENTUCKY PRACTICE DOMESTIC RELATIONS § 25:20 (2009) [hereinafter KENTUCKY PRACTICE]; *compare* KY. REV. STAT. ANN. § 600.010(2)(a) (LexisNexis 2009) (stating that one purpose of the juvenile code is to "strengthen and maintain the biological family unit" and family life) *with* KY. REV. STAT. ANN. (LexisNexis 2009) § 620.010 (stating that a child has a right to a safe, permanent home).

16. Hardin, *supra* note 13, at 111–13.

The "particularly difficult" Kentucky case,[17] T.G. v. Commonwealth,[18] illustrates many of the pitfalls a mentally ill mother can encounter in the juvenile court system. The mother, T.G., suffered from paranoid personality disorder.[19] She was hesitant to obtain or comply with treatment for fear of the consequences for her parental rights.[20] She needed time the law does not provide to make that treatment effective.[21] The chance that bias infected her caseworkers' efforts[22] and her treaters' later testimony[23] is high. Just because T.G. had paranoid traits did not mean no one was "out to get her": a symptom of T.G.'s illness was to believe her treatment was "part of a movement to discredit [her],"[24] but that belief may actually have been true!

The law governing T.G.'s case also imposed significant barriers to her regaining custody of her child based on her medical condition. The court held her responsible for "abuse or neglect" without necessarily considering whether her mental condition permitted her to form the necessary *mens rea*.[25] Her condition absolved the Cabinet from making "reasonable efforts" to provide appropriate services to reunify mother and child.[26] The law required the court to consider the mere fact of T.G.'s mental illness when determining A.J.M.'s best interests[27] including whether T.G.'s parenting had improved sufficiently so that she could provide for A.J.M.'s needs on a consistent basis over time.

This article will argue that mentally ill mothers face disproportionate legal impediments to reunification with children removed from their care for reasons not of their own making via the juvenile court and child welfare systems. Part II of this article describes the lived experience of mentally ill mothers using the context of the *T.G.* case.[28] Part III outlines Kentucky's substantive and procedural law governing dependency cases.[29] Part IV analyzes three features of juvenile law that disproportionately disadvantage mentally ill mothers: (1)

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17. 16 KENTUCKY PRACTICE *supra* note 15, at § 25:21 n.4.

18. Ky Cabinet for Health & Family Servs. v. T.G., 2008 WL 3890033 (Ky.).

19. Severe personality disorders, as T.G. experienced according to the evidence, are risk factors for abuse or neglect. *See* Nair & Morrison, *supra* note 12, at 525–26; Kathryn Kuehnle, et al., *Child Protection Evaluations: The Forensic Stepchild*, 38 FAM. & CONCILIATION CTS. REV. 368, 372 (2000).

20. *T.G.*, 2008 WL 3890033, at *8.

21. 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 107, 112 (2004).

22. *Id.* at 115-16 (discussing need for caseworker training, conceptual reframing of mental illness as a disability, and financial support for treatment); *see also* Brenda D. Smith, *Child Welfare Service Plan Compliance: Perceptions of Parents and Caseworkers*, 89 FAM. SOC'Y 521, 530 (2008) (describing "just desserts" theory of service plan development).

23. *See* Alexander, *supra* note 14, at 1487-90.

24. MOORE & JEFFERSON: HANDBOOK OF MEDICAL PSYCHIATRY § V, ch. 74. (2d ed. 2004).

25. *See* 16 KENTUCKY PRACTICE, *supra* note 15, at § 25:20.

26. *See* KY. REV. STAT. ANN. § 610.127(6) (LexisNexis 2009); KY. REV. STAT. ANN. § 620.020(10) (LexisNexis 2009).

27. KY. REV. STAT. ANN. § 620.023(1)(a), (2) (LexisNexis 2009); KY. REV. STAT. ANN. § 625.090(3)(a), (d) (LexisNexis 2009).

28. Ky Cabinet for Health & Family Servs. v. T.G., No. 2007-SC-000436-DGE, 2008 WL 3890033 (Ky. Aug. 21, 2008).

29. This article focuses primarily on Kentucky law to provide an in-depth exploration of one state, which is where the author practiced juvenile law for many years.

imprecise *mens rea* requirements for dependency, neglect and abuse; (2) child welfare agencies' unenforceable duty to make reasonable efforts to preserve or reunify families; and (3) parents' consequent inability to make sufficient "efforts and adjustments" in pursuit of reunification.

The article concludes that practical litigation strategies that emphasize educating social workers, mental health professionals and judges can overcome such legal disadvantages and contribute to system-wide change. "[L]aw performs a pedagogical role" within legal institutions and the spirit and conduct of law spreads deeply into the culture beyond.[30] Juvenile court judges are specialized judges whose work can be characterized as presiding over both an in-and-out of court set of institutions and processes.[31] A decision in one case necessarily influences decisions in other cases, and a critical mass of such decisions can adjust cultures.[32]

II. MOTHERING WITH MENTAL ILLNESS

A. The lived experience of a mentally ill mother in the child welfare system.

Perhaps the primary reason mothers of children under age eighteen do not seek needed mental health services is the fear of losing custody of their children.[33] Their fears are justified. Mothers with serious mental illness are many times more likely to lose custody of their children than healthy mothers.[34] Children of mothers with serious mental illness are at a heightened risk of depressed life outcomes,[35] but data showing that these children are at greater risk of maltreatment is elusive.[36]

Avoiding treatment in order to avoid child welfare attention may put a child at risk,[37] but that "hard choice" is not always clearly a bad one. Mothers

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30. *See* ALEXIS DE TOCQUEVILLE, DEMOCRACY IN AMERICA 315 (Penguin Books 2003) (1835); MARY ANN GLENDON, ABORTION AND DIVORCE IN WESTERN LAW 139 (1987).

31. Hardin, *supra* note 13, at 120–21.

32. Ira M. Schwartz, et al., *Myopic Justice? The Juvenile Court and Child Welfare Systems*, 564 ANNALS 126, 134–35 (1999) (arguing that juvenile court reform stagnates because of "complexes of conservative norms, values, attitudes, beliefs and opinions supporting ties to past practices").

33. *See, e.g.*, Carol M. Anderson, et al., *Why Lower Income Mothers Do Not Engage With the Formal Mental Health Care System: Perceived Barriers to Care*, 16 QUALITATIVE HEALTH RES. 926, 935-36 (2006); Joanne Nicholson, et al., *Focus on Women: Mothers With Mental Illness: I. The Competing Demands of Parenting and Living With Mental Illness*, 49 PSYCHIATRIC SERVS. 635 (1998), *available at* http://psychservices.psychiatryonline.org/cgi/content/full/49/5/635 (last visited March 2, 2009) [hereinafter Nicholson I].

34. Park, *supra* note 6, at 496; *see also* Alisa Busch & Allison Redlich, *Patients' Perception of Possible Child Custody or Visitation Loss for Nonadherence to Psychiatric Treatment*, 58 PSYCHIATRIC SERVICES 999, 999 (2007).

35. *See, e.g.*, Tina D. Du Rocher Schudlich, et al., *The Role of Family Functioning in Bipolar Disorder in Families*, 36 J. ABNORMAL CHILD PSYCHOL. 849, 849, 859 (2008); Oyserman, *supra* note 5; Andrea Chronis-Tuscano, et al., *Associations between Maternal Attention-Deficit/Hyperactivity Disorder Symptoms and Parenting*, 36 J. ABNORMAL CHILD PSYCHOL. 1237, 1246-47 (2008).

36. *See, e.g.*, MELTON, *supra* note 3, at § 15.05(a); Park, *supra* note 6, at 493.

37. For example, failure to seek care or comply with treatment when a mother has active psychiatric symptoms is a predictor of poor parenting skills. *See* Nair & Morrison, *supra* note 12, at 526. Lack of insight into mental illness, which can result from a lack of treatment, is associated with

with mental illness know treatment non-compliance may result in custody loss,[38] but they also know compliance limits their actual parenting ability.[39] For example, lithium, the "treatment of choice for manic-depressive illness" can have side effects such as reduced memory, drowsiness or nausea, all of which make caring for children more difficult,[40] but medication non-compliance can trigger active illness that might also leave children at risk.[41] A woman may also stop taking medications during pregnancy to protect the child's health to the detriment of her own.[42]

"Being mentally ill" is not all that defines a woman who happens to "be mentally ill," but it does inform and determine other aspects of her life. Most live in poverty,[43] a risk factor closely related to child maltreatment.[44] "Inadequate housing" – a ubiquitous problem of poverty – "appears to be a particularly potent risk factor" for abuse or neglect.[45] Mentally ill mothers also experience family disruptions, single-parent status, social isolation and related stressors that can put children at risk.[46]

In combination, such stressors can have snowballing effects on parenting.[47] As one study participant explained, "[w]hen we don't have milk and cereal and I don't have money to get it – that depresses me."[48] When such a response becomes a major depressive episode,[49] the mother may be unable to clean the

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higher levels of child maltreatment risk. Mrinal Mullick, Laura J. Miller & Teresa Jacobsen, *Insight into Mental Illness and Child Maltreatment Risk Among Mothers With Major Psychiatric Disorders*, 52 PSYCHIATRIC SERVS. 488, 491 (2001).

38. Busch & Redlich, *supra* note 34, at 1001.

39. Nicholson I, *supra* note 33.

40. E. FULLER TORREY & MICHAEL B. KNABLE, SURVIVING MANIC DEPRESSION: A MANUAL ON BIPOLAR DISORDER FOR PATIENTS, FAMILIES AND PROVIDERS 138, 142-46 (2002).

41. Risley-Curtiss, *supra* note 12, at 110.

42. *See e.g.*, Juv. Dep't. of Multnomah County v. Habas, 700 P.2d 225 (Or. 1985) (mother with bipolar disorder gave up lithium on advice of her physician during pregnancy, resulting in a two to three month stay in hospital and later removal of child and termination of parental rights order); Nicholson I, *supra* note 33.

43. "Nearly all individuals with long-term mental illness are poor." Carol Mowbray, et al., *Mothers With a Mental Illness: Stressors and Resources for Parenting and Living*, 81 FAM. SOC'Y 118, 119, 123–25 (2000) (study in which half of the mentally ill mothers reported a "major money crisis" in the past year that caused them "a great deal" of stress, second only to psychiatric crises).

44. MELTON, *supra* note 3, at § 15.05(a). *But see* Vernon Carter & Miranda Myers, *Exploring the Risks of Substantiated Physical Neglect Related to Poverty and Parental Characteristics: A National Sample*, 29 CHILD. & YOUTH SERVS. REV. 110, 118 (2007) (showing that "[p]rimary caregivers with a substance abuse problem and primary caregivers with mental health problems were the strongest predictors of substantiated physical neglect").

45. MELTON, *supra* note 3. (In fact, *T.G.* began as a "dirty house case," which is Kentucky slang for a proceeding arising from allegations of "unsafe and unsanitary [living] conditions.").

46. Oyserman, *supra* note 5, at 311.

47. For example, stress is understood to be a risk factor for relapse into manic-depressive illness or bipolar disorder. High-level stress in particular – such as stress from major financial crises – may trigger relapse. TORREY , *supra* note 40, at 103–04.

48. Mowbray, *supra* note 43, at 119, 125.

49. *See* LANA R. CASTLE, BIPOLAR DISORDER DEMYSTIFIED: MASTERING THE TIGHTROPE OF MANIC DEPRESSION 24 (2003).

house, remember a child's appointments and school activities, or even get out of bed in the morning.[50] Serious child safety concerns cannot be far behind.[51]

Raising children with mental or emotional disturbance is also a "common and overwhelming depression- and anxiety-producing stress[or]." [52] The effects of a mother's mental illness can also have deleterious emotional effects on the child,[53] even if insufficient to render her incompetent to raise the child,[54] triggering these potent stressors. Moreover, mental illness can have genetic roots;[55] mothers may be in denial about the child's problems and avoid mental health care for themselves that might improve their parenting.[56]

In fact, non-health-related interventions may be more effective for protecting a mentally ill mother's children from abuse or neglect compared to medications or therapy. Short term material support services, such as emergency cash, can tide a family over when cereal is financially out of reach.[57] One study recommends that social workers help mentally ill mothers obtain safer housing and social security disability or supplemental security income to preserve the family.[58] Harnessing a mother's social support system to provide child care in case of health emergencies may eliminate the need for expensive out-of-home foster care.[59]

More comprehensive services may be available to mentally ill mothers under conditions unrelated to their own health concerns. When a child receives mental or behavioral health treatment, the mother's stress may decline,[60] and by virtue of the child's condition, the family may be eligible for intensive, home-based family support services,[61] such as pre- and post-crisis interventions,

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50. *See* TORREY, *supra* note 40, at 37-38; MOORE & JEFFERSON, *supra* note 24, at § V, ch. 74.

51. Risley-Curtiss, *supra* note 21, at 110; Lenore M. McWey, et al., *Mental Health Issues and the Foster Care System: An Examination of the Impact of the Adoption and Safe Families Act*, 32 J. MARITAL & FAM. THERAPY 195, 201 (depression was most pervasive diagnosis in cohort of termination of rights cases in Virginia).

52. Anderson, *supra* note 33, at 932.

53. *See, e.g.*, Du Rocher Schudlich, *supra* note 35, at 849 (showing "small but significant indirect pathway from parental diagnosis of mood disorder to child bipolar disorder through impaired family functioning, via increased family conflict"); Chronis-Tuscano, *supra* note 35, at 1248 (presenting "convincing evidence that maternal ADHD symptoms are associated with parenting marked by lower levels of involvement and positive parenting, and higher levels of inconsistent discipline, negative parenting, and excessive commands"); Oyserman, *supra* note 5, at 311 (collecting studies).

54. Anderson, *supra* note 33, at 933–34.

55. *See, e.g.*, TORREY, *supra* note 40, at 107–08 (discussing bipolar disorder).

56. Anderson, *supra* note 33, at 932–33.

57. MELTON, *supra* note 3, at § 15.03(d); *cf.* Risley-Curtiss, *supra* note 21, at 116 (recommending social workers help mothers find financial assistance to avoid removal).

58. Mowbray, *supra* note 43, at 126–27.

59. Risley-Curtiss, *supra* note 21.

60. Anderson, *supra* note 33, at 932 (discussing study finding that "[b]y far the most common and overwhelming depression- and anxiety-producing stress [lower income] mothers endorsed was having to manage an emotionally or behaviorally disturbed child").

61. 922 KY. ADMIN. REGS. 1:400, sec. 4(2)(a) (2009).

respite child care,[62] and paraprofessional support with child management.[63] When children are at the greatest risk of removal, the federally supported "Family Preservation Program"[64] provides short-term and around-the-clock assistance of social workers with small caseloads and broad discretion to provide expensive services.[65] Denver provides another comprehensive program designed to integrate mental health services and parenting education, which decreased both the number of children in temporary foster care and mothers' hospitalizations.[66] The "Mother's Project" in Chicago produced similar outcomes from an integrated psychosocial program, intensive family support services and a therapeutic nursery.[67] These types of individual services, however, are often carefully rationed.[68]

Unfortunately, the child welfare and mental health professions contain biases and structural limitations that undervalue a mentally ill mother's parenting strengths and potential.[69] Some experts observe an "automatic assumption of parental unfitness of psychiatrically diagnosed patients."[70] A "well" father or husband can have an advantage in obtaining custody even if he is an inferior caregiver or has maltreated the child himself.[71]

Judges tend to adopt reflexively the conclusions and recommendations of mental health experts without challenge,[72] and many social workers lack the requisite training to make independent assessments of a mentally ill mother's current or prospective parenting ability or provide appropriate interventions to assist her with making improvements.[73] Mental health experts' opinions reflect an understandable bias in favor of "optimal family environments for children,"

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62. "Respite care" is a "time out" for a mother raising a mentally or emotionally disturbed child so stressors that could endanger the child do not mount to dangerous levels. *See* 922 KY. ADMIN. REGS. 1:400, sec. 4(5)(e).

63. Kentucky provides such services, 922 KY. ADMIN. REGS. 1:400, sec. 4(5)(f), with federal financial support; *see also,* 42 U.S.C. § 629.

64. KY. REV. STAT. ANN. § 200.575 (LexisNexis 2009).

65. *See* KY. REV. STAT. ANN. § 200.575(3) (LexisNexis 2009).

66. Benjet, *supra* note 4, at 244.

67. Theresa Glennon, *Walking with Them: Advocating for Parents with Mental Illnesses in the Child Welfare System*, 12 TEMP. POL. & CIV. RTS. L. REV. 273, 297 (2003).

68. Kentucky law limits the provision of Family Preservation Program services to circumstances in which the Cabinet can assure protection for children who are "at actual, imminent risk of out-of-home placement," and whose parents have not engaged in certain disapproved behaviors. *See* KY. REV. STAT. ANN. § 200.590 (LexisNexis 2009). The program's intensity means it will be "offered only if the Cabinet determines that it would be more effective than other existing programs or resources." *See* 922 KY. ADMIN. REGS. 1:410, sec. 2(6) (2009).

69. Risley-Curtiss, *supra* note 21, at 110-12, 114-15.

70. Benjet, *supra* note 4, at 238. Studies from the 1960s showed that even experts assumed mental illness was more detrimental to parenting than it was to marital relations and careers. *Id.* at 248.

71. *See* Joanne Nicholson, et al., *Focus on Women: Mothers With Mental Illness: II. Family Relationships and the Context of Parenting*, 49 PSYCHIATRIC SERVS. 643 (1998), *available at* http://ps.psychiatryonline.org/cgi/content/full/49/5/643 [hereinafter "Nicholson II"].

72. *See* Schwartz, *supra* note 32, at 131; *see also* Dana Royce Baerger, et al., *A Methodology for Reviewing the Reliability and Relevance of Child Custody Evaluations*, 18 J. AM. ACAD. MATRIMONIAL LAW 35, 35–36 (2002).

73. *See* Risley-Curtiss, *supra* note 21, at 115.

but the law censures only minimally competent parenting, not simply less than optimal parenting.[74] Many use tests and instruments that are only indirect indicators of parental competence or have not been validated for the mentally ill.[75] A mother is "projecting her own problems" or "denying reality," thereby confirming to third parties the diagnosis of pathology, if she disagrees with a mental health professional's opinions.[76] The impact is severe: many observers believe that experts for child welfare agencies disproportionately conclude that mentally ill mothers are incompetent.[77]

When the dust settles, a mentally ill mother receives less protection in juvenile court than a man in a criminal sentencing proceeding,[78] even though

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74. Benjet, *supra* note 4, at 239; David F. Bogacki & Kenneth J. Weiss, *Termination of parental rights: focus on defendants*, 35 J. PSYCHIATRY & L. 25, 32–33 (2007) (discussing Karen S. Budd, et al., *Clinical Assessment of Parents in Child Protection Cases: An Empirical Analysis*, 25 L. & HUM. BEHAV. 93 (2001) which found that the parental evaluation process includes confusion over optimal versus minimum fitness, as well as an overemphasis on parents' weaknesses compared to their strengths). By contrast, the court should be concerned with whether a child would be dependent, neglected or abused in the parent's custody, KY. REV. STAT. ANN. § 620.140(1)(b) (LexisNexis 2009), and/or with the extent to which mental illness "renders the parent unable to care for the immediate ongoing needs of the child," KY. REV. STAT. ANN. § 620.023(1)(a) (LexisNexis 2009).

75. Risley-Curtiss, *supra* note 21, at 111; Mullick, *supra* note 37, at 488; *see also* Karen S. Budd, *Assessing parenting capacity in a child welfare context*, 27 CHILD. & YOUTH SERVS REV. 429 (2005).

76. *See* Alexander, *supra* note 12, at 1493–94.

77. These observers suggest numerous possible reasons: because the fact of a referral alone from a knowledgeable layperson, such as a social worker, creates a subconscious assumption of pathology, *see* Marjory E. DeWard, *Psychological Evaluations: Their Use and Misuse in Illinois Child Abuse and Neglect Cases*, 54 DEPAUL L. REV. 971, 986-87 (2005); to preserve a lucrative relationship with the agency, *see* Alexander, *supra* note 12, at 1488; to avoid the risk of a false negative that puts either the child's safety or the professional's reputation at risk, *see* Nair & Morrison, *supra* note 12, at 527; to support subconscious assumptions that those who live in poverty, a condition that often characterizes the mentally ill, have greater pathologies, *see* DeWard, *supra*; and to maintain harmonious relationships with colleagues who suspect incompetency, *see* Nair & Morrison, *supra* note 12, at 527.

78. *Cf.* Barefoot v. Estelle, 463 U.S. 880 (1983). *Barefoot v. Estelle* emphasizes the minimal procedural protections even criminal defendants receive in sentencing hearings as to mental health professionals' expert testimony. *Barefoot*, long the leading pre-*Daubert* case on admissibility of mental health expert testimony, holds that the testimony of a mental health professional who has never examined a criminal defendant may be admissible as to the defendant's probability of future dangerousness in a criminal sentencing. *Id.* at 896.

Future dangerousness to society is conceptually linked to future dangerousness as a parent in that both are prospective, probabilistic semi-mental health inquiries that may be unduly prejudicial and require legal judgments about what dangerousness is and how much danger is too much. *See* MELTON, *supra* note 3, at § 1.04. Mental health experts and the admissibility of their testimony are central to judicial decisions as to future dangerousness of both types, but such evidence is "the clearest example of unreliable psychiatric testimony." Alexander, *supra* note 12, at 1485. There are such serious doubts about the mental health profession's competence to assess both future dangerousness of a criminal defendant to society, *see, e.g.*, *Barefoot*, 463 U.S. at 920-23 (Marshall, J., dissenting) (noting that the American Psychiatric Association and researchers conclude that "psychiatrists simply have no expertise in predicting long-term future dangerousness. A layman with access to relevant statistics can do at least as well and possibly better.") and future dangerousness of a mentally ill mother to her children, Benjet, *supra* note 4, at 240-41, 242-43, 245-46, that such evidence is often acknowledged to be sufficiently unreliable as to be inadmissible or at least be of minimal probative value. *E.g.*, Daniel W. Shuman, *The Role of Mental Health Experts in Custody Decisions: Science, Psychological Tests, and Clinical Judgment*, 36 FAM. L.Q. 135, 139-44 (2002) [hereinafter Shuman, *Role of Mental Health Experts*]; Donald N. Bersoff, *Judicial Deference to Nonlegal*

loss of custody and potential termination of parental rights may be even more of a deprivation to a mother than incarceration is to a father.[79] For example, a mental health professional's conclusions and recommendations may be admitted into evidence in juvenile court through a written report or social worker testimony, which subverts the adversary process because the professional is no longer amenable to cross examination.[80] Legislatures could require that states prove elements of a termination cause of action most susceptible to systemic bias against mentally ill women beyond a reasonable doubt,[81] but they usually require only clear and convincing evidence.[82] Though dependency and termination cases are a "continuum of proceedings," courts are not constitutionally required to appoint counsel for a mother early in the process.[83] The child receives more procedural protection in juvenile court,[84] but

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Decisionmakers: Imposing Simplistic Solutions of Problems of Cognitive Complexity in Mental Disability Law, 46 S.M.U.L. REV. 329, 355-57 (1992). In other words, the criminal sentencing and dependency contexts are linked in that the outcome can be driven by mental health professionals' expert testimony as to the principle party's "future dangerousness" and other issues where they may lack expertise, *see* MELTON, *supra* note 3, at § 1.04; Daniel W. Shuman, *What Should We Permit Mental Health Professionals to Say About "the Best Interests of the Child?": An Essay on Common Sense, Daubert, and the Rules of Evidence*, 31 FAM. L.Q. 551, 554-55 (1997), are basing their opinions on flawed data, *e.g.*, Shuman, *Role of Mental Health Experts*, *supra* at 140-54 (also implying testimony or other evidence based on some tests used in child custody evaluations may not be admissible under *Daubert*), and perhaps as an ethical matter ought not be testifying at all. *See* MELTON, *supra* note 3, at § 1.04 (lack of expertise as to dangerousness), § 15.06 (describing numerous ethical pitfalls for mental health experts in child welfare cases).

Despite these desultory similarities, the criminal defendant in a sentencing hearing has several protections a mentally ill mother in juvenile court does not. *Barefoot* emphasized the significance of the adversary process to protect defendants from unreliable or minimally probative mental health expert testimony. *Barefoot*, 463 U.S. at 901. Aside from routine cross-examination, in federal courts and some states, a criminal defendant has a meaningful opportunity to conduct a *Daubert* hearing. *Cf.* DeWard, *supra* note 77, at 975-78 (discussing *Daubert*'s departure from *Barefoot*, ostensibly imposing a stricter admissibility test even for expert mental health evidence), 1003-06 (arguing for more Daubert hearings in dependency cases while acknowledging challenges). Even in criminal sentencing hearings, defendants have the protection of a jury. *E.g.*, *id*. at 883. As this section discusses, mentally ill mothers receive none of these protections in juvenile court.

79. "It cannot be true that society lacks zeal in eradicating crime, thus there must be reasons other than softness on crime that explain why criminal defendants enjoy so many protections accused parents do not," Professor George Alexander observes. Alexander, *supra* note 12, at 1484; *see also* Amy Sinden, *"Why Won't Mom Cooperate?": A Critique of Informality in Child Welfare Proceedings*, 11 YALE J.L. & FEMINISM 339, 342 (1999) (discussing feminist reasoning). Many studies find that mothers who have lost custody or parental rights to their children experience anger and intense grief. *Cf.* Sands, *Maternal Custody Status*, *supra* note 9, at 322–23; Nicholson I, *supra* note 33.

80. *See* KY. REV. STAT. ANN. § 620.023(1)(a) (LexisNexis 2009) (where mental illness under consideration for purposes of determining best interests of child), 620.080(2) (LexisNexis 2009) (at temporary removal hearing).

81. *Cf.* Santosky v. Kramer, 455 U.S. 745, 769 (1982) (observing that Congress requires "evidence beyond a reasonable doubt" to terminate Indian parents' rights, because termination was even worse "than a criminal penalty").

82. This is the minimum acceptable constitutionally. *E.g.*, J.E.H. v. Dep't for Human Res., 642 S.W.2d 600, 603 (Ky. Ct. App. 1982).

83. *Cf.* R.V. v. Commonwealth, 242 S.W.3d 669, 672-73 (Ky. Ct. App. 2007) (holding that both the Fourteenth Amendment of the United States Constitution and Kentucky statute provide a right to appointment of counsel from the beginning of dependency proceedings, because they commence a "continuum of proceedings" that may result in termination of parental rights). *See generally*

severing the mother-child relationship has "far reaching" consequences for both.[85]

B. T.G. v Commonwealth.[86]

It was inevitable that T.G. would lose her three children. It was not inevitable that she would lose A.J.M. completely.

T.G.'s children had been in and out of her custody for more than ten years. "This time," the problem was a "dirty house,"[87] as well as financial and employment-related stressors.

Social workers for Kentucky's Cabinet for Health and Family Services prepared a prevention plan to insure A.J.M.'s safety in T.G.'s care,[88] and T.G. "consent[ed] to a psychological evaluation and agree[ed] to follow all recommendations."[89] Psychologist Dr. Linda Bailey diagnosed T.G. with "an anxiety disorder, most likely an obsessive compulsive type with evidence of paranoia" and recommended therapy and medication.[90] When the social workers learned that T.G. had not found appropriate housing and was behaving "erratically" with A.J.M. at daycare,[91] the Cabinet removed A.J.M. from T.G.'s care. A few months later, the Jefferson County (Louisville, KY) Family Court[92]

Lassiter v. Dep't of Soc. Servs., 452 U.S. 18 (1981) (appointment of counsel in termination case to be determined on case by case basis). States are divided as to a parent's right to counsel in a dependency proceeding, and few have considered whether appointed counsel may withdraw before "permanency hearings" that often lead to termination of rights. *See* Patricia Kussmann, *Right of Indigent Parent to Appointed Counsel in Proceeding for Involuntary Termination of Parental Rights*, 92 A.L.R.5th 379, at §§ 5–6 (2001 & Supp.).

84. For example, all states provide children with some sort of guardian at litem representation. *See* Jean Koh Peters, *How Children Are Heard in Child Protective Proceedings, in the United States and Around the World in 2005: Survey Findings, Initial Observations, and Areas for Further Study*, 6 NEV. L.J. 966, 996-97 (2006).

85. *See* Santosky v. Kramer, 455 U.S. 745, 760 n.11 (1982) ("In this case, for example, Jed Santosky was removed from his natural parents' custody when he was only three days old; the judge's finding of permanent neglect effectively foreclosed the possibility that Jed would ever know his natural parents.").

86. The material in the following 8 paragraphs comes from *T.G. v. Cabinet for Families and Children*, 2008 WL 3890033 (Ky.). This paper cites separately explanations from other law and quotations from the case.

87. Living in substandard housing is a known risk factor for abuse and neglect. MELTON, *supra* note 3, at § 15.03. Among the allegations of neglect and abuse against T.G. over the years were: a pattern of domestic abuse, T.G.'s non-compliance with required mental health treatment, the children's excessive school absences, abusive discipline, and unsafe and unsanitary conditions in the home.

88. T.G. signed the document, probably aware that the Cabinet would remove A.J.M. if she did not. *Compare* KY. REV. STAT. ANN. § 620.060 (LexisNexis 2009) *with* 922 KY. ADMIN. REGS. 1:330 sec. 3(12) (2009).

89. *T.G.*, 2008 WL 3890033, at *2.

90. *Id*.

91. *Id*.

92. Kentucky judicial districts have either "juvenile" courts to hear dependency cases or consolidated "family" courts. But for limited subject matter jurisdiction, family courts are "circuit courts," Kentucky's general trial courts. They hear dissolution and property distribution cases, child custody, visitation, maintenance and child support, adoption, termination of parental rights, certain domestic violence matters, paternity, dependency and juvenile status offense cases. KY. REV. STAT.

found that A.J.M. was an "abused or neglected child" and should be committed to the Cabinet's custody.[93]

Psychologist Dr. Patricia Aulbach diagnosed T.G. with paranoid personality disorder. A person with paranoid personality disorder exhibits "a pattern of pervasive distrust and suspiciousness of others,"[94] is "distrustful and on guard, quick to take offense and read malevolence into what others do and prone to harbor deep, long-standing resentments."[95] Sufferers are "[r]eluctant to confide in others because of unjustified fear that the information will be used against them in a malicious fashion."[96] They can seem "overt[ly] argumentative," "rigid and critical of others," and "cold and humorless."[97]

This diagnosis would discourage anyone who hoped for T.G.'s and A.J.M.'s reunification. Psychologist Dr. Sally Brenzel testified on the basis of four and one half hours of clinical interviews with T.G., observations of T.G. and A.J.M. together[98] and unreliable psychological test results.[99] Dr. Brenzel stated that "as A.J.M. gets older and more able to assert herself, T.G.'s mental illness will make it more and more difficult for her to properly parent A.J.M., . . . [and therefore,] her prognosis to successfully parent A.J.M. was poor."[100] Dr. Peggy Kinnetz, Ed.D., worried that "T.G. will likely isolate herself and A.J.M. because of her paranoia and mistrust of others."[101] Dr. Aulbach testified that treating T.G.'s condition would require "a long-term, trusting therapeutic relationship,"[102] and Dr. Brenzel doubted T.G.'s ability to maintain one.[103]

T.G.'s compliance with therapy and medication was always fraught with difficulty. A person with paranoid personality disorder is unlikely to seek out

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ANN. §§ 23A.100(1), (2) (LexisNexis 2009). Termination of parental rights cases always occur at the circuit court level. KY. REV. STAT. ANN. § 625.020 (LexisNexis 2009). This paper will refer to "family" court when discussing the *T.G.* case and in specific situations where its procedures are different from the traditional "juvenile" court with its limited jurisdiction of matters related to minors. *Cf.* KY. REV. STAT. ANN. § 24A.130 (LexisNexis 2009).

93. *T.G.*, 2008 WL 3890033, at *3.

94. John Q. Young, *Paranoid Personality Disorder*, *in* FERRI'S CLINICAL ADVISOR 676 (2009) [hereinafter FERRI].

95. MOORE & JEFFERSON, *supra* note 24, at § XIII, ch. 134; RAKEL, TEXTBOOK OF FAMILY MEDICINE 1422 (7th ed. 2007).

96. FERRI, *supra* note 94, at 676.

97. *Id.*; MOORE & JEFFERSON, *supra* note 24, at § XIII, ch. 134.

98. Observing parent-child interaction is "[a]n important and . . . underutilized component of parenting capacity assessment." Budd, *supra* note 75, at 434.

99. Dr. Brenzel used both the Rorschach Inkblot Test and the Thematic Apperception Test, "the popularity of which may be due in part to the perception that they reveal hidden aspects of personality or simply because most mental health professionals are trained to use them." Benjet, *supra* note 4, at 246–47. These tests are not empirically tested in a child welfare context, Budd, *supra* note 75, at 434, and expert testimony based on their results may not be admissible under the *Daubert* standard. *See* Baerger, *supra* note 72, at 62–63; DeWard, *supra* note 77, at 988-89.

100. *T.G.*, 2008 WL 3890033, at *9.

101. *Id.* at *13. The concern is consistent with the frequent course of the condition. "Some may literally withdraw into the protection of a hilltop fastness," states one psychiatry treatise, and "[m]any lead tensely quiet lives, left well enough alone by their neighbors who sense the danger in them." MOORE & JEFFERSON, *supra* note 24, at § XIII, ch. 134.

102. *T.G.*, 2008 WL 3890033, at *9.

103. *Id.* at *10.

mental health care or comply with treatment,[104] though the same is true to a lesser extent of mentally ill mothers without paranoid symptoms if treatment calls their fitness as caregivers into question.[105] Diagnosis does not dictate whether a mother believes mental health professionals are part of a dangerous system with too much power over her life.[106]

Nevertheless, T.G. embarked on a long series of unsuccessful patient relationships with mental health professionals who reported to the Cabinet or testified in court as follows:

> Dr. Katie LaJoie, Psy.D. – A.J.M. "easily soothed" at play sessions, but T.G. "exhibited obsessive behaviors" such as "cleaning the play area more than any parent Dr. LaJoie had ever seen"[107];
>
> Allison Johnson, LCSW – relationship ended after confrontation about T.G.'s mental health;
>
> Dr. Patricia Aulbach, Psy.D. – "T.G. was consistently worried about a conspiracy against her involving the Court, the Cabinet," and a local mental health clinic; that "T.G. feared that anything done during her sessions would ultimately be used against her by the Cabinet"[108]; and T.G. was "pre-occupied with the upcoming parental rights hearing"[109];
>
> Dr. Daya Singh Sandhu, Ed.D. – T.G. was afraid to take medication, because "the Cabinet would then think she was a psychiatric patient and not give her child back"[110]; and,
>
> Peggy Kinnetz, Ed.D. – "when T.G. has to interact with governmental agencies . . . she tends to react with suspicion and mistrust."[111]

The Kentucky Supreme Court observed from this record that T.G. had "made no real effort to address her mental health issues" in the prior ten years.[112]

Eight months after removing A.J.M. from T.G.'s custody, during T.G.'s course of treatment and therapy, the Cabinet filed a petition to terminate T.G.'s parental rights to A.J.M. The Cabinet's case focused on:

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104. *See* MOORE & JEFFERSON, *supra* note 24, at § XIII, ch. 134 (2d ed. 2004); RAKEL, *supra* note 95, at 1422.

105. *See, e.g.*, Anderson, *supra* note 33, at 935-36; Nicholson I, *supra* note 33; McWey, *supra* note 51, at 201.

106. Anderson, *supra* note 33, at 939.

107. *T.G.*, 2008 WL 3890033, at *3.

108. Parents in child welfare cases do not always know that their interactions with mental health professionals are not confidential. *See* Budd, *supra* note 75, at 432. T.G.'s guarded approach is often deemed counterproductive; courts look dismally on parents who refuse to release medical records, "[a]lthough . . . another way to look at it is 'not wanting to self-incriminate.'" McWey, *supra* note 51, at 208.

109. *T.G.*, 2008 WL 3890033, at *10.

110. *Id*.

111. *Id*. at *7.

112. *Id*. at *14.

> T.G.'s long-standing hostile relationship with the Cabinet, her inability to develop a lasting relationship with a therapist, her refusal to accept and adequately deal with her mental health issues, and the effect that T.G.'s unstable mental health would have on her ability to parent A.J.M.[113]

After a trial on December 20, 2005, the Family Court judge entered an order terminating T.G.'s parental rights to A.J.M. on the basis that "T.G.'s mental illness had rendered her incapable of providing essential care, protection, and basic necessities for A.J.M.," and there was no "reasonable expectation for significant improvement."[114]

III. KENTUCKY'S CHILD WELFARE SYSTEM

A. Purpose and mandate to juvenile courts.

Both juvenile courts and child welfare agencies must navigate between the Scylla of protecting children[115] and the Charybdis of parents' statutory[116] and constitutional interests "in the care, custody and [control] of their child[ren]."[117] The appropriate path is often difficult to discern. For example, despite the apparent adversarial presentation, parents and children share a "vital interest" in their relationship,[118] and the child's right to a safe and permanent home is not necessarily inconsistent with the maintenance of the parent-child relationship.[119]

Though child welfare policy is a matter of state enforcement, the strings attached to federal reimbursement of state foster care expenditures mandate respect for the family unit.[120] The Adoption Assistance and Child Welfare Act of 1980 required that states make "reasonable efforts" to preserve or reunify families to receive federal foster care cost reimbursement.[121] Federal priorities shifted with enactment of the Adoption and Safe Families Act of 1997, however, in favor of achieving permanent living arrangements for children, as opposed merely to preserving or reunifying biological families.[122]

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113. *Id.* at *4.

114. *Id.* at *13–*14; *see also* KY. REV. STAT. ANN. § 625.090(2)(E) (LexisNexis 2009).

115. Patricia A. Schene, *Past, Present, and Future Roles of Child Protective Services*, 8 FUTURE CHILD. 23, 24 (1998).

116. Hardin, *supra* note 13, at 111.

117. Santosky v. Kramer, 455 U.S. 745, 753–54 (1982).

118. *Id.* at 790.

119. *Cf.* M.E.C. v. Commonwealth, 254 S.W.3d 846, 850 (Ky. Ct. App. 2008) (pointing out that "[w]hile the state has a compelling interest to protect its youngest citizens, state intervention into the family with the result of permanently severing the relationship between parent and child must be done with utmost caution. It is a very serious matter.").

120. *See* Schene, *supra* note 115, at 29.

121. Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, §103(b), 94 Stat. 500.

122. Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, § 101, 111 Stat. 2115; *see* Theodore J. Stein, *The Adoption and Safe Families Act: Creating a False Dichotomy Between Parents' and Childrens' Rights*, 81 FAM. SOC'Y 586, 587 (2000). Most states immediately adjusted their state law accordingly. *See* Steve Christian, *1998 State Legislative Responses to the Adoption and Safe Families Act of 1997* (National Conference of State Legislatures, State Legislative Report Mar. 1999), *available at* http://www.ncsl.org/Default.aspx?TabId=4248 (last accessed Jun. 17, 2009).

Juvenile courts theoretically supervise state child welfare agencies' activities and protect the parties' legal rights,[123] but in practice, they struggle to perform this oversight function. Juvenile courts tend to be swamped with cases,[124] procedurally chaotic,[125] and mired in "love-hate" relationships with child welfare agencies. In some jurisdictions, the relationship is an antagonistic culture of fear and disrespect.[126] In others, courts are deferential to the point of capture by agency officials.[127]

The structure of juvenile courts also puts parents' interests at risk. Juvenile courts are problem-solving courts focused on treatment rather than punishment in a setting that is not "legalistic" or "adversarial."[128] Informality, however, can exacerbate already gaping power differentials between a usually poor mother with a mental illness and the state.[129] One regular juvenile court practitioner observes, "[a] mother may often find herself the only outsider in a room full of professionals."[130]

Further, "treatment" often has a psychological component, which places mentally ill mothers in particular at risk of substantive and procedural bias because of their medical conditions.[131] Mental health professionals are ubiquitous throughout the child welfare and juvenile court systems.[132] A

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123. Hardin, *supra* note 13, at 111.

124. Susan Robison, *Delivering on the Promise: Promoting Court Capacity to Improve Outcomes for Abused and Neglected Children* 8-9 (National Conference of State Legislatures Primer for Policymakers 2007). Between 1976 and 1996, the number of federally mandated hearings in juvenile cases rose from one to ten or more. *See* Hardin, *supra* note 13, at 116. The Adoption and Safe Families Act gave juvenile courts three new responsibilities, not to mention those states may have added at their own discretion. *See* Robison, *supra* at 9.

125. *See generally* Alberta J. Ellett & Sue D. Steib, *Child Welfare and the Courts: A Statewide Study With Implications for Professional Development, Practice and Change*, 15 RES. ON SOC. WORK PRAC. 339, 343 (2005).

126. *See*, *e.g.*, Brenda D. Smith & Stella E. F. Donovan, *Child Welfare Practice in Organizational and Institutional Context*, SOC. SERV. REV. 541, 553–54 (2003); Ellett & Steib, *supra* note 125, at 346.

127. *See* Schwartz, *supra* note 32, at 133-34; Baerger, *supra* note 72, at 35; Shuman, *Role of Mental Health Experts*, *supra* note 78, at 159.

128. Ellett & Steib, *supra* note 125, at 347–48. Not all observers believe juvenile courts or the child welfare system achieve this goal. *See* Schene, *supra* note 115, at 34; *see also* Richard E. Behrman, et al., *The Juvenile Court: Analysis and Recommendations*, 6 FUTURE CHILD. 4, 10 (1996).

129. *See* Sinden, *supra* note 79, at 378-87.

130. *Id*. at 353.

131. For example, a study of social work practice in Chicago revealed that courts routinely ordered psychological evaluation of parents in dependency cases as a standard practice, regardless of necessity. Smith & Donovan, *supra* note 126, at 554.

132. Qualified mental health professionals may do the following: (i) make the original report of dependency, neglect or abuse pursuant to Kentucky's duty to report abuse or neglect that does not recognize a therapist- or physician-patient privilege, *see* KY. REV. STAT. ANN. § 620.030(3) (LexisNexis 2009); (ii) perform psychological evaluations of parents or children on numerous occasions during an active case, *see* KY. REV. STAT. ANN. § 620.145(1)(b) (LexisNexis 2009) (by court order during pendency of juvenile case for purposes of determining custody or treatment); 922 KY. ADMIN. REGS. 1:330, sec. 3(14)(a) (2009) (at request of Cabinet during investigation of abuse or neglect); *see also* Smith & Donovan, *supra* note 126, at 554; (iii) testify as to a child's best interests, KY. REV. STAT. ANN. § 620.023(1)(a) (LexisNexis 2009); (iv) investigate or provide other advice as to custody arrangements by court appointment, KY. REV. STAT. ANN. §§ 403.290, 403.300 (LexisNexis 2009); and (v) provide court-ordered treatment of either parents or children, KY. REV. STAT. ANN. § 610.160 (LexisNexis 2009). Others with some training might include: (i) state child welfare agency social workers,

juvenile court can seem like a one-stop shopping center plying a huge array of psychological and social services, regardless of their likely efficacy.[133]

This culture undermines a juvenile court's efforts to protect both parents' and children's rights.[134] Hear the trial court judge in *T.G.*, Stephen George, describing an almost "clubby"[135] atmosphere in his courtroom: "[T]he major players have a vested interest in the success of the [Family Court]. The camaraderie and teamwork is exceptional. After all, everyone has the same goal, and that is to help families in need."[136] One practitioner is less convinced: "Two people working toward a shared goal clearly work more effectively if they cooperate. . . . But [these dynamics] serve to . . . treat[] any effort to frame problems in an adversarial context as unmotherly and harmful to the child."[137] As Ira Schwartz, former dean of the School of Social Work at the University of Pennsylvania points out: "[I]n many [] cases, the pressing issue most often cited is the extensive power wielded by child protective services."[138] Juvenile courts are a minefield even for the healthiest mothers, but it holds special cultural risks for the mentally ill.

B. Juvenile court procedure in dependency cases.

A mother's rights in the child welfare system depend on whether she has abused or neglected her child, and, if so, whether with the assistance of reasonable state efforts to reunify her family, she is able to improve her parenting enough to provide a safe home for her child. Social workers with the Cabinet for Health and Family Services investigate allegations of dependency, neglect or abuse and determine whether they can be substantiated administratively.[139] If cabinet officials substantiate such conditions, they either remove the child from the home[140] or provide the family with services and other assistance to protect the child from future danger according to a mutually agreeable "prevention plan."[141]

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though, unfortunately, social workers are all too often *not* trained to interact with and assess the needs of persons with serious mental illness, Risley-Curtiss, *supra* note 21, at 114-16; (ii) representatives of other service providers or agencies such as child advocacy centers, *see, e.g.*, KY. REV. STAT. ANN. §§ 620.020(4), 620.140(1)(c) (LexisNexis 2009); (iii) law enforcement officers, *see* KY. REV. STAT. ANN. § 620.040(5)(a) (LexisNexis 2009); (iv) court appointed special advocates, *see* KY. REV. STAT. ANN. § 620.100(1)(d) (LexisNexis 2009); (v) foster parents, *see* KY. REV. STAT. ANN. § 620.360 (LexisNexis 2009); (vi) members of foster care review boards, *see* KY. REV. STAT. ANN. § 620.190 (LexisNexis 2009); and (vii) members of multidisciplinary teams, *see* KY. REV. STAT. ANN. § 620.040(7)(b) (LexisNexis 2009).

133. *See* Erin May, Note, *Social Reformation for Kentucky's Legal System: The Creation of Unified Family Courts*, 92 KY. L.J. 571, 583-85 (2003/2004).

134. *See, e.g.*, Schwartz, *supra* note 32 at 131–32; Alexander, *supra* note 12, at 1487–88.

135. *See* Sinden, *supra* note 79, at 351.

136. May, *supra* note 133, at 584–85 (quoting email interview with Judge Stephen George, Jefferson Family Court, Kentucky, to Erin J. May (Oct. 15, 2002, 16:37:37 EST) (on file with author)).

137. Sinden, *supra* note 79, at 354–55.

138. Schwartz, *supra* note 32, at 131–32.

139. 922 KY. ADMIN. REGS. 1:330 sec. 9 (2009).

140. KY. REV. STAT. ANN. § 620.060 (LexisNexis 2009).

141. 922 KY. ADMIN. REGS. 1:330 sec. 3(12) (2009).

A "dependency case" in juvenile court begins with a petition alleging facts that if true would establish that a child is dependent, neglected or abused[142] or a request for emergency custody of a child at serious risk of harm.[143] Whether it initially removes a child or not, the juvenile court will hold a temporary removal hearing soon afterwards to determine "whether there are reasonable grounds to believe that the child would be dependent, neglected or abused if returned to or left in the custody of his parent."[144] If in the child's best interests, the court may enter a temporary custody order in favor of the Cabinet for Families and Children or another appropriate person or agency at that time or when needed later in the proceeding.[145]

Before entering the order, the judge must find that "alternative less restrictive means and services have been considered" to avoid removal.[146] As in all dependency proceedings where a child's best interests are concerned, the court "shall" consider relevant evidence of "[m]ental illness . . . of the parent, as attested to by a qualified mental health professional which renders the parent unable to care for the immediate and ongoing needs of the child."[147] The court "may" also "consider the effectiveness of rehabilitative efforts made by the parent or caretaker intended to address circumstances" putting the child at risk,[148] such as the mental health treatment in *T.G.* The court will then appoint an attorney to represent the mother for the pendency of the case, which can be many years.[149]

The court gains "jurisdiction" of the child after the parent stipulates or the court finds at an adjudication hearing that the allegations of the petition are true, and therefore, the child is dependent, neglected or abused.[150] After a separate dispositional hearing, the court enters an order to protect the child[151] who may require out-of-home care.[152] Before committing a child to the Cabinet's custody, "the court shall determine if reasonable efforts have been made by the court or cabinet to prevent or eliminate the need for removal."[153]

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142. KY. REV. STAT. ANN. § 620.070(a) (LexisNexis 2009).

143. KY. REV. STAT. ANN. § 620.060 (LexisNexis 2009).

144. KY. REV. STAT. ANN. § 620.080 (LexisNexis 2009).

145. KY. REV. STAT. ANN. § 620.090(1) (LexisNexis 2009).

146. KY. REV. STAT. ANN. § 620.090(1) (LexisNexis 2009).

147. KY. REV. STAT. ANN. § 620.023(1)(a) (LexisNexis 2009).

148. KY. REV. STAT. ANN. § 620.023(2) (LexisNexis 2009).

149. KY. REV. STAT. ANN. § 620.100(1) (LexisNexis 2009); *see also* R.V. v. Commonwealth, 242 S.W.3d 669, 672 (Ky. Ct. App. 2007) (Fourteenth Amendment forbids counsel appointed for parents in dependency cases to withdraw prior to permanency hearing, because hearing is part of "continuum of proceedings" that can lead to termination of parental rights.).

150. KY. REV. STAT. ANN. § 620.100(3) (LexisNexis 2009).

151. KY. REV. STAT. ANN. § 620.100(4) (LexisNexis 2009).

152. *See generally* KY. REV. STAT. ANN. § 620.140 (LexisNexis 2009).

153. KY. REV. STAT. ANN. § 620.140 (LexisNexis 2009).

If the court commits the child, the Cabinet begins planning to provide the child with a permanent living arrangement as quickly as possible.[154] The Cabinet prepares a "permanency" or "case" plan listing services the Cabinet will provide to facilitate family reunification and "objectives and specific tasks" the mother will pursue to improve her parenting skills.[155] Every six months, the Cabinet files a written "case progress report" listing services the Cabinet has provided and "a description of the efforts and progress of the parents."[156]

Every twelve months, the juvenile court holds a "permanency hearing"[157] where again the Cabinet must produce evidence of the "services and assistance" it has provided to the parents and a description of the parents' "efforts and progress."[158] Based on the Cabinet's efforts and the parents' progress, the court then determines if the Cabinet has made reasonable efforts toward reunification[159] or toward achieving another goal in the permanency plan.[160] The court may decide to change the permanency goal to adoption, which requires termination of the biological parents' rights to the child.[161] Therefore, after only a year, if the Cabinet has complied with its duty to make "reasonable efforts" to reunite a family, the court may conclude that the Cabinet should pursue termination of the mother's parental rights based on her "efforts and progress" on the road to rehabilitation.[162]

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154. Pub. L. No. 105-89, § 101 (a), 111 Stat. 2115; *see also* Commonwealth v. G.C.W., 139 S.W.3d 172, 177-78 (Ky. Ct. App. 2004). The Cabinet may even pursue both goals simultaneously. 922 KY. ADMIN. REGS. 1:140 sec. 1(2) (2009).

155. KY. REV. STAT. ANN. § 620.230(1), (2)(i) (Cabinet), (j) (parent) (LexisNexis 2009).

156. KY. REV. STAT. ANN. § 620.240(3) (Cabinet), (4) (parent) (LexisNexis 2009).

157. KY. REV. STAT. ANN. § 610.125(1) (LexisNexis 2009).

158. KY. REV. STAT. ANN. § 610.125(4)(c), (d) (LexisNexis 2009).

159. Cf. Commonwealth v. C.V., 192 S.W.3d 703, 703-04 (Ky. Ct. App. 2006) (though Cabinet had not shown it had made efforts toward its purported reunification goal at a prior permanency hearing to justify changing the goal to adoption, the Cabinet did not have to amend the goal and hold another permanency hearing in order to file a termination of parental rights petition); see also Ky. Rev. Stat. Ann. § 610.125(2) (LexisNexis 2009) (explaining that if the Cabinet decides it will not make reasonable efforts to reunify the family, court must hold a permanency hearing within 30 days). Kentucky law defines "reasonable efforts" as those required to reunify a family for purposes of dependency cases. Ky. Rev. Stat. Ann. § 620.020(10) (LexisNexis 2009). The term "reasonable efforts" is applicable to pursuit of multiple permanency goals in the federal Adoption and Safe Families Act. E.g., Pub. L. No 105-89, § 101(a) 111 Stat. 2115.

160. Federal law requires state courts to make this determination for foster care reimbursement purposes. New York State Office of Children and Family Services v. U.S. Dep't. of Health and Human Services Admin. for Children and Families, 556 F.3d 90 (2d Cir. 2009) (state must have judicial determination that state has made reasonable efforts to finalize permanency plan to receive federal foster care reimbursement, upholding 45 C.F.R. § 1356.21(b)(2)).

161. KY. REV. STAT. ANN. § 610.125(6) (LexisNexis 2009).

162. 15 KENTUCKY PRACTICE, *supra* note 15, at § 6:26 n.6.

IV. TERMINATION OF PARENTAL RIGHTS: MENS REA, REASONABLE EFFORTS AND THE RELENTLESS MACHINERY OF THE STATE

The myriad of challenges a mentally ill woman faces in a dependency case coalesce to increase the risk to her parental rights.[163] To terminate parental rights, a Kentucky court must find that a child is abused or neglected;[164] that termination is in the child's best interests;[165] and that one of ten "grounds" for termination exists.[166] During the "best interests" analysis, the court must "consider" whether: a mother's mental illness renders her unable to care for her child in the long term; the Cabinet made reasonable efforts to reunite the family; and the mother has made efforts and progress to permit a safe reunification.[167] These fact-sensitive standards[168] are significant legal hurdles for a mentally ill mother trying to retain parental rights to her child.

A. Definition of "abuse or neglect" and the necessity to show "intent."

Mentally ill mothers often come to the attention of social welfare agencies through reports of potential dependency, [169] neglect or abuse. [170] The substantive

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163. *See* McWey, *supra* note 51, at 205.

164. *T.G.* questions the constitutionality of relying on prior adjudications of abuse or neglect, because they will often come from juvenile courts that apply the preponderance of the evidence and not the constitutional clear and convincing standard. *T.G.*, 2008 WL 3890033, at *5.

165. KY. REV. STAT. ANN. § 625.090(1) (LexisNexis 2009).

166. KY. REV. STAT. ANN. § 625.090(2) (LexisNexis 2009).

167. KY. REV. STAT. ANN. § 625.090(3) (LexisNexis 2009).

168. *See* Suter v. Artist M., 503 U.S. 347, 358-60 (1992).

169. The definition of a "dependent child" is: "any child, other than an abused or neglected child, who is under improper care, custody, control, or guardianship that is not due to an intentional act of the parent, guardian, or person exercising custodial control or supervision of the child." KY. REV. STAT. ANN. § 600.020(19) (LexisNexis 2009).

170. The definition of "abuse and neglect" is:

> [A] child whose health or welfare is harmed or threatened with harm when his parent, guardian, or other person exercising custodial control or supervision of the child:
>
> (a) Inflicts or allows to be inflicted upon the child physical or emotional injury as defined in this section by other than accidental means;
>
> (b) Creates or allows to be created a risk of physical or emotional injury as defined in this section to the child by other than accidental means;
>
> (c) Engages in a pattern of conduct that renders the parent incapable of caring for the immediate and ongoing needs of the child including, but not limited to, parental incapacity due to alcohol and other drug abuse . . . ;
>
> (d) Continuously or repeatedly fails or refuses to provide essential parental care and protection for the child, considering the age of the child;
>
> (e) Commits or allows to be committed an act of sexual abuse, sexual exploitation, or prostitution upon the child;
>
> (f) Creates or allows to be created a risk that an act of sexual abuse, sexual exploitation, or prostitution will be committed upon the child;
>
> (g) Abandons or exploits the child;
>
> (h) Does not provide the child with adequate care, supervision, food, clothing, shelter, and education or medical care necessary for the child's well-being . . . ; or

differences are not entirely clear.[171] The superficial distinction is the parental culpability for the harm or risk to the child: abuse or neglect is intentional conduct while dependency does not arise from intentional conduct.[172] Some provisions stating grounds for an abuse or neglect finding can be read to require that "the actor's conscious objective is to cause [a] result or engage in [. . .] conduct,"[173] such as the basis for the abuse or neglect finding in *T.G.*: the parent "[c]reates or allows to be created a risk of physical or emotional injury . . . by other than accidental means."[174] "Creates" implies a purposeful act and "allows" suggests an omission with knowledge of the consequences.[175] The provision might also be read to permit a finding of "neglect" based on a negligent act.[176]

If the definition of abuse or neglect contains an intent requirement, however, T.G. did not abuse or neglect A.J.M. T.G.'s "failure to follow through" on treatment—which the court characterized as intentional, because she had a "theoretically treatable" condition[177]—was actually a manifestation of her condition.[178] While T.G. manifested obsessive impulses, negative parenting and other odd conduct with A.J.M., these were not the primary bases for the court's abuse or neglect finding. She did follow through with parenting classes and visitation, and engaged in "loving and caring" conduct toward A.J.M., who responded favorably.[179]

On virtually identical facts, an Oklahoma appellate court held in C.R.T. v. Oklahoma, that a mother with paranoid schizophrenia[180] could not be held responsible for not completing a treatment plan where her psychiatrist testified

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> (i) Fails to make sufficient progress toward identified goals as set forth in the court-approved case plan to allow for the safe return of the child to the parent that results in the child remaining committed to the cabinet and remaining in foster care for fifteen (15) of the most recent twenty-two (22) months.

KY. REV. STAT. ANN. § 600.020(1) (LexisNexis 2009).

171. A child can be abused or neglected under Kentucky law or the child can be dependent; both findings are impermissible. J.H. v. Commonwealth, 767 S.W.2d 330, 332 (1986).

172. 15 KENTUCKY PRACTICE , *supra* note 25, at § 6.9.

173. *See* KY. REV. STAT. ANN. § 600.020(32) (LexisNexis 2009) (definition of "intentionally" in Kentucky's juvenile code). Neither "intent" nor "intentionally" appears in the definition of abuse or neglect, only in the dependency definition. KY. REV. STAT. ANN. § 600.020(1) (LexisNexis 2009).

174. *T.G.*, 2008 WL 3890033 at 12 n.12.

175. *Cf.* RESTATEMENT (SECOND) OF TORTS § 8A (1977).

176. *See* Z.T. v. M.T., 258 S.W.3d 31, 36 (Ky. Ct. App. 2008) (referring to a ground for an abuse or neglect finding as describing "negligent" conduct).

177. *T.G.*, 2008 WL 3890033, at *12.

178. *See supra* text and notes at 94-97, 104-05.

179. *T.G.*, 2008 WL 3890033, at *3, *13. The case does not discuss actual damage to A.J.M. from T.G.'s negative parenting, though only a substantial risk of injury is sufficient to render a child neglected. KY. REV. STAT. ANN. §600.020(1)(b) (LexisNexis 2009); *cf.* E.C. v. D.C., 589 A.2d 1245, 1247 (D.C. Cir. 1991) (father failed to bond with child and was "overwhelmed" during only sporadic visitation).

180. Paranoid schizophrenia is *not* the same as paranoid personality disorder, but many started by exhibiting paranoid personality traits and have such symptoms. *See* MOORE & JEFFERSON, *supra* note 24, at § XIII, ch. 134.

that "denial of problems and failure to take medication are manifestations of the mental illness."[181] The court stated:

> ***Here, the "condition" [to be corrected] is the mental illness***. Mental illness was the basis for the deprived child adjudication and remained as Mother's problem to the time of trial. ***This*** is the condition that must be corrected. In addition, the overwhelming evidence here shows that the alleged failure to correct the condition follows and flows directly from the condition itself.[182]

That court concluded termination would violate the Fourteenth Amendment.[183]

Kentucky's leading family law treatise argues that the parents' acts or omissions may be so serious that "the court's inability to find traditional 'fault' on a parent's part" should not forbid a finding of abuse or neglect.[184] Yet case law is inconsistent.[185] Whether the parent is making *actual* progress towards resolving parenting deficiencies or whether the parent suffers primarily from intellectual challenges are the foundational distinctions between the cases, not *mens rea* in the abuse or neglect analysis.[186] The reason for the radically different results in *T.G.* and *C.R.T.* could be nothing more than a better record.

B. "Reasonable efforts" standard.

Whether a child welfare agency makes reasonable efforts to reunify a family may be the most important determinant of whether the family ever reunifies at all. Not surprisingly, Kentucky law requires that a juvenile court consider whether the Cabinet has made "reasonable efforts" every time it hears a removal petition.[187] The Cabinet makes reasonable efforts when it "exercise[s] . . . ordinary diligence and care . . . [and] utilize[s] all preventive and

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181. C.R.T. v. Okla., 66 P.3d 1004, 1010 (Okla. Civ. App. 2003).

182. *Id*. at 1009-10 (emphasis in original).

183. *Id*. at 1010.

184. It cites no authorities for this view. 16 KENTUCKY PRACTICE, *supra* note 25, at § 25:20.

185. *Compare* D.S. v. F.A.M., 684 S.W.2d 320, 322 (Ky. Ct. App. 1985) (separation from child where mother was maintaining contact with child, had placed child with relatives while making progress with treatment for her mental and emotional problems was not intentional, deliberate or willful) *with* O.C.E. v. Dep't of Human Res., 638 S.W.2d 282, 284 (Ky. Ct. App. 1982) (where "the child requires special care and training that the father cannot provide because of his severe mental deficiency and depression, termination of parental rights is appropriate) *and* Crum v. Commonwealth, 928 S.W.2d 355, 358 (Ky. Ct. App. 1996) (termination appropriate where mother "had allowed the children to be sexually exploited," could not protect children and her prognosis for change was poor given her mental retardation). Other states make this apparent distinction between mentally ill and intellectually challenged parents. *See* Bogacki & Weiss, *supra* note 74, at 39-40.

186. 16 KENTUCKY PRACTICE, *supra* note 25, at § 25:20 (recommending that case be read as one where it was not in the child's best interest to terminate the mother's rights because she was making progress with treatment and maintaining contact but not because she lacked intent).

187. *See* KY. REV. STAT. ANN. § 620.130(1) (LexisNexis 2009) (requirement that court "decide" if "alternatives less restrictive than removal . . . are adequate to reasonably protect the child" applies even if the child is not committed to the Cabinet or is to be placed with a non-state custodian); *see also* B.C. v. B.T., 182 S.W.3d 213, 217-18 (Ky. Ct. App. 2005) (less restrictive alternatives consideration "seems" to be equivalent to "reasonable efforts" to prevent removal requirement).

reunification services available to the community" [188] to "preserve or reunify a family."[189]

Much depends on the extent and quality of the Cabinet's efforts. The services a mother receives may determine how long it takes for her to become a sufficient caretaker for her child.[190] How long a mother requires to become a sufficient caretaker may determine how long her child remains in foster care.[191] How long a child remains in foster care often determines when the Cabinet will file a petition to terminate the mother's parental rights.[192] Favorable verdicts for mentally ill mothers in termination of parental rights proceedings are rare.[193] According to Kentucky termination law, the length of time the child spends in foster care can be the sole determinant of whether the child is neglected or abused, whether the Cabinet proves a ground for termination, and whether termination is in the child's best interests![194]

Despite these tremendous consequences, the Cabinet need not make "reasonable efforts" if a mentally ill mother will be unable to provide a safe home prior to the permanency hearing.[195] Without social service assistance, however, the mother may pose a significant risk of harm to her child, regardless of her intent to do so, making reunification impracticable. Therefore, a definition of abuse or neglect with a fuzzy *mens rea* requirement, the Cabinet's failure to make reasonable efforts, and the mother's consequent inability to provide a safe home are together an almost perfect recipe for termination of the mother's parental rights.

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188. KY. REV. STAT. ANN. § 620.020(10) (LexisNexis 2009). Preventive services prevent or eliminate the need for removal. KY. REV. STAT. ANN. § 620.020(9) (LexisNexis 2009). Reunification services are "designed to help reunify the family as quickly as possible." KY. REV. STAT. ANN. § 620.020(11) (LexisNexis 2009).

189. 42 U.S.C. § 671(a)(15)(B) (2009).

190. *See* Risley-Curtiss, *supra* note 21, at 114.

191. *See generally* Risley-Curtiss, *supra* note 21.

192. *See* Pub. L. No 105-89, § 103(a)(3), 111 Stat. 2115.

193. *See generally* McWey, *supra* note 51.

194. *See, e.g., infra* text and notes at 234-36 (discussing "15 out of 22 months" rule).

195. According to KY. REV. STAT. ANN. § 610.127(6) (LexisNexis 2009):

> Reasonable efforts as defined in KRS 620.020 shall not be required to be made with respect to a parent of a child if a court of competent jurisdiction determines that the parent has: . . . (6) Mental illness . . . that places the child at substantial risk of physical or emotional injury even if the most appropriate and available services were provided to the parent for twelve months.

The provision is consistent with the general rule that reasonable efforts are not required if they would be futile. Sherry S. Zimmerman, *Parents' Mental Illness or Mental Deficiency as Ground for Termination of Parental Rights – Issues Concerning Rehabilitative and Reunification Services*, 12 A.L.R.6th 417, § 9 (2006); *cf.* L.M.K. v. Dep't of Human Res., 621 S.W.2d 38, 40 (Ky. Ct. App. 1981). State statutes that measure the propriety of reasonable efforts by twelve month time periods subsume the federal policy that the one year prior to the permanency hearing is sufficient for parental rehabilitation. *See, e.g.*, M.A.J. v. S.F., 994 So.2d 280, 290-91 (Ala. Civ. App. 2008); Kurtis A. Kemper, *Construction and Application by State Courts of the Federal Adoption and Safe Families Act and Its Implementing State Statutes*, 10 A.L.R.6th 173, 193 (2006); *cf.* Commonwealth v. G.C.W., 139 S.W.3d 172, 177-78 (Ky. Ct. App. 2004).

Subtle differences in termination law, however, complicate the Cabinet's incentives. When evaluating the best interests of the child and the grounds for termination, the court "shall consider" both whether the Cabinet made reasonable efforts to reunite the family[196] and "[m]ental illness . . . which renders [the mother] *consistently* unable to care for the immediate and ongoing physical and psychological needs of the child for extended periods of time."[197] Twelve months may be insufficient for the mother's rehabilitation, but if the Cabinet does not make reasonable efforts as of the time it filed a petition based on the less rigorous dependency exception,[198] the mother's condition may have stabilized sufficiently from her own efforts by the trial date of the termination case. In this instance, she is not consistently unable to care for the child and the court need not consider it in the termination decision. Result: a mother who may still have serious parenting deficits may be about to receive custody of her child.[199]

The heavy statutory emphasis on mental health is another legal bias against mentally ill mothers. Juvenile law does not scrutinize mothers' chronic physical limitations, though these limitations also create stressors that can lead to deficient parenting and child maltreatment.[200] For example, at the time of trial in M.E.C. v. Commonwealth,[201] a mother who had struggled to complete her case plan due to multiple incarcerations for drug-related activity and hospitalizations for a head injury sustained in a near-fatal car wreck had not resolved her criminal issues,[202] and was in residential drug treatment for the third time in two years.[203] Nevertheless, in contrast with *T.G.*, the mother received high marks for her efforts to rehabilitate herself. In fact, the Kentucky Court of Appeals held that the Cabinet had failed to make reasonable efforts to reunite her with her children[204] and actually expressed concern that the state did not provide services while she was incarcerated![205]

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196. KY. REV. STAT. ANN. § 625.090(3)(c) (LexisNexis 2009).

197. KY. REV. STAT. ANN. § 625.090(3)(a) (emphasis added) (LexisNexis 2009).

198. For example, the dependency exception at the time of the termination trial is retrospective, focusing on whether not providing services if the mother has mental illness would place the child at risk over a twelve month period even if the mother receives all appropriate services, KY. REV. STAT. ANN. § 610.127(6) (LexisNexis 2009), while the termination factor focuses on the mother's long-term ability to provide consistently for the child. KY. REV. STAT. ANN. § 625.090(3)(a) (LexisNexis 2009).

199. *Cf.* M.E.C. v. Commonwealth, 254 S.W.3d 846, 854-55 (Ky. Ct. App. 2008).

200. *See* MELTON, *supra* note 3, at § 15.05(a).

201. The mother was a domestic violence victim; illegal drug user; both a felon and a crime victim; and received severe brain trauma with accompanying cognitive impairment that impeded completion of her case plan. M.E.C. v. Commonwealth, 254 S.W.3d 846 (Ky. Ct. App. 2008).

202. *Id.* at 850.

203. *Id.* at 850.

204. *See generally M.E.C.*, 245 S.W.3d 846. Anyone who reads *M.E.C.* may consider my description of the facts ungenerous, but I focus on the "bad facts" to show how to make a parent who is "trying" sound like a malingerer. The court relies on the Cabinet's failure to change its plan for reunification to accommodate the mother while incarcerated or hospitalized. *Id.* at 854. Yet M.E.C.'s case plan was reasonable for a drug addict who engaged in persistent criminal activity: "obtain a drug assessment and comply with its recommendations, maintain a bond with her children, establish a safe and secure home for the children, attend and complete parenting classes, and resolve her legal issues." *Id.* at 849. Though she was working full time in Louisville, Kentucky so

Many mentally ill mothers' experience is that the "the reasonable efforts standard is a 'dead letter,'"[206] because they lack meaningful private enforcement mechanisms.[207] The Americans with Disabilities Act (ADA) is rarely helpful after case planning.[208] Parents have neither § 1983 claims for state failures to comply with federal "reasonable efforts" mandates, nor does federal law provide a private right of action.[209] The Kentucky juvenile code's abuse or neglect investigation procedures also do not create liberty interests that trigger federal procedural due process protection.[210] Further, states retain discretion when providing preventive and treatment services[211] so they can better balance the competing interests of state, parent and child.[212]

In addition, federal administrative oversight of child welfare agencies' reunification efforts is mostly ineffective.[213] For instance, the Department of Health and Human Services rarely cuts off foster care reimbursement for failure to comply,[214] and states do not enforce their own standards with rigor.[215]

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she could receive substance abuse treatment, *id*. at 854, the court implies that the state should have facilitated phone calls and provided her transportation for the two hour trip to Bowling Green, Kentucky where the children were living. *Id.* at 853.

205. *M.E.C.*, 254 S.W.3d at 852 (explaining later only that *hospitalization* should not have deprived the mother of Cabinet services and not addressing incarceration).

206. *See, e.g.*, Will L. Crossley, *Defining Reasonable Efforts: Demystifying the State's Burden under Federal Child Welfare Legislation*, 12 B.U. INT'L L.J. 259, 259-60 (2003).

207. A child is in no better legal position if a child welfare agency fails to protect a child. *See generally* DeShaney v. Winnebago County Dep't of Soc. Services, 489 U.S. 189 (1989) (case filed by mother after Randy DeShaney beat his four-year-old son Joshua into a coma, causing profound retardation and life-long institutionalization).

208. *See* Terry v. Terry, 610 N.W.2d 563, 570-71, n.5 (Mich. Ct. App. 2000).

209. *See* Suter v. Artist M., 503 U.S. 347 (1992) (construing 45 U.S.C. § 1357(15)(e)(2) in conjunction with non-exclusive lists of examples of potential services states may fund with federal funds in 45 C.F.R. § 1340.14(f)).

210. Tony L. v. Childers, 71 F.3d 1182, 1185-1187, 1188 (6th Cir. 1995) (holding that the Child Abuse Protection and Treatment Act provided neither a § 1983 remedy nor a private right of action). According to the Sixth Circuit, the juvenile code lacked "substantive predicates to govern official decisionmaking" that mandate "a particular outcome" and might have permitted a § 1983 claim. *Id.* at 1189.

211. *See* Suter v. Artist M., 503 U.S. 347, 360 (1992); *Tony L.*, 71 F.3d at 1189-90.

212. *Tony L.*, 71 F.3d at 1186-87.

213. Crossley, *supra* note 206, at 286. Some states produce preprinted dispositional order forms that allow juvenile court judges simply to check a box saying state child welfare departments made reasonable efforts to avoid removal or to facilitate reunification, which is the source of the information states send to the Department of Health and Human Services, making the federal review cursory if it happens at all. *Id.* at 285. In a recent case where New York challenged the agency's failure to reimburse foster care expenditures in ten cases, however, the United States Court of Appeals for the Second Circuit held that federal law conditions reimbursement on some judicial finding that the state has made reasonable efforts to achieve permanency within twelve months of the child entering foster care. New York ex rel. New York State Office of Children and Family Services v. U.S. Dep't of Health and Human Services' Admin. for Children and Families., 556 F.3d 90, 100 (2d Cir. 2009). New York courts did not make any finding in the ten cases, and the court upheld HHS's refusal to reimburse. *Id.*

214. *See Suter*, 503 U.S. at 360-61; *cf. Tony L.*, 71 F.3d at 1188, n.12.

215. *See* Hardin, *supra* note 13, at 119-20 (referring to "[t]he variability and general laxity of court monitoring of reasonable efforts").

Kentucky courts must only "consider" services the Cabinet might have provided.[216]

The extent of state child welfare agencies' de facto discretion to choose and provide services is breathtaking. "Reasonable efforts" do not counteract bias and systemic limitations that interfere with providing the "right" services in a timely manner.[217] Therefore, the law stacks the deck against mentally ill mothers' chances of protecting their parental rights.

C. "Do your services": where "reasonable efforts" and "efforts and adjustments" collide.

Permanency planning is where the child welfare agency's obligation to make "reasonable efforts" to reunite families meets the parent's obligation to make "efforts and adjustments" to justify returning the child. Mentally ill mothers who lose custody in dependency cases face daunting deadlines for rehabilitation. In most states, child welfare agencies may begin termination proceedings after the child has been out of the home for only twelve months[218] and, in some states, only six.[219] The twelve-month permanency hearing creates a presumption that a year is long enough for parental rehabilitation,[220] but a mentally ill woman can barely obtain a psychological assessment and attend her first therapy appointment in six months.[221]

Winning this relentless race against the clock requires careful attention to a treatment plan's details and aggressive compliance with its terms.[222] Therapists who do not understand the aggressive deadlines mentally ill women face often testify that those women need many months if not years of treatment, when the real issue is "what would be needed for parents to demonstrate reasonable improvement" within the legal time limits.[223] But child welfare agencies and juvenile courts rely more on plan compliance than parenting improvement when making custody decisions.[224] "Do your services. Do what you're supposed to do and you'll get your kids back," one Chicago attorney told a

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216. 15 KENTUCKY PRACTICE, *supra* note 15, at § 6:18.

217. 16 *id*. at § 25:31.

218. *See supra* note 159.

219. *E.g.*, 2009 Ariz. Legis. Serv. Ch. 148, sec. 7(A)(2) (West).

220. *E.g.*, Commonwealth v. G.C.W., 139 S.W.3d at 177-78; *see also* Kemper, *supra* note 195, at 193. The attitude can be harsh: according to a leading Kentucky treatise, parents' "failure to complete the tasks and *accept the responsibility*" taken at the case planning stage "can lead to termination of parental rights." 15 KENTUCKY PRACTICE, *supra* note 15, at § 6:26 n.6 (emphasis added).

221. *Cf.* Risley-Curtiss, *supra* note 21, at 112-13 (primarily discussing Arizona law from prior to passage of six month rule). California also provides only six months of rehabilitation services. CAL. WELF. & INST. CODE § 361.5(a)(2) (West 2009).

222. *See* NATIONAL CENTER FOR YOUTH LAW, MAKING REASONABLE EFFORTS: STEPS FOR KEEPING FAMILIES TOGETHER 19-22 (2000).

223. *See* McWey, *supra* note 51, at 202, 206.

224. *See, e.g.*, Smith, *supra* note 22, at 525, 530, 544; Ellett & Steib, *supra* note 125, at 348.

client.[225] The advice is sound: non-compliance dramatically increases the likelihood that a child welfare agency will seek termination of parental rights.[226]

Kentucky courts may "consider" a parent's efforts and adjustments when determining if it is "in the child's best interest to return him to his home within a reasonable period of time."[227] Again, however, the mother will find herself in a vicious . Whether the Cabinet's service provision is reasonable depends on the mother's progress,[228] and the sufficiency of the mother's progress in turn often depends on services she receives from the Cabinet.[229] The mother ends up the loser in this chicken and egg game.[230]

T.G.'s problem is one that many mentally ill mothers face: the inability to make quick adjustments as a result of her medical condition.[231] She did make significant "efforts" by seeing so many therapists in a mere eight months, and after a year-and-a-half, she had established a brief but promising relationship with a therapist. That therapist's testimony even held out hope: "if T.G. continues to engage in therapy . . . she would be capable of a systematic and supervised return of A.J.M. in the future."[232] A victory for T.G., perhaps, but not from the court's perspective.[233]

Another AFSA amendment, the "15 of 22 months rule," is the unkindest cut of all. The "rule" requires child welfare agencies to seek parental rights termination if the child has been in foster care for "15 of the most recent 22 months."[234] A court may also find a child abused or neglected if the parent's failure to make "sufficient progress" toward case plan goals "results in the child remaining . . . in foster care for fifteen (15) of the most recent twenty-two (22) months."[235] A ground for termination is also that the child has remained in foster care for fifteen out of the most recent twenty-two months. Finally, the court must also consider evidence of the parent's efforts and adjustments when determining the child's best interests,[236] an inquiry similar to the standard for abuse or neglect. In other words, failure to make progress in 22 months may alone justify termination.

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225. Smith, *supra* note 22, at 554.

226. *See* Eve M. Brank, et al., *Parental Compliance: Its Role in Termination of Parental Rights Cases*, 80 NEB. L. REV. 335, 350-51 (2001).

227. KY. REV. STAT. ANN. § 625.090(3)(d) (LexisNexis 2009).

228. *See* 16 KENTUCKY PRACTICE, *supra* note 15, at §§ 25:25, 25:31.

229. *See generally* Risley-Curtiss, *supra* note 21.

230. A child welfare agency does not face enforcement of the reasonable efforts requirement, *see* Smith, *supra* note 22, at 522, but if a mother does not make sufficient progress on her plan, her parental rights will be in danger. 16 KENTUCKY PRACTICE, *supra* note 15, at § 25:31.

231. *T.G.*, 2008 WL 3890033, at *12.

232. *Id.* at *11.

233. *See* Sands, *Maternal Custody Status*, *supra* note 9, at 321–23.

234. *See* Pub. L. No. 105-89, § 103(a)(3), 111 Stat. 2115.

235. KY. REV. STAT. ANN. § 600.020(1) (LexisNexis 2009).

236. KY. REV. STAT. ANN. § 625.090(3)(d) (LexisNexis 2009).

V. RECOMMENDATIONS AND CONCLUSIONS

A mentally ill mother's lived circumstances along with the cultural and legal realities of the child welfare system are such that through no "fault" of her own, a mentally ill mother may be swept into a system that she cannot escape with her child. Early in a dependency case, a Kentucky juvenile court will appoint an attorney for the mother, however.[237] Sound legal representation can overcome many of systemic barriers that create such an outcome gap. At every step through the process, the top priority for an attorney representing a mentally ill mother in juvenile court and beyond must be to educate social workers, mental health professionals and judges as to the mother's condition, its effect on her parenting and appropriate treatment goals and services to permit a safe reunification prior to the first permanency hearing and to serve strategic needs in the event of termination proceedings.[238]

During the crucial case planning process, a knowledgeable attorney can be "the mother's social worker" and offer informed suggestions to address actual stressors and to achieve relevant treatment goals. The fight against one-size-fits-all plans of documentable tasks such as parenting classes, substance abuse support groups and mental health treatment may require lengthy negotiation,[239] but determines the chance of reunification. Practical services that assist mothers to overcome financial crises, find safe housing, coordinate a social support network, attend therapist appointments regularly[240] and obtain mental health care for their children could raise the quality of a mother's parenting enough to raise her child in her home safely, but may not always occur to a social worker untrained in case planning for mentally ill mothers.[241]

Attorneys must also be on the lookout for any caseworker bias or professional impropriety during case planning. One study shows that caseworkers too often want the mother to show she is putting her children first, doing penance for wrongdoing and accepting the power of "the system."[242] *T.G.* may be an example. At trial, the state relied on T.G.'s "long-standing hostile relationship with the Cabinet"[243] and its sense of entitlement to T.G.'s

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237. KY. REV. STAT. ANN. § 620.100(1) (LexisNexis 2009); *see also* R.V. v. Commonwealth, 242 S.W.3d 669, 672-73 (Ky. Ct. App. 2007) (holding that the Fourteenth Amendment to the United States Constitution required appointment of counsel at all stages of the "continuum of proceedings," including the dependency case in juvenile court, that might result in termination of parental rights). Not all states agree, and the United States Supreme Court has not ruled on the precise issue. *See* Kussmann, *supra* note 83, at §§ 5[a], 5[b], 6[a], 6[b] (2001 & Supp.).

238. *See* Glennon, *supra* note 67, at 297-99.

239. Court ordered services, *see, e.g.*, Ellett & Steib, *supra* note 125, at 348; administrative exigencies, Smith, *supra* note 22, at 554; the need for objective standards, *see* Brank, *supra* note 226, at 351; and lack of caseworker expertise, *see* Risley-Curtiss, *supra* note 21, at 115, all conspire to standardize plans.

240. In one case, "reasonable accommodations" pursuant to the Americans with Disabilities Act were bus tokens so family members could attend therapy sessions. *See* Ark. Dep't of Human Services v. Clark, 802 S.W.2d 461, 462 (Ark. 1991).

241. *See* Benjet, 4 note 4, at 248.

242. Smith, *supra* note 22,, at 530.

243. *T.G.*, 2008 WL 3890033, at *4.

"cooperation."[244] The plan was doomed to failure, however, because T.G. did not believe she had done "wrong,"[245] and no one ever explained why to the Cabinet or the court.

Title II of the Americans with Disabilities Act is a practical tool in advocating for more suitable services during case planning.[246] The ADA adds little to a mother's actual legal leverage,[247] because the substantive requirement is the same: "reasonable efforts" are co-extensive with the ADA's "reasonable accommodations."[248] An enforcement mechanism, however, can create an incentive for an agency to "play it safe" by providing extra accommodation.

The outcome in *C.R.T.*, contrasted with that in *T.G.*, is also a reminder that as the case moves into juvenile court, the focus of the mother's attorney's efforts to communicate the reality of her condition, its effect on her parenting, and a realistic treatment timetable simply shifts to the judge.[249] Lawyers must challenge mental health professionals' testimony that does not address actual legal standards or overestimates the amount of time needed to increase a mother's parenting to the minimum acceptable level[250] or courts may defer to these inapposite opinions, guaranteeing a heightened risk to the mother's parental rights.[251]

Further, attorneys must highlight to the court the limited extent of mental health professionals' expertise. As to future parenting prognoses, that expertise is also carefully compartmentalized[252]: mental health professionals are not experts as to society's legal and moral standards,[253] and minimum acceptable parenting competency is not an objective judgment.[254] Experts may also be unable to distinguish to a sufficient degree between intentional and unintentional parenting outcomes to identify abuse or neglect.[255] In these

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244. As Amy Sinden explains, "[i]n the child welfare context, however, 'cooperation' is frequently just a code word for the parent doing whatever the social worker tells her to do." *See* Sinden, *supra* note 79, at 354.

245. *See* MOORE & JEFFERSON, *supra* note 24, at § VIII, ch. 134.

246. 42 U.S.C. § 12132 (1990); 28 C.F.R. § 35.104 (2009). *See also* Zimmerman, *ADA*, *supra* note 195, at § 6. The mother usually must assert her ADA rights during or soon after the case planning process. Terry v. Terry, 610 N.W.2d 563, 570-71, n.5 (Mich. Ct. App. 2000).

247. For example, virtually all courts reject using the ADA as a defense in a termination proceeding. *E.g.*, *In re* C.M.S., 646 S.E.2d 592 (N.C. Ct. App. 2007); *Terry*, 610 N.W.2d at 569-70. Title II does provide a private right of action for failure to provide reasonable accommodations, *see* Zimmerman, *ADA, supra* note 195, at § 6, but this mechanism may be time and cost prohibitive if the child remains in foster care.

248. *See, e.g.*, *Terry*, 610 N.W.2d at 570-71.

249. *See Defense in Proceeding for Termination of Parental Rights on Ground of Mental Disability*, 46 AM. JUR. PROOF OF FACTS 3d 231, at § 5 (2009).

250. *See* Bogacki & Weiss, *supra* note 74, at 42 (recommending that parents' attorneys sharpen expert cross examination skills given how probative courts consider mental health professionals' testimony).

251. Benjet, *supra* note 4, at 239.

252. *See, e.g.*, Budd, *supra* note 75("Parenting assessments *cannot* . . . [p]redict future behavior with certainty.").

253. *See* MELTON, *supra* note 3, at § 1.04.

254. *See id.*, at § 15.04(a).

255. A mental health professional's expertise in risk assessment is so limited and the boundary between "investigation" of whether abuse or neglect is at risk of occurring versus "assessment" of

situations, they may invoke the all-too-tempting default conclusion that the child requires protection and the judge be none the wiser.[256]

Attorneys should explore how mental illness in context can affect inferences of intent to abuse or neglect. For example, a mentally ill mother may neglect her children if she fails to prepare for foreseeable inpatient care.[257] Though mental illness triggers her hospitalization, failure to plan is not a manifestation of the condition as failure to succeed with treatment was in T.G.'s situation. But when an acute financial stressor triggers a major depressive episode, a mother's inability to clean her house could be a manifestation of her medical condition but could also indicate a lack of preparation for foreseeable consequences of her condition.[258] Courts should demand a large quantum of evidence to support the extreme finding that the mother's "acts or omissions are so serious and the likelihood of improvement in parental capacity so small" that even though unintentionally, the mother has still "allowed to be created . . . a risk of physical or emotional injury" to the children.[259] Perhaps professional testimony alone should not suffice, but the attorney for the mother must justify that conclusion.

At termination trials, mothers often have opportunities to challenge the sufficiency of the state's efforts to reunite the family. Kentucky law provides a defense if a mother can show the state failed to provide pivotal services,[260] and if a mental health expert testifies that with appropriate services, a mother could make sufficient progress to permit reunification in a reasonable time.[261] Rhode Island requires the state to prove by clear and convincing evidence that it made reasonable efforts.[262]

Even limited judicial scrutiny of a child welfare agency's efforts to reunite during a termination of rights proceeding creates some incentives to provide services proactively and within the statutory timetable,[263] but a 2008 Rhode Island Supreme Court case illustrates the profound difference shifting the burden to the agency can make. That court held that a case plan that did not

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how to respond is sufficiently blurred that courts should require substantial corroboration to make a finding of abuse or neglect by clear and convincing evidence. *See id.*, at § 15.04.

256. This conclusion avoids the terrible consequences of being "wrong." *See* Alexander, *supra* note 12, at 1488.

257. *Cf.* Nicholson I, *supra* note 33.

258. *See supra* text and notes at 26-33.

259. KY. REV. STAT. ANN. § 600.020(1)(b) (LexisNexis 2009); *cf.* 16 KENTUCKY PRACTICE, *supra* note 15, at § 25:20.

260. KY. REV. STAT. ANN. § 625.090(4) (LexisNexis 2009); 5 WILLIAM B. BARDENWERPER, ET AL., KENTUCKY PRACTICE, METHODS OF PRACTICE, § 46:4 (4th ed. 2009).

261. The mother may not need an expert to satisfy her burden of proof. *See* McWey, *supra* note 51.

262. *Compare In re* Natalya C., 946 A.2d 198, 200 (R.I. 2008) (placing responsibility on agency to provide mental health services proactively where mother was unable to complete substance abuse treatment due to depression drug counselor urged her to address) *with* 16 KENTUCKY PRACTICE, *supra* note 15, at § 25:31 (Cabinet does not have to provide services if parent is not making efforts).

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include mental health services where the mother's untreated depression impeded her substance abuse treatment did not satisfy the "reasonable efforts" requirement.[264] The court stated that "services received must be designed to address or correct the particular situation that led to the children's placement in [the agency's] care or custody" and futility was "not at all relevant" as to whether the agency had made reasonable efforts:[265]

> As we expect a doctor, not his patient, to prescribe medicine to treat the patient's illnesses, we also expect the DCYF to fashion effective case plans to enable reunification between parents and children. It is unreasonable for DCYF to rely on parents . . . to diagnose their own problems and then conjure up effective treatment strategies.[266]

Though T.G. was not a reasonable efforts case, the Kentucky Supreme Court betrayed a fundamentally different attitude toward T.G.'s and the state's comparative responsibility for T.G.'s "failure to follow through," that can arise from a legal culture inclined to err on the side of the state especially when the mother's deficiencies arise from mental health problems.[267]

Despite receiving suitable services, a mentally ill mother may make sincere efforts but not progress within the statutory time limits, and the attorney must tie the reason for this to the illness without implying that the mother is "consistently unable" to care for the child's ongoing needs "for extended periods of time."[268] Such distinctions are possible. Poverty and other stressors can obscure the true cause of child maltreatment when they blend with mental health deterioration,[269] so that the progress of a mother who receives mental health services as opposed to more appropriate emergency cash will lag behind that of a mother equally motivated but without health issues.[270] Like many mentally ill mothers, T.G. initially identified financial problems as the primary stressor in her life and downgraded her health condition; perhaps she did not receive the most productive services.

Even where mental health care is the most productive intervention, it is often insufficient to beat the AFSA deadlines. A woman may wait many months for requisite mental health treatment.[271] Medicaid managed care and low

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264. *Natalya C.*, 946 A.2d at 202, 204.

265. *Id.* at 202.

266. *Id.* at 204.

267. *Cf.* TOCQUEVILLE, *supra* note 30, at 314-15 (arguing that the influence of lawyers and the jury system on the law is such that the law becomes part of everyday language and that stare decisis reinforces the substance of the law).

268. KY. REV. STAT. ANN. § 625.090(3)(a) (LexisNexis 2009) (emphasis added).

269. *See supra* text and notes at 43-59.

270. *See* Risley-Curtiss, *supra* note 132, at 114-16; *see Habas*, 700 P.2d 225.

271. Gerard Gallucci, et al., *Impact of the Wait for an Initial Appointment on the Rate of Kept Appointments at a Mental Health Center*, 56 PSYCHIATRIC SERVICES 344, 345 (2005) (delay between initial contact and scheduled appointment is 0-47 days at Johns Hopkins Bayview Medical Center community psychiatry outpatient program); Elizabeth M. Webb, *Needs Assessment Workshop Presentation Health and Independent Individuals*, Jul. 24, 2006, *available at* http://lburgareava.blogspot.com/2006/07/lynchburg-area-mental-health-needs.html (wait time for individual and family counseling at center with sliding scale fees is one to two months in Central Virginia); Martha B. Knisley, *Testimony to Senate Subcommittee on the District of Columbia: FY 2006*

reimbursement levels depress the quality of low-income mothers' mental health services.[272] These women are often undertreated with less expensive and less effective medications that take longer to "tweak" to proper dosages and cause side effects that interfere with parenting.[273] Many Medicaid patients are simply treated incorrectly.[274] Ideally, the mother's attorney would identify these issues at the case planning stage, but if not, she must unpack these problems later for a judge whose basic experience may include only medical treatment paid by private health insurance.[275]

Finally, anything attorneys can do to keep a child out of foster care may be dispositive for mentally ill mothers facing the fifteen of twenty-two months clock.[276] Substance abuse, often co-morbid with mental illness,[277] is also not treatable within this time frame.[278] An inappropriate case plan,[279] mental health professionals who do not understand AFSA's strict deadlines,[280] or lack of access to services may lead inexorably to loss of parental rights.[281] Chillingly, in one study of 180 appellate court cases decided between 1986 and 2002, no family reunited before AFSA's time requirements ran out.[282]

Funding for Federal Foster Care Initiatives in the District of Columbia, Mar. 10, 2005, *available at* http://dmh.dc.gov/dmh/cwp/view,a,11,q,624998.asp (wait time for child psychiatric exams was three months in FY 2004 and for psychological exams it was two months).

272. *See* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 832-33 (2008).

273. One Medicaid managed care reviewer criticizes the "belief that newer treatments are generally inherently better than older ones. . . . When do we ever have a pharmaceutical representative promoting any of the older, tried and true medications such as Lithium or Thorazine[?]" *See* Juliana I. Ekong, *The Role of a Behavioral Health Medical Director in Medicaid Managed Care*, 79 PSYCHIATRIC Q. 33, 40 (2008). Newer mood stabilizers such as Depakote and Lamictal have fewer, less serious side effects than lithium, TORREY, *supra* note 40, at 137-57.

274. *See generally* Alisa B. Busch et al., *Quality of Care in a Medicaid Population With Bipolar I Disorder*, 58 PSYCHIATRIC SERVICES 848 (2007).

275. "Dirty houses" and inadequate living conditions are prime indicators for abuse, *see* MELTON, *supra* note 3, at § 15.03(d)(2), but the underlying cause may indicate different services. *See supra* text and notes at 26-33.

276. *See generally* Risley-Curtiss, *supra* note 21. Months may pass before a woman's first appointment with a therapist. *See supra* note 271.

277. *See* McWey, *supra* note 51, at 196, 201-02.

278. Crossley, *supra* note 206, at 291-92.

279. *See* Brank, *supra* note 226, at 351.

280. *See* McWey, *supra* note 51, at 206-07.

281. *See* Risley-Curtiss, *supra* note 21, at 115.

282. *See* McWey, *supra* note 51, at 209.