Mothers' Mental Health Evaluations in Foster Care Practice: A Social Constructionist, Qualitative Data-Mining Study

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MOTHERS’ MENTAL HEALTH EVALUATIONS IN FOSTER CARE PRACTICE:
A SOCIAL CONSTRUCTIONIST, QUALITATIVE DATA-MINING STUDY

by

MICHELLE SALVAGGIO

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

2015
This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

MOTHERS’ MENTAL HEALTH EVALUATIONS IN FOSTER CARE PRACTICE:
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by

MICHELLE SALVAGGIO

Adviser: Professor Willie Tolliver

This qualitative research study utilizes social constructionist theory and the client career perspective as a framework for developing a grounded theory that explains how mothers’ mental health evaluations function in the context of foster care practice. Using clinical data-mining methodology, the foster care records of sixteen mothers were purposively selected. Selection criteria included having completed psychiatric and psychological evaluations and having one child or more in foster care. The sample was divided into subgroups of substance users ($n = 9$) and those who did not use substances ($n = 7$), mothers who acknowledged their mental illness ($n = 6$) and those who did not ($n = 10$). Findings describe the sample’s demographic profiles and psychosocial characteristics, impact of acknowledgment on utilization of mental health evaluations and the relationship among variables such as mental health diagnosis and service plan adherence on children’s permanency outcomes.

Emergent themes informed the formulation of the study’s grounded theory. Substance abuse accounted for slight variations between the two groups. Drug users were more likely to be African-American and a year older than mothers who refrained from drug use. The whole sample was single mothers of low socioeconomic status whose children tended to have special
needs. Although both groups experienced severe psychosocial stressors, substance abusers were slightly more likely to experience childhood trauma and foster care placement. The effect of acknowledgment was mixed with six mothers (3 who acknowledged, 3 who did not) reunifying with their children. Service plan adherence and taking responsibility for their children’s maltreatment also affected children’s permanency outcomes.

The grounded theory posits that mothers’ mental health assessments function as an organizing mechanism for the foster care agency’s development of the mothers’ service plans. The mothers are socially constructed as women in need of evaluations due to their attitudes and behaviors. Following the completion of the assessments, service recommendations are purported and expected to be followed by the mothers. Implications for practice, research, policy and administration are discussed, especially for applying a trauma-informed practice lens and solution-focused casework models for work with mentally ill mothers with children in foster care.
Acknowledgments

My research questions and subsequent dissertation study have been shaped by my personal and professional experiences in the areas of mental health and child welfare practice, and there are many individuals to recognize as I complete this journey. Firstly, this project would not have been possible without the support of the New York City foster care agency where I worked and conducted the research study. Everyone from the executive director to the program director, supervisors, case workers and support staff were very helpful, pleasant and resourceful in the study’s data gathering process.

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Then, there are the friends, fellow colleagues, co-workers, supervisors, teachers and parents I met along the way that have inspired my research interests and desire to improve the child welfare system. I was lucky enough to be a consultant and board member to the Child Welfare Organizing Project, a parent advocacy organization where I met so many parents who shared their stories of coping with the foster care system. The organization was so welcoming to me, and I learned so much.

Finally, I must thank my family. My parents supported my academic pursuits from a young age, and my siblings gave me plenty of material to study. My mother-in-law has provided unconditional support. My husband has been my rock and backpack, and his support and love is everything.
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CHAPTER 1: INTRODUCTION

For mothers whose children have been removed and placed into foster care, the experience of navigating the child welfare system is influenced by a myriad of factors. These mothers are expected to form healthy, productive relationships with workers in the context of a significant power differential, within which their performance is judged in terms of their compliance with mandated services. Conversely, workers must contend with the complex process of assessing 1) what is truly in the best interests of children; 2) whether mothers have demonstrated adequate behavioral changes for their families to be reunited; and 3) the future risk of maltreatment. Due to the inherent challenges in making life-altering judgments about such critical concepts, referral for mental health evaluations is intended to aid child welfare workers in objectively and validly assessing mothers’ capacity to care for their children.

Evaluators conducting parental mental health assessments are also asked to make judgments of parenting capacity in the absence of specific indicators that define the minimum threshold of parenting skills (Budd, Clark, & Connell, 2011). Additionally, current assessment guides and standardized instruments are individually focused and less appropriate to evaluate the parent-child relationship and parenting skills (Erikson, Lilienfeld, & Vitacco, 2007). Furthermore, instruments that comprise traditional psychological evaluations have not been systematically validated to assess the parenting capacity of mentally ill caregivers (Carstairs, 2011).

In considering the varied functions of mental health evaluations in the context of foster care practice, a wide range of referral justifications have been documented. In some cases, mothers’ parenting capacity, mental health status and service needs are being evaluated (Budd & Springman, 2011). Other circumstances call for an assessment of the family’s appropriateness
for reunification, adoption or termination of parental rights (Budd et al., 2011). Irrespective of the specific purpose of the evaluation, Tippins and Wittmann (2005) emphasize the gravity of the assessment as it relates to the legal process,

> Forensic psychological assessments in contested custody matters are often pivotal documents that can have a dramatic effect on the trajectory of the litigation and, ultimately, on the form a particular child’s life will take after judicial disposition. The courts afford culturally sanctioned weight to behavioral science, and these documents are often eagerly awaited because of their potential value in providing leverage for one side over the other and for their capacity to move cases toward stipulation (p. 193).

Once the evaluation is conducted, the document takes on a life of its own, and its trajectory can have long-term implications for the family. Although the assessment has become significant in the family court context, critics question whether any mental health professional, despite his or her education and level of expertise, should be entrusted with answering the ultimate legal question of where the child will reside (O’Donohue & Bradley, 1999; Spreng, 2010; Tippins & Wittmann, 2005). Therefore, the role of the evaluator is to provide information that will inform legal decision-makers about the emotional difficulties affecting an individual’s ability to parent; the definitive legal matters, specifically regarding custody and visitation, are the province of the judicial system (Budd, Naik-Polan, Felix, Massey, & Eisele, 2004).

The purpose of the dissertation is to describe and examine the phenomenological impact of mothers’ mental health evaluations in the context of foster care practice. The study posits the following research questions: 1) What are the demographic profiles and psychosocial characteristics of mothers referred for mental health evaluations, and are there differences based on whether the mothers abuse substances? 2) Are there differences in how the mental health evaluation functions for mothers who acknowledge versus those who do not acknowledge their
mental illness? 3) What are the parenting qualities and mental health symptoms identified as having an impact on children’s permanency outcomes? 4) What other service and/or case factors affect case outcomes (i.e. service plan adherence, visiting, etc.) for mothers that have been referred for mental health evaluations?

The remainder of this chapter will include discussion of the scope of the problems of mental illness and child maltreatment and the context of foster care practice shaping the dissertation inquiry. This will incorporate exploration of the prevalence of mental health problems and child maltreatment as well as the inherent challenges of obtaining those accurate statistics. In addition, consideration of the history of foster care, including racial basis, media portrayals of child abuse and the impact of poverty are critical to understanding the complexity of modern day foster care practice.

**Scope: Mental Illness**

Current research estimates that approximately half of Americans will experience a mental health disorder at some time in their lives, with the initial onset typically occurring in childhood or adolescence. With regard to specific diagnostic categories, lifetime prevalence estimates for mood disorders are 21%, anxiety disorders 29%, substance use disorders 15% and impulse-control disorders 25%. In terms of age at which disorders manifest, median age of onset is generally younger for anxiety and impulse-control disorders (11 years) than for substance use (20 years) and mood disorders (30 years) (Kessler et al., 2005). Furthermore, recent data from the Substance Abuse and Mental Health Services Association (SAMHSA) 2011 National Survey on Drug Use and Health indicates that in the 1-year study period approximately 45 million American adults (19%) experienced mental illness (U.S. Department of Health and Human Services, 2012c).
According to current estimates (USDHHS, 2012c), approximately 8 million mentally ill adults (17.5%) have a co-occurring substance use disorder. Furthermore, recent statistics (USDHHS, 2012c) state that a substantial subset of the mentally ill adult population is the 11.5 million individuals (5%) coping with serious mental illness (SMI). SAMHSA defines SMI as a diagnosable mental health disorder that in the past year has had a significantly negative impact on individuals’ functioning in occupational, educational and relational aspects of their lives. According to SAMHSA statistics, among individuals with SMI in the past year, approximately 23% had a co-occurring substance use disorder (USDHHS, 2012c).

An individual’s gender, race and marital status and the intersection of these variables also has an impact on vulnerability to mental illness. Women are twice as likely to experience mood and anxiety disorders and three times as likely to experience eating disorders in comparison to men. Men, however, outnumber women in their prevalence of substance use and antisocial personality disorder (Riecher-Rossler, 2010), which includes behavior such as lack of empathy for others, cruelty to animals and recurrent difficulties with the law (American Psychiatric Association, 2000). With regard to race/ethnicity, current research indicates that Hispanics and non-Hispanic African-American individuals demonstrate a lower lifetime risk for disorders such as depression and anxiety disorders when compared to non-Hispanic Caucasian individuals. Bipolar disorder has been the only instance in which non-Hispanic African-Americans have greater lifetime prevalence than Caucasians (Breslau et al., 2006). In considering marital status, recent statistics report that married men and women exhibit significantly fewer mental health difficulties than those who are unmarried (DeKlyen, Brooks-Gunn, McLanahan, & Knab, 2006).

Sexual orientation also holds the potential for affecting individuals’ susceptibility to mental health problems. In Everett (2015), depressive symptoms were more highly correlated
with changes in sexual identity, rather than just identifying as a homosexual. Therefore, if an individual initially identified as heterosexual and then reported a progressive change toward being attracted to the same sex, there was an associated increase in reporting of depressive symptoms. Everett (2015) emphasized that there were no significant differences in depressive symptoms among heterosexual, gay and lesbian participants whose identities were stable over time. Shapiro, Peterson and Stewart (2009) found that for lesbian mothers, there is no direct relationship between sexual orientation and mental health problems but that homosexual women experience increased stress and sadness due to living in a social and legal context of stigma and discrimination.

The experience of poverty also influences caregivers’ susceptibility to developing and managing mental health difficulties. Heflin and Iceland (2009) conducted a secondary analysis of data from the Fragile Families and Child Wellbeing Study. The study is a longitudinal investigation of about 4,700 births with an oversample of unmarried families from 20 large American cities. Women who reported difficulty paying bills and loss of phone service exhibited a significantly higher likelihood of being depressed when compared to their peers that did not report these hardships. During the first year of data collection 16% of mothers met criteria for a diagnosis of major depressive disorder, 20% of the mothers were depressed at year three. Empirical evidence has consistently established an association between financial stress and serious mental illness (Kahng, Bybee, Oyserman, & Mowbray, 2008; Mowbray, Oyserman, Bybee, & MacFarlane, 2002).

According to Afifi, Cox and Enns (2006) mothers who have been separated or divorced are at increased risk to develop mental health problems; these mothers have a greater likelihood of having mood, anxiety and antisocial personality disorder in comparison to married mothers.
Mothers who have never been married exhibit a slightly increased risk to experience posttraumatic stress disorder (PTSD) and substance abuse as compared to married mothers.

According to current estimates (Hinden, Gershenson, Williams, & Nicholson, 2006), more than half of American families have a mentally ill family member. With regard to child protective cases, a Canadian investigation (Westad & McConnell, 2012) found that mothers’ mental health problems were identified in nearly 20% of a sample of open child protective services cases. In order to more clearly delineate characteristics of and service provision to families involved with the child welfare system, Staudt and Cherry (2009) conducted a secondary analysis of the dataset obtained from the 1994 National Study of Protective, Preventive and Reunification Services (NSPPRS). The researchers utilized a nationally representative sample of open child welfare cases (n = 2109) where data collection involved telephone interviews with caseworkers regarding problems faced by primary caregivers and the services they received. Workers reported that 35% of caretakers exhibited substance abuse or mental health difficulties, and 5% were described as having both problems. The National Survey of Child and Adolescent Well-Being (NSCAW) revealed that of a nationally representative sample 2,959 caregivers that have experienced a child protective services (CPS) investigation, 40% met criteria for major depression and 9% for substance dependence at some point over 3 years (Burns et al., 2010).

**Scope: Child Maltreatment**

Current statistics reported by the Child Abuse and Neglect Data System (USDHHS, 2012a) indicate that approximately 6.2 million children in this country have been subjects of CPS investigations, and 681,000 children have been victims of maltreatment. It is essential to point out however, that these estimates count each child victim once regardless of the number of
With regard to maltreatment type, neglect is by far the most common, comprising 78% of reports to State Central Registries. Eighteen percent of children were determined to be physically abused, 9% were sexually abused, 8% were psychologically maltreated, and 2% experienced medical neglect. These percentages total more than 100% because many children endure multiple forms of abuse. An additional 10% of children experienced abuse coded as "other" depending on statewide classification systems. Circumstances such as abandoning or threatening to harm the child would meet such criteria (USDHHS, 2012a). It has been argued (Baker, Brassard, Schneiderman, & Donnelly, 2013) however, that official reports underestimate the actual occurrence of child maltreatment. For example, instances of sexual abuse are often shrouded in secrecy and not reported to the authorities (Moore, Robinson, Daily, & Thompson, 2015).

As a result of the most current, formally validated maltreatment reports (USDHHS, 2012b), approximately 400,540 children in this country reside in foster care settings. With regard to their gender, there is an almost even split with 52% male and 48% female. The average age of foster children is 9.3 years old. With regard to race/ethnicity, 41% of foster children are White, 27% are African-American and 21% are Hispanic. Asians, American Indian and mixed race children comprise the other 11%.

**Impact of Race and Racial Bias**

Though state intervention into family life is purported to be an objective, unbiased process, the statistical reality is that African-American children are disproportionately represented in the foster care population. African-American children comprise just 15% of American children (U.S. Government Accountability Office, 2007), but they constitute 27% of all children residing in foster care settings (USDHHS, 2012b). According to the Fourth National
Incidence Study of Child Abuse and Neglect (NIS-4) conducted in 2010, there are significant racial differences in the incidence of maltreatment; that is, rates of abuse and neglect for African-American children are considerably higher than their Caucasian peers. These findings significantly depart from the three previous cycles of the NIS. Study authors state this may be due to an expanded sample size and enhanced precision of statistical tests (Sedlak et al., 2010). Additionally, the researchers suggest that children’s experiences of risk factors may have changed so as to increase their chances of being abused such as the low socioeconomic status of many African-American families in comparison to their White counterparts (Sedlak, McPherson, & Das, 2010).

Once African-American children are involved with the child welfare system, they experience poorer permanency outcomes than White children. In a recent study of the Texas child welfare system, Rivaux et al. (2008) found that although risk scores for Caucasians were higher than African-Americans, Caucasians were more likely to receive family-based treatment, and African-American families were more likely to have children placed into foster care. Although the authors call for further investigation to delineate the causal relationship between race and placement rates, poverty and lack of community resources for African-American families are additional lenses through which to explain the disparity. Furthermore, African-American children experience longer lengths of stay in foster care in comparison to their Caucasian peers (McRoy, 2005). They are less likely to be reunified with their biological families (Connell, Katz, Saunders, & Tebes, 2006), and they have fewer chances of exiting foster care to adoption than Caucasian children (McRoy, 2005).

Recent research has explored challenges facing African-American families involved with the child welfare system. In a qualitative study in which child welfare workers were
interviewed, Kriz and Skivenes (2015) found that more than half of the respondents acknowledged that prejudice, racism and bias are structural realities facing African-American families. The workers emphasized that as a result many African-American families are more likely to distrust public assistance services, experience an elevated level of anxiety and stress and that African-American children are overrepresented in the child welfare system. A California study (Putnam-Hornstein, Needell, King, & Johnson-Motoyama, 2013) found evidence that between birth and the age of five, African-American children are more than twice as likely as their Caucasian counterparts to be reported for maltreatment, have a substantiated case and enter into foster care. Upon further examination, however, results indicated that African-American children also had an increased concentration of risk factors associated with child welfare involvement such as low socioeconomic status, the mother’s young age and absent fathers. When those variables were controlled for, African-American children of low socioeconomic status were actually less likely than poor White children to have maltreatment reports, substantiated reports and foster care placements. The authors (Putnam-Hornstein et al., 2013) recognized the reality of racial disparities in statistical data, but they also emphasized the nuances of race that incorporate ingrained and systemic challenges facing people of color, specifically with regard to poverty and family structure.

Impact of Poverty

Poverty has been established as a significant correlate of child maltreatment in the child welfare literature (Jonson-Reid, Drake, & Zou, 2013). According to Sedlak et al. (2010) there is a significantly elevated risk of child abuse and neglect in families earning less than $15,000 per year; children residing in poor families are more than 5 times as likely to experience some type of maltreatment as other children. Their likelihood of being abused is threefold, and their
chances of being neglected are sevenfold. According to 2010 U.S. Census data, the poverty threshold for a family of four is approximately $22,000 (U.S. Census Bureau, 2010), and 21.6% of American children reside in families with incomes below the federal poverty level. In Macartney (2011), statistics indicate that more than one in five children are living in poverty in the United States and that Caucasian and Asian children have poverty rates below the national average. Children of color have higher rates with approximately 38% African-American, 32% Hispanic and 23% of multiracial children living in poverty. In the state of New York, 901,000 children are living in poverty.

The overrepresentation of the poor among families affected by the child welfare system raises additional questions about the relationship between income level and child maltreatment. The statistical discrepancies between socioeconomic groups may indicate differences in identifying and recognizing child abuse rather than its actual occurrence. Wealthier families may be capable of concealing maltreatment due to greater access to resources and less involvement with social services organizations (Downs, Moore, & McFadden, 2009). According to the U.S. Government Accountability Office (2007), indigent families are more likely to encounter public officials to have their concrete needs met. Due to mandatory reporting requirements, interactions with public employees place families at increased risk of being reported to the State Central Registry.

Passage of the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193), commonly referred to as welfare reform, has had a significant impact on the child welfare system and the well-being of public assistance recipients. The law allows flexibility for states to establish restrictions such as refusing cash benefits to infants born into families currently receiving public assistance. Dworsky, Courtney, and Zinn (2007) utilized a combination of
survey and administrative data to track 1,075 Wisconsin families receiving public assistance. Over a 5-month data collection period, 38% of the families had been investigated for child maltreatment allegations, and 11% of the children had experienced an out-of-home placement. The authors (Dworsky et al., 2007) concluded there is an increased risk of contact with the child protective system for White families and those that have experienced prior child protective investigations and out-of-home placements for their children.

From the standpoint of actual risk of abuse or neglect, however, empirical findings have been mixed with regard to maltreatment type. Hence, there is empirical evidence to validate the association between poverty and physical abuse (MacMillan, Tanaka, Duku, Vaillancourt & Boyle, 2013); however, the weakest correlation has been shown between sexual abuse and socioeconomic status (Finkelhor & Jones, 2006). Although there is evidence for the relationship between poverty and neglect (Jonson-Reid et al., 2013), Carter and Myers (2007) found that participants receiving benefits from entitlement programs such as the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) were less likely to have physical neglect substantiated and that primary caregivers were twice as likely to have physical neglect substantiated if they had mental health or substance abuse issues. In addition, there is evidence to suggest that mothers experiencing poverty and mental illness lose custody of their children at a significantly higher rate than mothers not experiencing these stressors (Hollingsworth, 2004; Sands, Koppelman, & Solomon, 2004).

**Media Portrayal of Child Maltreatment and Deaths**

Child maltreatment in the United States has commanded public attention through the media’s emphasis on the horrific reality of severe physical abuse and child deaths (Pritchard, Davey, & Williams, 2013). High profile cases such as the 2010 Marchella Brett-Pierce case in
New York City send repeated and all-too-familiar shock waves through the entire child welfare community. Not only was 4-year-old Marchella repeatedly brutalized and discovered weighing only 18 pounds at the time of her death, but her family was supposed to have been monitored by the Administration for Children’s Services (ACS), New York City’s public child welfare agency. Subsequently, both the family’s child protective worker and his supervisor have been legally charged with falsifying records and criminally negligent homicide (Gay, 2011).

As a result in New York City, a chilling precedent has been set in holding individual case workers legally accountable for their practices in child welfare settings. Over the years, child fatalities have polarized public opinions about complex issues of culpability that have historically led to increased removals of children in a climate of panic and greater difficulty to attract well-qualified professionals to the child welfare field (Buckley & Secret, 2011). They have as well been precipitators of efforts at reform.

In the United States, the frequency of child deaths caused by maltreatment is a sobering reality. Pritchard and Sharples (2008) reported on World Health Organization data (WHO) drawn from the years 1974-2002 in which child (birth-14 years old) homicide rates rose by a ratio of 1.33 in the United States. These statistics are juxtaposed with other developed countries such as England, Wales, Japan and Germany; all of which demonstrated substantial reductions in their child homicide rates. The authors (Pritchard & Sharples, 2008) offer the explanation that American budget cuts to social services programs have had a detrimental impact on the child protection system. Furthermore, mentally ill parents, as well as violent fathers who have prior criminal convictions for violence are most at risk of committing child fatalities (Pritchard et al., 2013).
Recent statistics from 2011 estimate that approximately 1,570 children died as a result of abuse and neglect as compared to 1,685 children from 2009 (USDHHS, 2012a). Prevention programs that educate the public on the dangers of parents and children sleeping together, the importance of securing medications and weapons and supervising children’s water play have been credited for decreases in child fatalities (USDHHS, 2010).

**Historical Background: Child Welfare Policy and Services**

The perception of childhood as a distinct phase of development is a relatively recent phenomenon intricately intertwined with the social and economic forces that have affected the American family. In Colonial America state intervention into family life focused on the maintenance of social order and the management of impoverished children and families that were not able to productively contribute to society (McGowan, 2005). Almshouses and orphanages were established for children whose parents were unable to support them. Black children were included in the almshouses but were distinctively excluded from the majority of orphanages before the Civil War due to their status as slaves (Billingsley, 1972). By the mid-19th century, eastern cities were transforming through population growth and immigration. Social reformers were critical of children’s living conditions in urban communities, and in 1853 Charles Loring Brace created the New York Children’s Aid Society. A foster care model was created in which city children would be transported out West to live in more wholesome surroundings. By the 20th century, a clear consensus emerged that child protection is a province for government intervention through the efforts of organizations such as the Pennsylvania Society for the Protection of Cruelty to Children and the Child Welfare League of America (Myers, 1998). In 1950 the White House Conference on Children focused attention on the specific needs of foster children. What followed was the first research initiative on foster
children in nine communities in the late 1950’s, and researchers discovered the phenomenon of ‘foster care drift.’ Children would linger in care for years because there was no aid available to support family reunification (Samantrai, 2004).

Concern about child maltreatment re-emerged with the seminal paper on battered-child syndrome published by Dr. Henry Kempe and colleagues in 1962. Radiological tests supported the occurrence of physical abuse of children with untreated broken and fractured bones. The document drew media attention and elevated child maltreatment as a social problem in the national consciousness (Tomison, 2001). Starting in California in 1963, state legislatures ratified reporting laws and within the span of four years, every state had enacted reporting legislation (Myers, 1998). In 1974 the Child Abuse Prevention and Treatment Act (CAPTA, PL 93-247) determined federal definitions for child abuse and neglect and instituted guidelines for state mandatory reporting laws, timely investigation of suspected maltreatment, protection of children found to be or at risk of abuse or neglect and the provision of comprehensive services. The Adoption Assistance and Child Welfare Act (AACWA) of 1980 established the state’s responsibility for ensuring children’s permanence and providing assistance to biological families (AACWA, PL 96-972). On a fiscal level, it was designed to direct federal funds towards preventive services as opposed to out-of-home placement (McWey, Henderson, & Tice, 2006).

Despite passage of the AACWA, the population of children in foster care continued to increase. The Family Preservation and Support Services provisions of the Omnibus Budget Reconciliation Act (OBRA, PL 103-66) were passed in 1993 to allocate additional funding for preventive services. Passage of the Multiethnic Placement Act of 1994 (PL 103-382) supported state programs to diligently recruit and retain foster and adoptive parents reflective of the racial and ethnic backgrounds of the children in that state, and programs were forbidden to deny any
person the opportunity to become a foster or adoptive parent based on race or ethnicity. Despite these efforts, the foster care population continued to grow, fewer adoptions took place, and the system was not equipped to fulfill its responsibility for service provision (McWey et al., 2006).

With the passage of the Adoption and Safe Families Act in 1997 (ASFA, PL 105-89), the role of family court has significantly expanded in the context of child welfare practice (Hardin, 2005). This federal policy’s core principle is the timely attainment of legal permanency for foster children in the form of family reunification, adoption, legal guardianship by relatives and discharge to independent living. States are to conduct the child’s first permanency hearing within 12 months after placement, and if the child has been in foster care for 15 of the most recent 22 months, court proceedings are to be initiated for termination of parental rights (TPR). Mandatory TPR proceedings can be prevented if an exception exists such as the children being in relative kinship care, if the state agency has demonstrated evidence why TPR is not in the child’s best interests, or if the parents were not provided with adequate resources to complete their service plans as described in the reasonable efforts requirement (Klee, 2002).

With regard to the ultimate goal of reunification, the law specifies that ‘reasonable efforts’ must be made to support this goal. In some instances, however, this goal will not be pursued such as in the case of a parent having exposed the child to ‘aggravated circumstances’ as defined by the jurisdiction of the state, the parent has committed assault, murder or voluntary manslaughter resulting in the death or bodily injury of a child or had their parental rights terminated to a sibling of the child who is the focus of the proceeding. Some states, however, have incorporated parental mental illness or disability into their definition of aggravated circumstances. According to Kaplan, Kottsleper, Scott, Salzer, and Solomon (2009), Alaska, Arizona, California, Kentucky and North Dakota have language within their statutes that
identifies parental mental illness as a basis for not providing reasonable efforts to reunify the family. Conversely, states such as Idaho and Utah have different statutes that indicate that a diagnosis of mental illness or disability cannot be the sole basis to forgo family reunification efforts. Considering the potential gravity of a parent’s mental health status, it is essential that appropriate assessment and treatment methods are identified and utilized to assist parents. The stigma associated with mental illness is interconnected with the history of American mental health policy.

**Historical Background: Mental Health Policy and Services**

Similar to poor children and families, those deemed insane in colonial America were perceived primarily as a social and economic burden rather than persons in need of medical treatment or social services. Care of the mentally ill was the domain of families and almshouses which housed other poor, disabled individuals. General medical hospitals started to admit mentally ill patients by the early 1770s, and by 1773 a public mental hospital opened in Williamsburg, Virginia (Fellin, 1996). Efforts to incorporate European perspectives such as the moral management approach that focused on individuals’ feelings and the damage of harsh treatment were hindered by the prevailing view of patients’ personal responsibility for their mental illnesses (Coy, 2006). By the 1840s, however, social reformers successfully advocated for the expansion of state mental hospitals, and more than 300 facilities were constructed between 1845 and 1945. Mental health advocates firmly purported that indigent, mentally ill individuals could receive more benevolent care and services while separated from the local community and that their care was the moral obligation of the state. By the late 19th century, however, a lack of sufficient funding and the reluctance of competent professionals to practice in
institutional settings led to hospitals serving a custodial rather than treatment function (Fellin, 1996).

In a historical analysis, Jimenez (2010) discussed how the definition of who suffered from a mental disorder and the populations served expanded considerably in the early 20th century with the emergence of outpatient mental health clinics and the impact of Sigmund Freud and psychoanalysis. Psychotherapy became a legitimate domain for upper and middle class individuals that could afford treatment. The number of problems that came to be viewed as mental disorders increased to include manic depression or what is now called bipolar disorder, schizophrenia and postpartum depression. The indigent and chronically mentally ill, however, continued to languish in public mental hospitals, and by the 1940s, a two tiered system of mental health services had been established, the private and public sectors. Clinical practice in public mental hospitals was largely ignored as a growing number of troubled and discarded individuals resided in large state-run facilities, and they were subjected to ineffectual and harmful services such as shock treatment, submersion in ice water and sterilization.

Beginning in the late 1940s, the vision of deinstitutionalization involved shifting the locus of mental health care and treatment from the state hospital to the community. According to Fellin (1996), the development and utilization of psychotropic medications in the 1950s had a significant impact on hospitals’ ability to discharge individuals to the community. In 1946, passage of the National Mental Health Act (Public Law 79-487) established the National Institute of Mental Health (NIMH), with the objective of advancing research, education and services in the field of mental health. NIMH endorsed the Mental Health Study Act of 1955 (Public Law 84-182), legislation that required a scientific investigation of the United States’ mental health system. The result was the 1961 report, *Action for Mental Health*;
recommendations included enhanced capacity for community mental health programs such as clinics and partial hospitalization, increased psychiatric beds in every general hospital and enriched treatment for chronic clients housed in state mental hospitals. In 1963 President John F. Kennedy utilized the report to elevate the status of mental illness and mental retardation on the national agenda, and the Mental Retardation Facilities and Community Mental Health Centers Construction Act, which envisioned one mental health center for every 200,000 persons, was passed in 1963.

The populations of American psychiatric hospitals significantly decreased after 1963. At that time, being mentally ill became recognized as a disability for which individuals could receive government assistance (Breggin, 1991). In 1966 the federal government established Medicare and Medicaid health plans for the elderly, poor and disabled. Although federal support of community services decreased during the 1970s, some outpatient clinics received federal funding on a limited basis until the 1980s when financial responsibility was transferred to the state level with the passage of the Omnibus Reconciliation Act of 1981 (P.L. 97-35) (Fellin, 1996). Critiques of the deinstitutionalization movement have emphasized that few psychiatric patients truly became autonomous. Many clients were transferred into supportive housing programs or nursing homes, typically ill-equipped to manage their complex needs. Still others were released without stable living arrangements to the community as homeless individuals (Breggin, 1991). Furthermore, court decisions such as O’Connor v. Donaldson in 1975 rendered states unable to involuntarily commit persons to state mental hospitals unless they were deemed a danger to themselves or others. Therefore, clients who were admitted would be discharged after a brief period of treatment, but with scarce community resources available, many clients would end up back in the hospital, nursing homes or jails (Jimenez, 2010).
The deinstitutionalization movement has had a significant impact on the lives of mentally ill women and their prospects of pursuing a typical developmental trajectory. Such aspects of adulthood include the greater possibility of engagement in intimate relationships, having children and becoming mothers. Many mentally ill mothers are, however, raising their children in a context of incredible hardship such as being exposed to trauma, single motherhood and poverty. Similar to criticisms of the deinstitutionalization movement, community mental health programs have been generally inadequate to support the needs of mentally ill mothers (Sands et al., 2004). Mothers experiencing mental health difficulties and in need of treatment may decide not to seek help for fear of being stigmatized, losing custody of their children (Park, Solomon, & Mandell, 2006; Spreng, 2010) and not having access to high-quality services with culturally diverse mental health providers (Maton, Kohout, Wicherski, Leary, & Vinokourov, 2006). Depending on the diagnosis assigned, mothers may be perceived as being deficient in their ability to provide a basic standard of safety and care for their children (Nicholson, Biebel, Hinden, Henry, & Stier, 2001).

**Impact of Parental Mental Illness on Children**

Exactly how parents’ mental illnesses affect children is contingent upon a constellation of factors. The research of etiology, or the underlying causes of children’s mental disorders, incorporates an understanding of how the interactions among genetic influences, emotional processes and environmental events affect children’s overall functioning (Nikolas, Klump, & Burt, 2015). Contextual elements such as the family being socially isolated, having chronic exposure to stress, residing in a dangerous community and lack of resources can exacerbate risk and contribute to negative outcomes for children (Budd et al., 2011). In contrast, protective factors such as parents’ insight into their mental illness (Mesidor & Maru, 2015), the ability to
communicate with and nurture their children, a sense of spirituality that provides meaning to adverse life events (Black & Lobo, 2008), treatment adherence and empathy support the family’s resiliency in the face of significant stressors (Leitz, 2011).

The symptom characteristics, severity and chronicity of mental health disorders will have a potentially significant impact on parents’ ability to provide a safe, appropriate level of care (Seymour, Giallo, Cooklin, & Dunning, 2015). Anxiety and mood disorders are of the most common mental health diagnoses in the American population (Kessler et al., 2005) and cover a wide range of symptom presentations characterized by feelings of worry, fear, pessimistic mood, irritability, significant psychological distress, disordered eating and sleeping habits, low energy, negative self-worth and decreased concentration (APA, 2000). Such disorders can manifest in different ways such as a series of episodes in which the individual recovers and then has a symptom recurrence at a later time, a time-limited fashion in which the disorder dissipates in a moderately brief time span and a chronic course in which the disorder persists throughout adulthood (Sinkewicz & Lee, 2011).

Children of mothers experiencing symptoms of anxiety and mood disorders are more likely to experience intense loneliness and a low level of emotional well-being (Abraham & Stein, 2010) elevated risk of demonstrating behavior problems (Piche, Bergeron, Cyr, & Berthiaume, 2011) and substance abuse and interactions with the legal system (Mowbray, Bybee, Oyserman, MacFarlane, & Bowersox, 2006). Furthermore, heredity is an especially potent risk factor in mood disorders such that children of depressed parents are more likely to become depressed themselves, as much as three times the rate of their peers (Weissman et al., 2006), and children of parents with bipolar disorder can be as much as 14 times more likely than their peers
to develop bipolar disorder, two to three times as likely to develop mood and anxiety disorders and four to six times as likely to develop any clinical disorder (Birmaher et al., 2009).

Less common though just as potentially damaging, schizophrenia and other psychotic disorders affect a parent’s ability to differentiate reality from fantasy such as the parent experiencing hallucinations, delusions (i.e. false beliefs that the parent is Jesus), paranoid thoughts and disorganized speech or behavior (APA, 2000). Such children are likely to experience the parents’ emotional and physical unavailability due to frequent hospitalizations and withdrawal, feelings of fear and confusion in learning of the parents’ hallucinations and delusions and experiencing shame and isolation from extended family members (Somers, 2007). Similar to mood disorders, children of psychotic parents are more likely to exhibit schizophrenia and other psychotic disorders themselves (Gibbon, Ferriter, & Duggan, 2009), and they are also at risk of experiencing comorbidity, the phenomenon of two or more disorders co-occurring at an increased rate than would be anticipated merely by chance (Kaplan, Crawford, Cantell, Kooistra, & Dewey, 2006). Another study found that schizophrenic adults who also had a history of childhood conduct problems and substance abuse were more likely to engage in violent acts (Swanson et al., 2008).

**Fathers and the Impact of Family Structure**

The dynamics of spousal relationships influence the manner in which parents’ mental health disorders affect children’s functioning. Although there is evidence to suggest that children residing in two-parent families experience higher self-esteem, school achievement (Booth, Scott, & King, 2010) and less behavioral problems than their peers in single-parent families (Ryan, Claessens, & Markowitz, 2013), the benefits of being raised in this family structure depend on the quality of the care giving environment (Combs-Orme & Renkert, 2009).
Spousal concordance refers to the proclivity for individuals to choose mates with characteristics similar to themselves (Van Orden et al., 2012), and in the domain of emotional health, spousal similarity has been evident in substance abuse (Low, Cui, & Merkangus, 2007), and in depression and anxiety (Butterworth & Rodgers, 2006). With regard to couples exhibiting personality disorders, Knabb, Vogt, Gibbel and Brickly (2012) found that husbands were more likely to present with personality types characterized by psychosis, negativity, depression and avoidance. Conversely, the investigators found that wives were more likely to exhibit personality disorders distinguished by narcissism, compulsions and histrionic or highly dramatic behavior. Furthermore, current research conducted by Gerstorf, Windsor, Hoppman and Butterworth (2013) reported that spousal concordance in mental health tends to be stable over time. Therefore, for children residing with two mentally ill parents, they are at an increased risk for detrimental outcomes due to their genetic predisposition and child rearing environment (Lee, Taylor, & Bellamy, 2012).

Since numerous variables can shape children’s experiences of their parents’ mental illnesses, the quality of relationships with fathers warrants further exploration. In comparing the differences between maternal and paternal relationships, Flouri (2010) concluded that for young children, emotional and behavioral functioning is most strongly predicted by interactions with their mothers and that fathers demonstrate a stronger impact on the child’s cognitive functioning. In addition, Bogels and Phares (2008) have emphasized that fathers are instrumental in supporting children’s development of independence and transition to the world outside of the family which serve as protective factors when children are at risk of developing mental health disorders. Conversely, fathers’ lack of involvement, warmth and discouragement of the child’s autonomy can result in increased distress for the child. Fathers’ consistent engagement in their
children’s lives has been linked to the reduced occurrence of boys’ behavioral problems and girls’ emotional disturbances (Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2008).

For families involved in the child welfare system, however, mothers acting alone outnumber fathers with regard to maltreatment reports (37% vs. 19%) and child deaths (29% vs. 17%) (USDHHS, 2010). In addition to women’s increased chances of developing mental health disorders such as depression and anxiety in comparison to men (Riecher-Rossler, 2010), mothers being monitored by child welfare services typically experience a confluence of life stressors such as poverty, low educational level, housing instability and domestic violence that can further exacerbate mothers’ vulnerability to developing mental health problems (Marcenko, Lyons, & Courtney, 2011). Assessment of mothers’ emotional well-being is especially salient because of the empirically established association among mental health problems, risk of child maltreatment (Burns et al., 2010; Kohl, Kagotho, & Dixon, 2011; Rinehart et al., 2005) and children’s placement into foster care (Marcenko et al., 2011). Depression in particular has been linked to mothers being reported to CPS, especially when they are poor, reside in urban environments and have children with behavioral problems (Burns et al., 2010).

With the implementation of ASFA and the shortened time periods for mothers to resolve the challenges that precipitated the children’s placement, mentally ill mothers are facing formidable pathways toward regaining custody of their children. Some mothers experience stigma in being diagnosed as mentally ill (Mizock & Russinova, 2015), further emotional deterioration, noncompliance with services and ultimately their loss of parental rights (McWey et al., 2006). In addition, children placed into foster care are more likely to experience emotional or behavioral difficulties in comparison to their peers (Ellermann, 2007; Minnis, Everett, Pelosi, Dunn, & Knapp, 2006). Upon reaching the age of adulthood, many young adults are likely to be
discharged from the foster care system without any stable familial connections; they are more vulnerable to homelessness, living in poverty and experiencing depression (McRoy, 2005).

**Dissertation Overview**

The following chapter reviews the literature on mothers’ mental health evaluations that clearly documents the need for further research, thus demonstrating the importance of this dissertation study. Chapter 3 includes a literature review encompassing case factors that can affect children’s permanency outcomes, especially with regard to referral reason, type of placement and length of stay in foster care. Chapter 4 presents the conceptual and theoretical frameworks forming the study’s background and structuring the investigation’s core research questions. In addition, Chapter 4 involves description of the dissertation’s methodology, with a particular focus on the author’s utilization of clinical data-mining of foster care case records. The research methodology section in particular will consist of an account of the strengths and weaknesses of the qualitative research design, the study’s sampling frame and strategies for data collection, organization and analysis.

Chapter 5 will begin the presentation of study findings with a description of the study’s sample, including the mothers’ demographic profiles and psychosocial characteristics. Chapter 6 addresses the question as to whether mothers’ acknowledgment of their mental illnesses has an impact on the children’s permanency outcomes. This includes a discussion of both acknowledgment and permanency as processes that exist on a continuum, rather than having distinct end points. Chapter 7 encompasses description and analysis of the abundance of other variables that can affect children’s permanency outcomes, especially with regard to mothers’ mental health symptoms and case factors such as mothers’ adherence to foster care service plans, visitation and maltreatment type. Chapter 8 concludes the dissertation study with a summary of
the study’s results, specifically with regard to grounded theory regarding how the mental health evaluation functions in the context of foster care practice as well as the investigation’s implications for research, practice, policy and administration.
CHAPTER 2: LITERATURE REVIEW: PARENTAL MENTAL HEALTH EVALUATIONS

Mothers’ forensic mental health evaluations are significantly different from clinical formulations in therapeutic settings. With regard to mothers’ mental health assessments in the context of foster care practice, Budd et al. (2011) distinguish these reports by a set of core principles. Firstly, the purposes of the assessments are predetermined by the legal questions presented, and evaluations are typically mandated by the court or foster care agency. Furthermore, mothers have little to no autonomy in the assessment process since the referral source establishes the information to be sought, and the evaluator decides which assessment methods to utilize. Finally, an objective and impartial stance is maintained by the mental health professional since the goal of the assessment is to gather and synthesize information, rather than developing a helping relationship. This is in stark contrast to individuals voluntarily seeking mental health treatment, whereas clients will share their stories and collaboratively work with clinicians to make life changes (Adler, 2013).

The evaluation process is structured according to the discipline and conceptual framework of the forensic mental health professional. In Gitterman and Heller (2011), social work assessment and practice are guided by ecological theory in that individuals are viewed as having transactional relationships with their environments; therefore, parenting is evaluated in the context and interactions of personal, social and environmental factors. Conversely, when psychologists are conducting evaluations, they typically utilize a clinical interview and battery of intellectual and personality tests to assess the emotional and cognitive functioning of adults and children (Erikson et al., 2007). In addition, a psychiatrist also makes use of a clinical interview and medical tests as necessary to assess for the presence of mental disorder and whether
medications are needed to manage the client’s difficulties (American Academy of Child & Adolescent Psychiatry, 2012).

Budd et al. (2011) outlined a set of core principles for evaluators to utilize when conducting assessments of parents under suspicion of abuse or neglect. Primarily, the evaluation is focused on parenting and the quality of the parent–child relationship. For example, if the clinician is exploring aspects of the adult’s personality, then there needs to be a connection between personality traits and parental capacity and incapacity, by demonstrating how they create a risk or protective factor, respectively, or how they facilitate or inhibit the parent from benefiting from rehabilitative services. Furthermore, the assessment ought to include a functional component that emphasizes actual parenting skills and activities of daily living. The evaluation encompasses a constructive process of recognizing skills and strengths as opposed to focusing on deficits. Finally, Budd (2005) proposes the application of a minimally adequate standard of parenting; the evaluator must consider if the qualities are indicative of the minimum threshold of parenting skills essential to protect a child’s well-being, given the context of the family’s strengths and risk to the child. For example, according to Mesidor and Maru (2015), although maternal depression poses potential risk to the emotional bonds between mothers and their children, this risk may be mitigated by factors such as the mother’s ability to manage her symptoms, understand her challenges and having a supportive family network.

Guidelines for Best Practices

The American Psychological Association (APA, 2013) provides an organizing framework and best practice guidelines for the administration of psychological evaluations in the context of child protection concerns. The principal function of the assessment is to present clinically relevant, reliable findings and recommendations for cases in which a child’s well-being
may have been compromised. Furthermore, it is essential for clinicians to remain focused on addressing the explicit referral questions since there may be dissension among the different parties (i.e. mother, father, foster care agency) involved in the child protective matter. Also, when the objective of the assessment is to explore difficulties in the parent-child relationship, psychologists must be attentive to the following: parenting capacity, especially factors related to the episode of child maltreatment, the child’s overall functioning, including circumstances or factors relevant to maltreatment of the child, the child’s well-being and emotional needs and the corresponding fit between the two. In support of psychologists maintaining a neutral perspective, it is important for evaluators to avoid dual relationships that could be detrimental and compromise their ability to be objective, competent and effectual in the assessment process. Moreover, it is highly recommended for clinicians to use various sources and methods to gather information and to avoid making conclusions that are not sufficiently corroborated by the information gathered.

Model programs have been implemented in a number of states to ensure that parents’ forensic evaluations are conducted in a comprehensive, consistent and efficient manner. In Kentucky the Comprehensive Assessment and Training Services Project (CATS) has been instituted (D’Amour, Ferrada-Videla, Rodriguez, & Beaulieu, 2005). This project incorporates input from caseworkers, legal professionals and clinicians, and the multidisciplinary team uses triangulated methodology so that multiple professionals participate in the evaluation process. Assessments occur at the family’s home, professionals’ offices and children’s schools. Also, team members review documentation such as standardized assessments of functioning and family history. The finished product is made available prior to court proceedings to inform the permanency decision-making process (University of Kentucky, 2015).
In Chicago’s Cook County juvenile court, a three-year, longitudinal study has been in progress comparing parents’ forensic evaluations conducted within a pilot program and those completed by three mental health providers (Budd, Felix, Sweet, Saul, & Carleton, 2006). Researchers identified critical evaluation components from the forensic literature such as multiple sessions, settings and sources and then analyzed each program’s ability to incorporate those elements into the assessment process as well as deliver the assessment and written document in a timely manner. The pilot clinic delegated responsibility among four different departments of clinical coordination, education and resources, administration and program evaluation. The education unit provided training on program protocols and services offered, and program evaluation documented client outcomes. In comparison to the other groups, findings indicated that the pilot clinic both completed evaluations substantially faster and consistently included recommended forensic elements within the evaluations. Assessment of total family functioning was limited, however, because parents were the only family members evaluated under this model.

Overview: Assessment Tools for Forensic Evaluation

Psychological assessment tools provide the evaluator with informative data by which to identify the client’s psychological assets and limitations, detect the presence of mental illness and to distinguish personality traits that could present challenges for the client’s future functioning (Geffner, Conradi, Geis, & Aranda, 2009). In addition, clinical assessment tools have been designed to gather information about individuals’ emotional and cognitive functioning such as intelligence measures and mental health concerns, and this data has typically been used to inform treatment planning (Conradi, Wherry, & Kisiel, 2011). Other tests are specifically
purposed to evaluate psychological states for court-involved decision-makers, such as an individual’s risk for violence and possibility of recidivism (Austin & Drozd, 2012).

**Quantitative, Self-Administered Assessment Tools**

Quantitative assessment tools are of the most widely used tests by psychologists (Ackerman & Pritzl, 2011) and are comprised of multiple choice, self-report questionnaires. The clinician scores and interprets the data based upon normative standards established when tests were created (Erickson et al., 2007). The MMPI-2 is one of the most commonly utilized quantitative assessment tool in forensic evaluations of mothers involved in family court litigation (Archer, Buffington-Vollum, Stredny, & Handel, 2006), and this measure may be useful to clinicians assessing personality traits detrimental to parenting such as being aggressive, egocentric, grandiose or antisocial (Budd et al., 2011). Following completion of the 567-item true/false questionnaire, scores are interpreted with regard to validity and clinically relevant symptoms. Threats to profiles’ accuracy include mothers misrepresenting their level of clinical distress and engaging in random patterns of answering questions. Since defensive response styles are common to those being assessed in the family court context, it is essential for clinicians to use the most robust strategy for determining the profile’s validity (Erickson et al., 2007). In terms of gender, Roma et al. (2014) found that women were more likely than men to underreport their mental health symptoms in forensic assessments regarding child custody.

Challenges are inherent to the process of obtaining accurate MMPI-2 profiles of court-involved parents. Carr, Morretti, and Cue (2005) examined the test results of a sample of 91 biological mothers, 48 biological fathers and 25 stepfathers receiving court-mandated assessments. Validity scales were represented as the L scale that indicates a propensity to disagree with the presence of minor issues, and the K scale that implies a slight defensiveness
toward questions. Results indicated that enhanced self-presentation on L and K scales threatened the validity of about 60% of participants’ profiles. Similar results were found in an investigation by Stredny, Archer and Mason (2006) whereby 127 parents completed the MMPI-2 in the course of forensic mental health evaluations. Participants were significantly more likely to endorse items on the L scale in comparison to the K scale. Furthermore, Resendes and Lecci (2012) detected moderately increased L scale scores in their analysis of the MMPI-2 profiles of 136 family court-involved parents undergoing parent competency evaluations.

Due to the uniquely powerful stressors presented by family court litigation, it is essential for clinicians to be able to distinguish between mothers who are attempting to present well when their parental competence is being scrutinized and those whose deception suggests significant clinical dysfunction (Erickson et al., 2007). Researchers vary in their approach of how to manage this significant challenge when administering the MMPI-2 in the context of mothers’ forensic evaluations. In Carr et al. (2005), the authors recommended that parents are informed of the validity scales prior to evaluation so as to prevent dishonest responses. Also, it was indicated that judges and lawyers are educated as to the instrument’s validity scales and the possibility for parents to “fake good” in an effort to regain custody of their children. Others caution against relying too heavily on MMPI-2 profiles in the context of mothers’ forensic evaluations since the MMPI-2 is a personality test with adequate reliability and validity to assess psychopathology rather than an instrument to evaluate parenting competency (Sanders & Katz, 2013; Stredny et al., 2006). Since there is no established link between MMPI-2 personality profiles and parenting capacity (Ellis, 2012), the appropriate utilization of the MMPI-2 in the context of foster care practice is one of a global assessment of mothers’ maladaptive emotional functioning. Therefore, the assessment functions as an additional data source to supplement case
documentation, conference notes and collateral communications that pertain to mothers’ overall functioning, personality and progress toward case goals (Budd et al., 2011; Erickson et al., 2007).

The Millon Clinical Multiaxial Inventory-III (MCMI-III) (Millon, 1997 as cited in Erickson et al., 2007) is another quantitative, self-administered assessment tool commonly utilized in parents’ forensic evaluations (Ackerman & Pritzl, 2011; Archer et al., 2006). For the purpose of assessing adults’ level of psychopathology, the measure poses 175 true/false questions that make up 28 scales of varying personality types such as avoidant, schizotypal and borderline. The MCMI-III has yielded mixed results in its application to court-mandated mental health evaluations in the context of foster care practice. Similar to the MMPI-2, defensive response styles are accounted for in the administration of the MCMI-III. In an investigation of 259 parents undergoing forensic mental health evaluations, the defensiveness scale emerged as the most frequently occurring elevation on the MCMI-III personality profiles. In addition, other recurrent, but moderate increases were evident on measures of compulsive, narcissistic and histrionic personality traits (McCann et al., 2001 as cited in Erickson et al., 2007). Comparable results were found in a sample of 42 men and 85 women whose parenting competency was evaluated in the course of permanency hearings. Although scales measuring histrionic, narcissistic and compulsive personality characteristics were modestly elevated, they remained below standard scores indicating maladaptive personality traits (Stredny et al., 2006).

Concerns regarding the underlying validity of the MCMI-III have been raised in the literature (Erickson et al., 2007; Rogers, Salekin, & Sewell, 1999). Firstly, although the measure has been touted widely as a personality assessment tool, significant questions have been raised regarding the evaluation’s ability to accurately diagnose personality disorders. A meta-analysis
of 33 separate MCMI-III empirical investigations demonstrated the assessment’s diagnostic limitations. Adequate construct validity was evident for just three of the evaluation’s twenty-eight scales; those scales included schizotypal, avoidant and borderline personality traits (Rogers et al., 1999). Furthermore, the MCMI-III manual states that increased scores for compulsive, narcissistic and histrionic personality characteristics commonly occur. This compromises clinicians’ ability to accurately interpret test results, develop a clinical case formulation and articulate treatment recommendations (Erickson et al., 2007). In addition, since the normative sample on which the scales are based did not include typically functioning adults, there is no way to compare scores between clinical subjects and the general population. Therefore, the instrument may inadvertently over diagnose examinees (Craig, 2006 as cited in Budd et al., 2011). Finally, Loinaz, Ortiz-Tallo and Ferragut (2012) asserted that the MCMI-III is limited with regard to assessing an adult’s risk for violence. In the interpretation of MCMI-III personality profiles, it is essential for clinicians to consider contextual factors such as the circumstances under which the evaluation is taking place and mothers’ desire to present well (Erickson et al., 2007).

In order to more specifically assess behaviors associated with parents’ risk for child maltreatment, the Child Abuse Potential Inventory (CAPI) (Milner, 2008 as cited in Milner & Crouch, 2012) has emerged as a widely used measure in parents’ forensic evaluations (Archer et al., 2006; Budd et al., 2011). A recent survey of 213 psychologists indicated that more than 50% of the sample utilized the CAPI in child custody evaluations (Ackerman & Pritzl, 2011). The CAPI consists of a 160-item, self-report questionnaire intended to measure parents’ capacity for physical maltreatment of children. For example, parents are asked whether they agree with statements such as “Children should never disobey” or “A good child keeps his toys and clothes
neat and orderly’’ (Rodriguez & Eden, 2008, p. 127). The overall physical abuse score is calculated from six subscales assessing parents’ experiences of distress, rigid parental beliefs, being unhappy, difficulty interacting with children, problems within the family environment and interpersonal challenges with others outside of the family.

Similar to the MMPI-2 and the MCMI-III, the CAPI consists of validity scales to determine the authenticity of the participants’ responses. Lying, responding in a random fashion or inconsistent response patterns yield three distortion patterns including faking good, faking bad and random response (Milner & Crouch, 2012). In a secondary analysis of Chaffin et al. (2004), Costello and McNeil (2014) analyzed the response profiles of 110 parents who had physically abused their children. Less than a quarter of the participants exhibited “faking good” profiles resulting from an increased lie scale and random responding. The “faking good” group had a significantly lower IQ and depression level than the non-faking group. Otherwise, there were few differences between the groups who both had an average of 2 past physical abuse referrals, and 11 of the caregivers in the faking group and 25 parents in the non-faking group had their children removed from their custody. In addition, there were similar rates of substance abuse between the two groups with 6 of the faking and 23 of the non-faking group reporting a lifetime diagnosis of alcohol or drug abuse. Parents in the faking group did not present themselves more favorably than the comparison group since both groups demonstrated more negative parenting behaviors such as criticism and negative touch as opposed to positive parenting behaviors such as praise and positive touch. In addition, both groups had similar recidivism rates of 25% for the faking group and 23% for the comparison group. The authors emphasized the importance of behavioral observations due to the potential for discrepancies with self-report data.
Although this assessment tool is widely utilized by clinicians, the instrument’s evidence base is sparse (Costello & McNeil, 2014). The instrument’s level of external validity (i.e. generalizing the study sample’s findings to a larger population) has been criticized because its prior testing and norms are based on studies of nonclinical groups of parents and college students. One study utilized a study sample comprised of 41 parents (34 mothers, 7 fathers) drawn from a multifamily intervention group for abusive or high-risk parents. Scores on the CAPI were compared to parents’ conduct during encounters with their children and individual risk factors that have been correlated with abusive behavior. High risk correlates included elevated level of parental distress, support of harsh disciplinary strategies, inappropriate expectations of children’s behavior and poor problem-solving skills. Correlational analysis revealed a statistically significant relationship between CAPI scores and observed parenting style. Results supported the construct validity of the instrument. Significant relationships were found among some (parental perceptions of internalizing and externalizing problems) but not all risk factors (poor problem-solving skills and belief in the value of corporal punishment) (Haskett, Scott, & Fann, 1995).

Determining whether mothers are at risk of maltreating their children in the future is perhaps the most challenging component of the foster care placement decision-making process. Chaffin and Valle (2003) utilized a sample of 459 parents taking part in 27 different community-based family support programs. The majority of the participants were mothers of low socioeconomic status; approximately one third of the sample met the criteria of being high-risk according to their CAPI scores. Administration of the CAPI assessment occurred at participants’ admission to the program and after their completion of the services. Subjects were followed for 2 years to determine whether they were reported for child abuse and neglect. Results indicated
that when the CAPI assessment tool was administered prior to the participants’ engagement in support services, the measure successfully predicted whether subjects would have maltreatment reports. Conversely, investigators found that when the CAPI was administered after the participants completed their interventions, abuse scores failed to reflect changes in maltreatment potential. For instance, subjects indicated as demonstrating improvement in their CAPI scores were comparable to those identified whose scores remained the same or worsened.

Approximately 14% of the sample was reported for child maltreatment in the follow-up period. More than half of the reports were for neglect, and nearly a quarter were for physical abuse and neglect combined. Physical abuse comprised 10% of the reports, and 8% of participants were investigated for sexual abuse (Chaffin & Valle, 2003). These findings are consistent with current trends in the occurrence of maltreatment types, specifically with the majority of reports being for neglect (USDHHS, 2012a). Study developers recommended further study of the predictive validity of the CAPI, especially when measuring physical abuse potential following completion of intervention programs (Chaffin & Valle, 2003). Other than Costello and McNeil’s 2014 secondary analysis of Chaffin et al. (2004), there has been no further research supporting or refuting the CAPI’s ability to assess parents’ physical abuse potential.

**Assessment of Cognitive Functioning**

Mothers’ overall cognitive functioning can be evaluated using standard intellectual assessment tools. The Wechsler Adult Intelligence Scale Third Edition (WAIS-III) is a performance-based test that is both commonly administered in practice and endorsed as relevant for use in forensic evaluations (Archer et al., 2006; Lally, 2003). In the course of the assessment process, participants engage in tasks such as organizing blocks to replicate a design. In addition to assessing general intelligence, the WAIS-III measures concept areas such as verbal abilities,
nonverbal reasoning, problem-solving skills and perceptual organization. Similar to many objective assessment tools, the WAIS-III has clearly defined procedures for administering, scoring and interpreting test data. The WAIS-III has demonstrated adequate reliability, validity and normative scores to serve as a comparison for individuals’ performance (Medoff, 2003).

Critics of this tool have asserted that intelligence is not a static entity but that test performances are dependent upon an interaction between biological characteristics such as genetics and environmental factors such as educational experiences and culture (Suzuki & Aronson, 2005). This discussion has been at the epicenter of the ongoing debate regarding racial differences in IQ such that African-Americans generally have lower scores than Caucasians (Rushton & Jensen, 2005). Due to the overrepresentation of foster care involved families of color (USDHHS, 2012b), cognitive assessments depicting African-American mothers with low IQ scores can potentially impact permanency outcomes. For example, low IQ scores comprise one of the diagnostic criteria of mental retardation, a chronic disorder in which the individual manifests difficulty in functioning before the age of 18, specifically in relation to self-care, home living, academic and interpersonal functioning and communication (Morrison & Anders, 2001).

Mothers with cognitive limitations face significant intrinsic and extrinsic challenges in the care of their children. Prejudicial beliefs continue to prevail that parents with intellectual disabilities are more likely to harm their children than their nondisabled counterparts. It is neglect; however, that is the most common form of maltreatment among cognitively impaired parents, similar to that of the general population (Booth, Booth, & McConnell, 2005; McConnell, Feldman, Aunos & Prasad, 2011; McConnell & Llewellyn, 2002). McGaw, Scully and Pritchard (2010) reported that both typically functioning and intellectually disabled mothers are at increased risk of harming their children when there is a confluence of stressors in their lives.
This includes the mothers’ own histories of trauma and abuse, coping with physical and other disabilities in addition to their cognitive limitations, parenting children with special needs and having partners without an intellectual disability but with a history of antisocial behavior or criminal involvement.

In an effort to explore how intellectually impaired parents fare in child welfare proceedings, Llewellyn, McConnell, and Ferronato (2003) conducted an Australian study that compared family court outcomes among parents experiencing intellectual disabilities, psychiatric diagnoses, substance abuse and those with no diagnosis. Single mothers with psychiatric diagnoses and cognitive impairments comprised approximately one-third of the sample. Study results indicated that parents with intellectual disabilities were more likely to have their children placed into foster care; children of parents with psychiatric diagnoses, specifically those who were not abusing substances, were more likely to remain at home under court-ordered supervision. The researchers conjectured that the persistent and chronic nature of cognitive impairments may cause some family court judges to seriously doubt whether mothers can improve their parenting skills in a reasonable time period. Conversely, depending on the nature of the mental health disorder, parents with high intellectual functioning who are diagnosed with a psychiatric disorder may be perceived as more amenable to change with appropriate psychotherapy and medication.

Additional studies have corroborated the findings of Llewellyn et al. In a Canadian study (McConnell et al., 2011), mothers’ cognitive impairment significantly predicted the increased likelihood of substantiated maltreatment reports. In addition, the McConnell et al. investigation noted that intellectually disabled mothers were also more likely to be perceived as uncooperative and that perceived lack of cooperation was also a strong predictor of maltreatment case
substantiation and court involvement. Booth et al. (2005) presented a cross cultural investigation analyzing the difference in permanency outcomes for intellectually disabled parents in Australia and England. Both samples indicated an overrepresentation of intellectually disabled parents involved in permanency proceedings. More than half of the English parents had children placed into nonrelative foster care. Conversely, Australian children were more likely to be returned to their parents’ care or placed with relatives. The authors explained the results in terms of differences in law and perspective on permanency planning. Similar to the United States, English family court judges have the power to terminate parental rights and free children for adoption. Australian judges do not have the same power, and there is more societal pressure to preserve families.

**Projective Assessment Tools**

Projective assessment tools such as the Rorschach Inkblot Method and the Thematic Apperception Test have been widely used by psychologists since the 1940’s (Budd et al., 2011; Hagen & Castagna, 2001). In contrast to objective instruments, projective measures utilize ambiguous images and open-ended questions to discern individuals’ personality traits and clinically relevant attributes from their responses. Since the stimuli presented are deliberately vague, the clinician’s interpretation process is guided by the examinee’s manner of contemplation, which is meant to reveal significant features of their internal world. Upon scoring and interpreting individuals’ responses, psychologists construct a clinical formulation of the examinee’s cognitive and emotional condition (Erickson et al., 2007).

When administering the Rorschach Inkblot Test, clinicians present a set of 10 inkblot images that vary in size, shape and color, and the examinee is queried as to what he or she observes. Although there are several formal systems that provide guidance to psychologists who
are administering, scoring and interpreting the Rorschach (Mihura, Meyer, Dumitrascu, & Bombel, 2013), the Rorschach Comprehensive System (CS; Exner, 2002 as cited Erickson et al., 2007) has been treated as the system of choice for the majority of psychologists. The CS provides clear, standardized guidelines for all aspects of the process, such as seating arrangements, order of card presentation, instructions for examinees and the manner in which evaluators can ask questions of the participant. Unless the psychologist specifies whether he or she has utilized these standards, however, it is unclear which system is guiding scoring and interpretation (Hunsley, Lee, & Wood, 2003). Furthermore, questions have been raised regarding how extraneous factors such as the evaluator’s appearance and the testing environment can impact examinees’ responses and contaminate test results (Masling, 1992 as cited in Hunsley et al., 2003). Managing contextual factors would seem particularly challenging for mothers participating in court-ordered mental health evaluations whose parenting capacity, cognitive ability and emotional state have been called into question.

Considering the intense debates surrounding the measure’s normative scores, reliability and validity of data to accurately diagnose mental health disorders (Garb, Wood, Lilienfeld, & Nezworski, 2005; Hunsley et al., 2003; Meyer & Archer, 2001; Weiner, 2001) and whether the assessment tool meets admissibility standards for expert psychological testimony in court (Grove, Barden, Garb, & Lilienfeld, 2002; Ritzler, Erard, & Pettigrew, 2002), the Rorschach has been embroiled in controversy regarding its suitability for parents’ forensic evaluations (Budd et al., 2011). For example, in Grove et al.’s (2002) analysis, researchers found that the flawed norms of the Rorschach’s CS system caused psychologists to classify typically functioning adults as considerably maladjusted and mentally ill. The potentially dire consequences of being misdiagnosed in the family court context for parents as well as children are apparent (Erickson et
al., 2007). Conversely, an inherent strength of the Rorschach purported in the literature has been its ability to distinguish examinees’ experiencing thought disorders and psychosis (Mihura et al., 2013; Lilienfeld, Wood, & Garb, 2000).

Empirical evidence has been scant however, with regard to the utilization of the Rorschach Inkblot Method in the context of family court evaluations. Although the Rorschach does not specifically assess parenting ability (Carstairs, 2011), this measure provides information on personality variables potentially relevant to parenting such as impulsivity and agitation (Mihura et al., 2013). Carstairs (2011) analyzed case record data from 53 parents, composed primarily of Caucasian British mothers, referred for psychological evaluations due to indicated cases of child neglect. The results indicated that 75% of the sample showed elevated scores indicating ineffective methods of coping with stressors and the proclivity to overlook subtleties and nuances of situations that could lead to neglecting children’s needs and care. In comparing her results to other evaluation studies of child custody litigants, Carstairs (2011) concluded that parents implicated in child neglect cases demonstrated markedly increased rates of defensive postures, avoidant personalities and limited coping skills. For one mother that was evaluated twice, once following her son’s removal from her care, and the second time after two years of therapy, the clinician utilized the Rorschach as a monitoring tool to denote change from the first to second administration. The author’s original assessment described the mother as having a serious thought disorder, negative attitude toward psychotherapy, low level of introspection and lacking interpersonal skills. Following the second administration, she noted positive changes in the mother’s ability to cope with stress, to be more finely attuned to situations and having an improved capacity for introspection (Carstairs, 2011).
Another standard projective assessment tool is the Thematic Apperception Test (TAT) 
(Murray, 1943 as cited in Lilienfeld et al., 2000). The clinician presents a set of vague images to 
examinees who are asked about what they see. For example, examinees may view a picture of a 
males character walking away from an upset woman, and assessors will ask individuals to create a 
narrative based on the people and scenes depicted on the cards. When the measure was 
constructed, the developer theorized that individuals reveal unconscious material such as 
underlying drives, feelings and personality conflicts in the process of crafting their stories. As 
per the test’s original instructions, every story should illustrate what 1) took place leading up to 
the event shown on the card, 2) is happening on the card, 3) will happen to the characters in the 
future, and 4) the figures in the scene are experiencing mentally and emotionally (Murray, 1943 
as cited in Lilienfeld et al., 2000). Similar to the Rorschach, the TAT has sparked debate 
regarding psychometric properties of validity and reliability and standardized practices of 
administration (Groth-Marnat, 2003 as cited in Erickson et al., 2007; Hibbard, 2003; Hunsley et 
al., 2003; Lilienfeld et al., 2000; Medoff, 2003). Despite its continued usage, a recent survey 
indicated that 82% of practicing clinicians rated the TAT as an unacceptable measure of an 
individual’s risk for violence (Lally, 2003).

Inherently challenging in the interpretation of the TAT is distinguishing the authenticity 
of participants’ responses. For some individuals, personality features scored are markedly 
different from whom the individual actually is. This phenomenon, referred to as the “Walter 
Mitty” effect (Loevinger, 1987 as cited in Erickson et al., 2007), demonstrates that the manner in 
which individuals respond in the testing context could indicate their high regard of a personality 
characteristic rather than a true character trait. In addition, the TAT may be vulnerable to an 
“inhibition effect” in which examinees are suppressing or otherwise stifling expression of a
specific attribute. For example, individuals may falsely appear to exhibit high levels of achievement motivation and low levels of aggression (Lilienfeld et al., 2000). Furthermore, the testing environment, especially whether conducted in an individual or group setting, has been shown to have an effect on TAT profiles (Schultheiss & Brunstein, 2001).

Although it may seem redundant to state that more research is needed, this is an apt statement for the use of psychological assessment tools in mothers’ forensic mental health evaluations in the foster care context. Debates regarding the reliability, validity and standardization of administration practices of various psychological tests call into question the evaluator’s ability to formulate clinically sound assessments, diagnoses and service recommendations. All the while, life-altering decisions are being made based upon these instruments. While proponents of the TAT (Dhar & Mishra, 2014; Verdon et al., 2014) and other evaluation tools propose that the measures’ findings are just another piece of information, critics caution against the addition of potentially relevant but invalid data to existing clinical information. This combination could actually result in the diminished accuracy of clinical formulations, mainly due to psychologists giving too much credence to invalid data (Garb et al., 2005). Therefore, empirical studies of mothers engaged in family court litigation are needed in order to broaden the knowledge base concerning the normative psychological functioning of this population. For example, Carstairs (2011) recommended replication of her Rorschach study with a larger sample size and a matched control group to compare psychological profiles of parents who neglect their children versus those who do not and for assessments to be conducted and scored by evaluators blind to whether or not the parents are neglectful. Ultimately, the goal of such research is to develop best practices in the utilization of psychological tests for evaluating parents’ relational capacity that complements their children’s distinct needs (Stahl, 2011).
Utilization of Parental Mental Health Evaluation in the Family Court Context

Despite the widespread use of parents’ mental health evaluations in the child welfare system, there is a dearth of research about their utilization in practice. In an effort to identify current trends, Budd, Poindexter, Felix and Naik-Polan (2001) analyzed a random sample of 190 mental health evaluations ordered for family court investigations in Cook County, Illinois. Researchers sought to identify who is conducting evaluations, which assessment procedures are administered, referral concerns addressed and whether evaluations have an effect on court outcomes.

In the Budd et al. investigation, the majority of evaluators held a Ph.D. (32%), Psy.D. (22%), or M.D. (15%); 8% of evaluators listed no credentials. Assessments were categorized as psychological, psychiatric, parenting assessment team (PAT), substance abuse, bonding/parenting and other evaluations such as those with a social worker or neurologist. The most common reasons for referral included family reunification, termination of parental rights and adoption. Most assessments were single-session psychological evaluations. Conversely, PAT evaluations occurred over the course of 2-18 sessions. The most frequently utilized procedures were projective and objective personality tests; there was significant use of written records across all assessment types except for psychological evaluations. Parent-child observations occurred infrequently across all evaluation types except for PAT assessments. Descriptions of presenting problems were clearly stated in less than half of all reports (5-41%). Parental deficits were emphasized more frequently than strengths across all evaluation types (Budd et al., 2001). Legal dispositions were more likely to cite service and placement recommendations from evaluations that occurred through the court’s mental health providers (36%) than those assessments from community-based clinicians (21%) (Budd et al., 2004).
Butler, Atkinson, Magnatta, and Hood (1995) investigated the impact of court-ordered mental health evaluations on judicial outcomes in child abuse and neglect cases in Toronto, Canada. The sample included 59 assessments of single mothers considered to be of elevated risk with significant rates of family instability, domestic violence and substance abuse. With regard to placement, study findings indicated significant correlations among dispositions recommended by child protection workers, mental health evaluators and the judicial system with regard to preserving the family and parental rights. Specifically, the correlation between clinicians and judges was high and significant explaining 22% of the variance; that is, the recommendations from court-ordered evaluations were followed in a substantial number of cases. For most families the outcome involved the children being made permanent wards of the state, with the parents having visitation rights. The next most common placement decision included termination of parental rights such that children would be legally freed for adoption.

In the Butler et al. study, the researchers explained discrepancies among evaluation dispositions based on differing roles within the child welfare system. Child protective workers are frequently in open conflict with the interests of the parent as the children’s interests are paramount; they are primarily concerned with the potential for continued maltreatment. Conversely, clinicians engage families as a neutral and objective professional assessing what is best for the children and the family as a whole, rather than emphasizing the children’s imminent safety. Incongruities between the stances of child welfare authorities and mental health evaluators tended toward whether or not to preserve the parent-child relationship. Disagreements among the judicial system and the other organizations were potentially impacted by theoretical differences between mental health practice and the law, differential influence of
child protection concerns and parental rights and the presence of additional information being available to judges when they rendered their verdicts.

Although the aforementioned research study (Butler et al., 1995) is twenty years old, the findings are relevant due to its direct correlation to the current dissertation topic, specifically with regard to the relationship between mothers’ forensic mental health evaluations and children’s permanency outcomes. The Butler et al. article reflects the collaborative nature of the permanency decision-making process that involves child welfare workers, law personnel and service providers. More current research is scant with regard to this phenomenon. Although it did not focus on mental health assessments, a more recent study (He, Traube, & Young, 2014) focused on how child welfare workers, substance abuse service providers and court personnel perceived the parenting capacity of substance abusing parents. In comparison to child welfare workers, substance abuse treatment providers expressed a mixed but largely negative perspective. They were more likely to express feeling that substance abusing parents were not able to be effective parents, that sustained abstinence must be the standard when permanency decisions are rendered, that parents should be incarcerated for not complying with family court orders, but they were more likely to believe that parents could maintain recovery with treatment. Results indicated only slight differences between child welfare and legal personnel. The only substantial difference was that legal personnel were more likely than child welfare workers to report that substance abusing parents are not capable of effectively parenting their children. In addition to the article’s discussion on improving training and implementation of cross-system collaboration work (He et al., 2014), further exploration is warranted with regard to the impact of workers’ perspectives on permanency outcomes.
For mentally ill mothers facing termination of parental rights (TPR), appealing the judges’ rulings holds the potential for preserving the parent-child relationship. In order to account for the impact of child welfare policy on TPR outcomes from 1980 to 2006, McWey, Henderson and Alexander (2008) examined the rate at which parents were able to appeal the TPR and have their cases overturned in the state of Virginia. Results indicated that cases were more likely to be overturned from the time period of 1980 until 1993 (47%) than from 1997 to 2006 (5%). Those caregivers identified as mentally ill were less likely to prevail in the appeals process, and parents with established cognitive impairments were more likely to have their cases overturned. Other factors such as whether the parents abused drugs or had children with special needs did not demonstrate a statistically significant difference in rates of TPR. The investigators explained the findings in terms of stigma regarding the parenting competency of the mentally ill and also that the principal components of the ASFA law, most notably the expedited creation of stable homes for children, have strongly influenced permanency outcomes (McWey et al., 2008).

Factors Affecting the Assessment Process

Quality of legal representation and persistent structural issues in family court are crucial factors impacting mentally ill mothers’ experiences with the foster care system and assessment process, specifically those individuals that cannot afford an attorney and are provided with a court-appointed lawyer. According to Guggenheim (2007), there is a significant gap between what should occur theoretically and what actually takes place in family court proceedings. With regard to mental health evaluations and other recommended services, families frequently experience significant delays in accessing court-mandated services and long adjournments of several months between court dates. Furthermore, Guggenheim (2007) emphasizes the considerable disparity in the legal representation of children and parents. In New York for
example, children are represented by attorneys in the Juvenile Rights Division of the Legal Aid Society; lawyers attend an intensive training program and have a consistent impact on the formation of public policy. In contrast parents’ lawyers are members of panels with large caseloads and few resources.

Legal and mental health advocates (Spreng, 2010) have taken issue with the substantial obstacles hindering mentally ill mothers from reunifying with their children from the foster care system. According to recent analysis of state statutes pertaining to TPR, Lightfoot, Hill and LaLiberte (2010) found that as of August 2005, there are 37 states that specify disability as a basis to terminate parental rights. With regard to specific types of disabilities, 32 states identify intellectual disabilities as a rationale for TPR, 18 specify emotional disturbance and 7 indicate physical illnesses. Twenty-one states utilize the archaic term mental deficiency, language that is not representative of what is currently known about intellectual, emotional and physical challenges. Due to the potential for various forms of prejudice, focus needs to be more proximal—i.e., on the caregivers’ abusive behavior rather than their diagnosis and questionable predictions of abusive behavior (Lightfoot et al., 2010). In their recommendations to lawyers and parents aiding in their own defense, Kundra and Alexander (2009) propose the use of Title II of the Americans with Disabilities Act (ADA) (42 U.S.C. §§ 12102 et seq), specifically in TPR cases. That is, the law clearly specifies that disabled Americans are not to be discriminated against by public institutions such as government entities at the state and local level. Therefore, Title II indicates that public institutions are obligated to provide mentally ill parents with equitable access and opportunity to take part in programs and services, and those reasonable accommodations are made to ensure effective participation.
Mothers coping with mental health problems and cognitive limitations face considerable challenges in regaining custody of their children from the foster care system (Spreng, 2010), such as inadequate legal representation (Guggenheim, 2007), increased likelihood of their rights being terminated since the passage of ASFA (McWey et al., 2008) and workers’ negative attitudes regarding their parenting capacity (He et al., 2014). In addition, assessment tools that have been developed for identifying mental health disorders are now being utilized to support clinicians’ recommendations regarding mothers’ services and permanency. Therefore, current psychological assessment practices are extremely limited in their ability to evaluate parenting capacity and future risk of maltreatment. Furthermore, there is a limited evidence base regarding how mothers’ mental health evaluations are utilized in the context of foster care practice, specifically with regard to permanency outcomes. The current dissertation study aims to address this gap in the literature, especially since foster care agencies continue to refer mothers for forensic mental health evaluations in an effort to gather information relevant to the permanency decision-making progress (Budd et al., 2011). In the next chapter, the literature review will continue with an exploration of factors affecting permanency outcomes, especially type of placement, parental substance abuse, length of stay and race.
CHAPTER 3: LITERATURE REVIEW: CASE FACTORS AFFECTING PERMANENCY OUTCOMES

Since achieving timely permanency for children is a fundamental component of foster care practice, understanding how to support families in this process is essential for children to experience a sense of belonging, positive self-image and healthy connections to others (Samantrai, 2004). According to current national statistics, family reunification (52%) and adoption (25%) are the primary case goals for children in foster care (USDHHS, 2012b). As an alternative to focusing on a single permanency goal, concurrent planning is an approach in which multiple goals are considered simultaneously, such as reunification and adoption. This framework is characterized by an honest dialogue with parents regarding the consequences of failure to complete their service plans, discussion of voluntary surrender of parental rights and placing children with families willing to pursue adoption if reunification efforts are unsuccessful (D’Andrade, 2009). Although recent federal legislation has supported concurrent planning in foster care practice, whether and how it is utilized is at the discretion of each state’s division of children’s services (Child Welfare Information Gateway, 2012).

More than half of the children exiting foster care are ultimately reunified with their natural families, and approximately 20% are adopted. For children with alternative case goals, permanency outcomes range from guardianship or long-term foster care with extended family to emancipation or discharge to independent living. Although the average length of stay is 21 months, 46% of children being discharged from foster care have been in placements for less than a year (USDHHS, 2012b).

Permanency planning, or the manner in which child welfare professionals work with families to promote children’s long-term stability (Tilbury & Osmond, 2006), merits a closer
examination in families affected by mothers’ mental health issues. Although the mental health concerns of mothers pose a significant challenge to the permanency planning process, there are additional variables to consider in assessing the family’s appropriateness for reunification. The purpose of the following section is to explore how foster care case characteristics such as reason for placement, placement type, children’s age, time in care and parental visiting affect case outcomes for families that have been impacted by maternal mental illness.

**Permanency, Neglect and Mothers’ Mental Illness**

As stated above, neglect is the most common form of child maltreatment in the United States (USDHHS, 2012a), and it poses a significant threat to successful reunification (Barber & Delfabbro, 2009; Bundy-Fazioli, Winokur, & Delong-Hamilton, 2009; Lopez, Del Valle, Montserrat & Bravo, 2013). For neglectful families, however, there is usually more than one episode of maltreatment to be addressed. Such families are typically coping with multiple life stressors resulting in neglectful behaviors. Definitions of neglect vary by state, and there is debate in the field as to whether neglect should be conceptualized as lack of care versus inadequate fulfillment of children’s needs (Mennen, Kim, Sang, & Trickett, 2010).

Anxiety and mood disorders, specifically depression, have been implicated in harsh and neglectful parenting that could result in children being placed into foster care. In a recent analysis of mothers that have been investigated by CPS, depression emerged as a significant risk factor for neglect and emotional maltreatment, especially toward young children between the ages of three and ten (Kohl et al., 2011). Due to the considerable proportion of child welfare involved mothers exhibiting depression (Burns et al., 2010), this is particularly concerning. For mothers experiencing symptoms of anxiety and mood disorders, their parenting behaviors are more likely to be comprised of less nurturance, supervision and increased rejection of children.
(Elgar, Mills, McGrath, Waschbusch, & Brownridge, 2007), all behaviors evident of neglect and emotional maltreatment.

**Permanency and Parental Substance Abuse**

Recent estimates indicate that parental substance abuse precipitates more than half of children’s foster care placements (Testa & Smith, 2009). The misuse of drugs and alcohol can compromise parenting capacity as evidenced by physical, emotional and mental impairments, use of the family’s financial resources to obtain substances, recurrent interactions with the legal system and estrangement from family members. Furthermore, neglectful parenting may occur when the children’s basic needs for nutrition, monitoring and nurturing are unmet due to the parent’s focus on procuring and using illicit drugs, and children are at increased risk of developing their own substance use disorders (USDHHS, 2009). Parental drug abuse has been associated with children’s increased lengths of stay in foster care (Brook, McDonald, Greigoire, Press, & Hindman, 2010), foster care reentry (Brook & McDonald, 2009), and mothers’ increased risk of experiencing domestic violence and mental illness (Forrester & Harwin, 2006; Marcenko et al., 2011).

Through quantitative experimental and quasi-experimental studies, “best practice” models have been deductively arrived at to address the complex needs of families affected by parental substance abuse and foster care. When compared with traditional drug treatment services, integrated programs, or those substance abuse treatment programs that offer comprehensive services focusing on enhancing child and maternal well-being, have been found to be more effective in improving parenting capacity outcomes. For example, when children reside in the treatment facility with their mothers, such programs support mothers’ ability to build stronger attachments with their children, experience improved mental health and support
positive parenting skills outcomes such as decreased risk of maltreatment, enhanced emotional attunement and sensitivity (Niccols et al., 2012). An Illinois study compared the traditional model of foster care casework practice with a pilot program. The new initiative included the addition of a substance abuse recovery coach that performed a variety of functions including engagement, assessment and coordination of services. Compared to casework practice as usual, the model’s results yielded a higher rate of reunification and parents’ utilization of substance abuse services. Eighty-four percent of the parents in the pilot program engaged in substance abuse services, compared to 74% of those in the control group. The likelihood of reunification was 1.28 times greater for families receiving services from the recovery coach (Ryan, Marsh, Testa, & Louderman, 2006).

In their qualitative clinical data-mining analysis of nine successfully reunified families affected by substance abuse in New York City, Cordero and Epstein (2005) inductively derived dimensions of effective casework practice. This included restoring parent-child relationships, supporting relapse prevention plans and addressing domestic violence relationships among substance-abusing parents, a pattern common to the study sample. In the legal context, family drug courts offer immediate enrollment in substance abuse services as an alternative to incarceration; parents are assigned a case manager, participate in randomized drug screenings and engage in case reviews regarding permanency decision-making (Fenster, 2005). Other recommendations include using diagnostic screening tools to guide treatment referral, utilization of certified substance abuse counselors, home visitors and training caseworkers in the processes of addiction and recovery (Maluccio & Ainsworth, 2005).

Carlson, Smith, Matto, and Eversman (2008) explored how various stakeholders in the child welfare arena experience foster care practice in the context of maternal substance abuse.
The sample was comprised of drug using mothers who had experienced reunification, child welfare caseworkers and substance abuse providers who engaged in focus groups and individual interviews. In preparing for reunification with their children, substance abusing mothers emphasized various types of assistance they utilized to move the process forward. Services included consistent engagement in substance abuse treatment utilizing a 12-step paradigm of acknowledging a higher power, communicating with other substance abusers, staying abstinent and following service plan recommendations such as parenting classes, obtaining housing and attending all court dates and child visits. In addition, providers and mothers agreed that bolstering mothers’ support systems by ending relationships with substance-abusing and/or abusive partners is essential to successful reunification. Mothers and providers agreed that significant challenges to reunification included mothers coping with their children’s emotional and behavioral problems while also managing their recovery, utilizing positive parenting strategies to restore the adult/child balance such as setting limits and not overcompensating due to maternal guilt. The authors proposed development of interventions such as social support and parenting education classes co-facilitated by substance abuse service providers and child welfare workers to facilitate the development of skills necessary for maintaining recovery and reunification. This would incorporate emotionally preparing family members to be reunified while also addressing children’s experiences of being neglected and their concerns about mothers relapsing into substance abuse, as well as improved coordination between the substance abuse and child welfare service systems. The positive impact of social support and completion of substance abuse treatment was also reflected in Lewandowski and Hill (2009).
Permanency and Kinship Care

Nearly a quarter of children removed from their homes are residing with relatives in kinship foster care settings (USDHHS, 2009). States differ with regard to how they define kinship care, so the numbers can be misleading. Some jurisdictions only count relatives that are licensed foster parents; other states include all relatives regardless of licensure. Kinship foster care arrangements provide parents and children with the support system of the extended family for the preservation of family relationships (Downs et al., 2009). Research has supported the benefits of kinship care such as decreased frequency of children running away from the foster home and increased visiting opportunities with the natural family (Chapman, Wall, & Barth, 2004). As a result, children are more likely to be placed with their siblings and remain within their neighborhoods and schools (Generations United, 2006). With regard to placement stability, children in kinship care move fewer times than children in non-kinship foster care (Courtney & Prophet, 2011; Cross, Koh, Rolock, & Eblen-Manning, 2013; Strijker, Knorth, & Knot-Dickscheit, 2008; Winokur, Crawford, Longobardi, & Valentine, 2008) and are less likely to reenter the foster care system in the future (Shaw, 2006).

Despite indicators of enhanced well-being, children in kinship foster care present unique challenges with regard to permanency outcomes. Children placed with relatives tend to experience a slower rate of reunification than their peers residing in typical foster care placements (Connell et al., 2006; Pabustan-Claar, 2007; Winokur et al., 2008). Numerous hypotheses have been offered to explain this phenomenon. Littlewood, Swanke, Strozier and Kondrat (2012) found that kinship caregivers are more likely to be older, African-American, single, unemployed and have a low educational level and socioeconomic status. Furthermore, relative foster families are less likely to receive resources, training and prior notice of their role...
as kinship foster parents (Pabustan-Claar, 2007). Harris and Skyles (2008) criticized foster care practice that involves an overuse of kinship care placements—e.g., placement with relatives may reduce efforts to reunifying children with their biological families. “If slow reunification rates are indeed the norm for children in kinship foster care, it is still unclear if these slower rates can be attributed to the agency, the birth family, the foster child, the caregiver, or some combination of these factors” (Cuddeback, 2004, p. 630). Likewise, it remains unclear whether this statistical norm represents a prudent and protective ideal or goal displacement.

Some child welfare researchers have questioned whether the relationship between placement into kinship foster care and delayed reunification is a universal phenomenon. Employing secondary analysis of large child welfare agency data-sets, Koh and Testa (2008) used propensity score matching to examine selection bias in kinship foster care cases in Illinois. Similar to the aforementioned studies (Connell et al., 2006; Pabustan-Claar, 2007; Winokur et al., 2008), their findings indicated significantly delayed reunification rates for children placed in kinship foster care settings for up to two years as compared to children placed with non-kin caregivers. After three years in foster care, however, the reunification rates were approximately equal for children in both placement settings. Raghunandan and Leschied (2010) found that for a sample of children exposed to domestic violence, nearly 70% of the children in kinship care were reunited with their families within the 3-month study period and that they also experienced placement stability and overall positive adjustment in care as evidenced by few incidents of behavioral problems. Finally, in a Spanish sample, Lopez et al. (2013) presented findings indicating that although the success rate of reunification was higher for children in kinship as opposed to non-kinship care, the time of stay was approximately one year longer than children in non-kinship foster care placements.
Permanency and Visiting

Frequency of parental visiting is a robust predictor of family reunification (Barber & Delfabbro, 2009; Leathers, Falconnier, & Spielfogel, 2010; Lopez et al., 2013). Children that have consistent contact with their parents experience a smooth adjustment to placement into foster care, enhanced emotional well-being, decreased behavioral problems and shortened time in placement (Downs et al., 2009; Hess, 2005; Metzger, 2008). The actual occurrence of visiting, however, is affected by a range of organizationally determined variables such as program policies and norms, time constraints, resources for transportation, requests from natural and foster parents and caseworkers’ perceptions about the children’s best interests. In addition, parents may exhibit low motivation or lack of bonding with their children, mental or physical illness or mental retardation, or children may refuse to visit (Hess, 2005).

Beyer (2008) emphasizes the challenges of visitation in typical child welfare practice. Family visits often take place in an office setting, infrequently and in the presence of caseworkers and foster parents. Mothers’ feelings of loss, anger and concern with complying with mandated services may compromise the quality of visitation and the mothers’ ability to focus on the children’s needs. Furthermore, visitation does not allow an environment that addresses the resolution of the maltreatment that precipitated foster care placement. Innovative programming is an essential element to enhancing the frequency and quality of families’ visiting experiences. Visit coaching is an alternative to how supervised visitation is traditionally conducted in foster care agencies, and the model is described and purported by the aforementioned Beyer (2008). The visit coach is an active participant that supports mothers to demonstrate their best parenting ability in caring for their children. In the course of each visit, visit coaching encompasses assisting mothers to identify their children’s needs, prepare for their
children’s feelings and behavior, support mothers’ efforts to be fully present and attentive, recognize mothers’ strengths and use coaching for them to enhance their skills and help mothers cope with their own emotions to support their consistent visitation and keeping negativity out of the visits. This model, however, is recommended by the author when the family no longer requires supervised visits, and the coach is assisting the family’s safe reunification.

Nesmith (2013) described a Minnesota program piloting a visiting guidebook tool with the objective of supporting productive visits for parents, children and foster parents. The guidebooks were designed to be short and accessible with a focus on visit preparation, promotion of open, effective communication, recognition of how strong feelings can affect visitation, utilization of visits to enhance parent-child bonding and facilitating smooth transitions at the beginning and ending of visits for both parents and children. Of 133 research participants, which included parents, foster parents, children and social workers, there was a generally favorable response to the guidebook. As evidenced by pre and posttests, children and parents appeared to experience positive gains as a result of the intervention. Parents reported feeling more confident balancing coping with their own and their children’s emotions, considering what their children wanted to gain from visitation and honestly communicating their feelings with their children. Children reported that the intervention normalized the conflicted emotions elicited through visitation and provided guidance for expressing their feelings. Foster parents and social workers noted improvements in the parents’ skill building with regard to communication.

**Permanency and Length of Stay**

Time spent in foster care has been shown to have a significant impact on whether children are reunified with their natural families. In the foremost study of foster children, Maas and Engler’s 1959 study concluded that the likelihood of family reunification declines
significantly after 18 months in care. Employing a longitudinal study design Fanshel and Shinn’s innovative 1978 investigation yielded more refined patterns regarding permanency and length of stay. They found that 24% of children were discharged within one year or less, 20% exited from care in two to three years, 17% were in care four to five years and 39% remained in care by the end of the five year period (Waldfogel, 2000). The designs of these investigations have been critiqued by Waldfogel (2000). Maas and Engler’s study was only cross-sectional, and Fanshel and Shinn’s research selectively eliminated children that experienced brief stays in foster care. Despite their shortcomings, these studies and their critiques initiated critical discourse about this phenomenon and its practice and policy implications.

More current research reveals relationships among time in care, age and permanency. As discussed in Chapter 1, the Adoption and Safe Families Act of 1997 (ASFA, PL 105-89), dictates expedited timeframes for children to attain permanency and that for children in care 15 of the last 22 months, a termination of parental rights petition is likely to be filed. Therefore, after the child’s first year in care there is an increased chance that permanency deadlines will pass, and family reunification will be eliminated as an option (Phillips & Mann, 2013). When children spend longer periods of time in foster care, they are less likely to be reunified with their families (Wulczyn, 2004). Age is significant for infants who experience lower rates of family reunification and greater possibilities for adoption (Connell et al., 2006). The evidence base regarding age and reunification continues to develop; another investigation found that younger children were more likely than older children to be reunified with their families (Hines, Lee, Osterling, & Drabble, 2007). Hill (2005) found that although young age at entry was negatively correlated with family reunification, it did not persist as a significant predictor when utilized for multivariate analysis.
Biehal (2007) emphasized the difference between descriptive findings and explanatory results when considering the relationship between children’s length of stay in foster care settings and permanency. The author posited that there is no empirical evidence supporting a causal relationship between the passage of time and permanency outcomes. Other variables such as agency practices, service provision, parents’ feelings of ambivalence and placement reasons encapsulate a more comprehensive explanation regarding the relationship between length of stay and permanency outcomes. Iglehart (2004) has questioned the literature’s reliance on studying characteristics of parents and children rather than considering the larger context of foster care casework practice. She recommended further study of how caseworkers’ attitudes and organizational policies are influencing practice decisions, how workers mediate between the client and the agency and how that process is supported or hindered by administrators. In the ultimate goal of providing permanency for children, it is essential for researchers to ascertain effective aspects of foster care casework practice.

**Permanency and Race**

Hill (2005) endeavored to explore the relationship between race and permanency by analyzing the impact of variables such as maltreatment type, caregivers’ engagement in services and children’s age of entry into foster care. Utilizing a sample of 1,034 children who experienced out-of-home placements, study findings indicated that 34% of White children, and 9% of African-American children reunified with their natural families. Rates of family reunification were higher among families in which caregivers engaged in services, achieved a high school diploma, maintained employment and did not exhibit substance abuse. Furthermore, Caucasian and older children were more likely to reunify with their families than African-American and younger children. Children that were neglected were less likely to be reunified
than those who had been abused. When those variables were entered into a logistic regression equation, however, effects of age and maltreatment type all but disappeared. The greatest predictors of reunification included caregivers’ race, engagement in services, employment skills and not having a substance problem. When African-American and Caucasian parents shared the same desirable characteristics, Caucasian youths are still three times more likely to reunify than their African-American peers.

However, the investigation of Hines et al. (2007) yielded wholly different results regarding the relationship between permanency and race. In comparing African-American and Caucasian children residing in a large, ethnically diverse county in California, the researchers reported that African-American race did not affect how quickly families reunified. The authors concluded that this finding could be related to their more detailed analysis of case record data rather than relying on administrative databases gathered from individual states. Furthermore, the investigation examined variables predictive of reunification at the child, family and systems level. For the whole sample, reunification was predicted by a case finding of neglect, the child being of a young age and the mother being married. Furthermore, for each ethnic group there were different sets of predictive factors for reunification. Neglect, young age at entry and mother’s marital status were all significant predictors of reunification for Caucasian families. Younger children and mother’s employment were predictive of reunification for Hispanic families. For African-Americans, young age was associated with reunification, and children were less likely to reunify if their mothers abused drugs. The study’s most significant finding is that Asian children were less likely to reunify than their Caucasian peers. Furthermore, out of all the variables analyzed, such as maltreatment type, maternal substance abuse or children’s disability status, the authors were unable to identify a logistic regression model able to predict
reunification for Asian families. The researchers call for additional research on Asian families as they are often excluded from empirical studies due to small sample sizes and their historical underrepresentation in the foster care population.

Similar findings were reflected in Nwabuzor Ogbonnaya (2015), an investigation of the impact of race on foster care placement for families affected by domestic violence. The researcher engaged in secondary analysis of data from the National Survey of Child and Adolescent Well-Being. More than half of the sample were of low socioeconomic status, 19% of the parents abused drugs, 20% had significant mental health problems, 32% had a history of child maltreatment and 43% had prior maltreatment reports. In comparing Caucasian, Hispanic and African-American families, the researcher found no racial differences in time to out-of-home placement. Other variables emerged as having a greater impact on time to foster care placement. These factors included severe domestic violence, prior maltreatment reports and the affected children being 3-5 years old. Based on study findings, the researcher concluded that for children residing in domestic violence situations, the child welfare worker’s decision-making process appears to be more greatly impacted by perceptions of child safety rather than bias.

**Foster Care Reentry**

Estimates of foster care reentry range from 3-32% (Kimberlin, Anthony, & Austin, 2009). At the federal level, a 12-month timeframe is utilized to operationalize the occurrence of foster care reentry in examining permanency outcomes per state (Shaw & Webster, 2011). Shorter lengths of stay have been correlated with foster care reentry (Fuller, 2005; Shaw, 2006; Wells & Correia, 2012). Parental substance abuse (Bronson, 2005; Kimberlin et al., 2009; Shaw, 2006), parenting skills deficits (Wells & Correia, 2012), a history of unsuccessful reunifications (Farmer & Wijedasa, 2013), poverty, African-American race and children’s physical and mental
health conditions (Bronson, 2005; Kimberlin et al., 2009; Shaw & Webster, 2011) have all been correlated with foster care reentry. In addition, children that have been neglected (Shaw, 2006) are more likely to reenter out-of-home placements.

Reunification failures may occur when children are returned to their homes too quickly, without the proper resources to support the family or when caregivers have not addressed the circumstances that precipitated placement (Kimberlin et al., 2009). Critics of the efficacy of reunification services question whether families are receiving adequate support following the children’s return home and whether established standards for reunification are appropriate (Miller, Fisher, Fetrow, & Jordan, 2006).

**Data Trends and Limitations**

Inherent strengths of the vast permanency literature involve the wide utilization of quantitative analysis of original and available data to statistically explore and interpret trends in the data. Typically, researchers tend to utilize state administrative databases for the purpose of secondary analysis of large existing datasets. This allows for sufficient statistical power and the possibility of generalizability to other contexts. Or, if the entire population is enumerated, description rather than prediction is most appropriate. The statistical techniques of logistic regression, event history analysis, proportional hazards analysis, bivariate probit modeling analysis and propensity risk scoring focus on isolating specific predictors of reunification and control for extraneous variables that could influence study outcomes.

However, administrative databases are rarely constructed with future research explorations in mind. More likely they contain the minimum number of variables that are gathered by the states (Mcdonald, Poertner, & Jennings, 2007) and anticipated for program
monitoring purposes (e.g., the proportion of parents having mental health evaluations and whether those assessments affect reunification practice).

Along with these quantitative studies, qualitative designs are needed to further describe, disentangle and possibly explain these complex, contextually bound relationships, isolate key variables and generate promising theories for further exploration. In the summary of Hines et al. (2007), for example, the authors found that none of the variables typically explored in the permanency literature was effective in predicting outcomes for Asian clients. Surely, this is a location for more subtle, differentiated and culturally attuned forms of analysis.

Likewise, further research is necessary to delineate the family and service characteristics conducive to successfully reunifying families. Although there has been considerable discussion in the social work field about interdisciplinary collaborative practice, operationalizing this term and how it could be successfully implemented in practice has yet to be defined (Lalayants, 2010). Challenges include differences in professional ideology and agency culture, inflexible organizational structures, inadequate resources with regard to staff and funding, lack of ongoing training, poor communication and information sharing and financial uncertainty of program initiatives (Harwath & Morrison, 2007; Sloper, 2004).

In the next chapter, the dissertation study’s conceptual framework and research methodology are described and explained in terms of addressing the investigation’s aims and objectives. As stated above, qualitative research designs allow for a more detailed and nuanced exploration of research questions. This study’s conceptual framework provides the background for the exploration of how mothers’ mental health evaluations function in the context of foster care practice, and the methodology articulates how the investigation is conducted.
CHAPTER 4: CONCEPTUAL FRAMEWORK & METHODOLOGY

In exploring the function and phenomenological impact of mothers’ mental health evaluations in the context of foster care practice, this investigation utilizes two theories to form the study’s conceptual framework and one research approach to the investigation’s methodology. In the sections that follow, the client career perspective, clinical data-mining and social constructionism will be described and discussed in their application to answering the study’s research questions.

Client Career Perspective

The client career perspective originated as the “moral career” which refers to individuals’ change processes through identity and varying social positions and their attitudes, desires and motivations toward those positions (Becker, 1963 as cited in Parizot, Chauvin, & Paugam, 2005). Early sociological writings on the client career perspective include Erving Goffman’s 1961 essay, *The Moral Career of the Mental Patient* (Goffman, 1961 as cited in Gove, 2004) and Howard Becker’s 1963 work, *The Outsiders* (Becker, 1963, as cited in Sanders, 2013). Each theorist was interested in identity development among those living on the fringe of society. Goffman’s research focused on individuals’ experiences of psychiatric hospitalization, such as life prior to admission, experiences within the hospital and the time after the person has been officially discharged from the facility. Essentially, the individual undergoes a transformation as he is now classified as a person with mental illness (Goffman, 1961, as cited in Gove, 2004). The career trajectory is determined in the interface between his internal world and environmental structures affecting his progression toward a healthy functioning level (Hoffman, 2003). Becker’s work described the process by which certain individuals are identified as “social deviants,” such as how people violate social norms, continue to engage in those behaviors,
viewing themselves as deviant and being labeled as such (Becker, 1963, as cited in Sanders 2013). Becker focused specifically on how individuals come to identify themselves as marijuana users through their socialization process and integration of their social group’s structure and rules. Also, Becker emphasized that substance use does not inevitably lead to addiction and could be a controlled activity (Jarvinen & Ravn, 2014).

In the present day, entrance into and treatment for so-called deviant behavior has become a prevalent application of the client career perspective. Some examples include cigarette smoking (Peretti-Watel, Halfen, & Gremy, 2007); gambling (Jackson, Dowling, Thomas, & Holt, 2008); mental health treatment (Malpass et al., 2009; Parizot et al., 2005); participation in a citizen’s militia (Melder, 2014) and homelessness (Meanwell, 2008). In 1984, Everett Hughes expanded the concept of career to distinguishing meaningful events over the course of a person’s lifetime. Since then, the client career perspective has been broadened and applied to provide a greater depth of understanding underlying the processes and pathways of a range of experiences related to identity formation (Johnson & Best, 2012).

The client career is inherently affected by the individual’s ability to manage life stressors and experience a positive level of fit with his or her environment. Successful navigation of these processes leads to personal growth, while stagnation can negatively impact an individual’s functioning to the point of stress and dysfunction (Gitterman & Heller, 2011). Pathways to individual dysfunction vary in time of onset, and there have been comparisons drawn between challenges originating in early childhood versus adolescence. In comparing childhood versus adolescent onset, individuals experiencing childhood onset of dysfunction tend to exhibit harsher, more aggressive behavioral problems, elevated levels of family conflict, lack of empathy and negative peer socialization. For adolescents, teenage rebellion, encompassing
exploration of nonconventional values including difficulty with authority figures and constraint correlate with their onset of antisocial behavior (Dandreaux & Frick, 2009).

Describing the processes by which individuals transform their identities has been another application of this paradigm. Johnson and Best (2012), Liamputtong (2006) and Radcliffe (2011) have provided analyses of individuals negotiating their identities as parents under diverse family constellations. Johnson and Best (2012) focus on the phases of acceptance experienced by the parents of gay children as they progress from heterosexual parent to supporters of their children’s homosexual lifestyle. Stages focus on how parents alter their self-concept in the course of daily interactions, reorganize their social relationships, experience definitional shifts in parenting routines and engage in social action that publicly support their children’s right to live on their own terms. For Radcliffe (2011), the objective was to excavate the lived experiences of women simultaneously navigating motherhood and substance abuse treatment. Typical themes elicited from these interviews involved pregnancy being the catalyst for the women’s return to substance abuse treatment, their identification with a disease model of addiction, their profound struggles to maintain sobriety and striving for typical family lives. Finally, in Liamputtong (2006), the author explored how women experienced self-transformation in becoming mothers while also being Southeast Asian immigrants. The women shared the joys and challenges of motherhood, especially their familial bonds, managing their children’s behavior, maintaining a high moral character and negotiating a new culture, language and customs.

The possibilities for the utilization of the client career perspective are only limited by the research questions being posed. As stated above, standard applications of this framework have involved exploring the identity formation of vulnerable populations, especially mentally ill and drug using individuals and their interactions with systems of care. Complicating matters for the
women in the current study, their client careers are inherently and profoundly shaped by their interactions within the foster care organization (Hasenfeld & English, 1978). In their groundbreaking book *Human service organizations*, Hasenfeld and English (1978) claim that human services organizations are distinguished “from other bureaucracies by two fundamental characteristics: (a) their input of raw material are human beings with specific attributes, and their production output are persons processed or changed in a predetermined manner, and (b) their general mandate is that of service, that is to maintain and improve the general well-being and functioning of people” (p. 1). The metaphor of individuals as raw materials similar to parts being assembled in a factory, intimates the lack of voice and participation on the part of the client. That is, human services are often involuntary and mandated, similar to the mothers in the current investigation. In exploring and describing the mothers’ client careers, the interactions with and impact of the foster care agency cannot be underestimated.

**Clinical Data-Mining**

As clients receiving services from the foster care agency, accounts of the mothers’ careers are recorded and become part of their case records. Workers routinely document their interactions with clients, services provided, clients’ level of compliance with services, characteristics of clients and outcomes. Although case records are primarily utilized for supervisory, administrative and accountability purposes, they also reflect what is occurring in natural practice environments (Fook, 2002) and illuminate the mediating effect of the case worker between the organizational context and the client (Hayes & Devaney, 2004). Epstein (2001) defines practice-based research as “the use of research-inspired principles, designs and information gathering techniques within existing forms of practice to answer questions that emerge from practice in ways that inform practice” (p. 17). Within that practice-based model,
clinical data-mining (CDM) is a retrospective research approach whereby agency records are utilized as qualitative and/or quantitative data to be systematically gathered, coded, analyzed and interpreted in order to reflect on the organizational, practice and policy implications of their results (Epstein, 2010). This strategy is particularly applicable to child welfare case records due to the substantial amount of information routinely recorded in such files; in addition, case records can be examined in an unobtrusive manner to produce reliable and valid information to inform case practice (Cordero & Epstein, 2005).

A growing knowledge base has begun to take shape with regard to utilizing CDM to describe and evaluate contemporary child welfare practice. For example, Cordero (2004) analyzed characteristics of successful foster care practice in families that were reunified following the children’s placement for neglect, domestic violence and substance abuse. Themes elicited involved the child welfare professionals’ ability to access and cultivate families’ resiliency to repair and restore attachment bonds and for the worker to directly address the precipitants of the child’s placement. Hanssen (2003) applied CDM in her study of intensive family preservation services (IFPS) for the purposes of elucidating the relationship among client characteristics, presenting problems and client outcomes and to assess her own program’s fidelity to the IFPS model. Findings indicated that the program was true to the IFPS model and was highly effective (88% of the cases had children remain with their families for at least 30 days after case closure). Furthermore, results indicated that family advocacy and education were most significant in preventing children’s placement outside of the home and that IFSP was most effective in families with children with emotional and behavioral challenges, families experiencing domestic violence and in supporting family reunification. Lalayants (2010) utilized CDM methodology to describe and evaluate best practices of substance abuse, mental health and
domestic violence multidisciplinary consultation teams in child protection. In the study’s focus on the collaborative process among team members, child protective workers and supervisors, concepts such as having sufficient resources, dedication, effective communication and guidance emerged as integral to implementing and maintaining high standards of practice. In their analysis of child protective workers’ experiences with the aforementioned multidisciplinary consultation teams, Lalayants, Epstein, and Adamy (2011), found that workers experienced the consultations as significantly beneficial in the assessment of child maltreatment, providing referrals, arriving at decisions about case outcomes and expanding caseworkers’ clinical expertise. Although the consultation services were intended to be culturally sensitive and strengths-based assessments of children and families, criticisms involved a dearth of culturally informed consultations, an emphasis on family deficits rather than strengths, and/or strengths-based interventions and a shortage of multi-disciplinary integration and collaboration.

Together with the aforementioned discussion of the client career perspective, CDM provides significant promise for research involving description, analysis and evaluation of social work practice. Essential to the continued utilization of CDM in child welfare research, however, is for researchers to have the opportunity to gain access to case records. In order to neutralize potential challenges involving authority, defensiveness and territoriality, the researcher must be able to effectively navigate the political and organizational terrain of child welfare practice (Epstein, 2010). Foster care workers in particular face significant stressors, especially when considering a generally negative public opinion of foster care practice, community members’ lack of trust in the agency’s capacity to protect children due to past tragedies and the implementation of new documentation and reporting mandates (Schwartz, 2011).
Social Constructionism

Although organizations have standardized formats for case recordings, foster care workers are not blank slates as they gather, organize, interpret and record information about their daily practice. Workers bring their own perspectives to bear on how they prioritize and make meaning of information they acquire in their work with families. In addition, workers are functioning under the auspices of their agencies, bureaucracies that manage case practice with clearly delineated rules and regulations as well as varying organizational cultures and practices. As such, organizations determine practice parameters such as the target population, problem definition, assessment and intervention procedures, documentation and how much autonomy and authority is granted to the workers. Decision-making in the context of child welfare practice demonstrates program policies and requirements, and the organizational culture and atmosphere has an impact on how employees feel about their work and themselves (Samantrai, 2004). Likewise, organizational structures and cultures mediate how even standardized interventions are applied (Chen, 2012).

Social construction theory combined with CDM offers a novel approach to illustrate the process by which workers make sense of information regarding mothers’ mental health evaluations in the context of foster care practice. Although CDM and social construction theory have never been linked, the analysis of available data in the form of foster care case records is a concrete example of how foster care workers construct their practice, specifically with regard to mothers who have been referred for mental health evaluations. Social construction theory is primarily concerned with how individuals distinguish, define and construe their environments. Such perceptions are shaped and established in the course of social interchanges among individuals in their cultural and historical context (Payne, 2005). “Thinking is seen not as a
private or personal activity, but as a micropolitical and interactional process concerned with and
categorizing everyday life and developing arguments that justify preferred realities and courses
of action” (Parton & O’Byrne, 2000, p. 17).

The foster care case record wields significant power with regard to a family’s life since
what is documented demonstrates mothers’ efforts to complete the service plans mandated for
them. A mother who does not attend therapy or parenting skills classes is in jeopardy of being
labeled as noncompliant, resistant and lacking the appropriate motivation to be reunified with her
children. These designations may or may not be valid, but in the context of a power differential
between worker and involuntary client they are real in their consequences.

According to Urek (2005), language is the mechanism by which social constructions are
created. Furthermore, oral and written narratives communicate interpretations of social reality
for an intended audience. The foster care case record is not a static entity that objectively reports
what is occurring in practice. When the worker is writing notes and reports, her depiction of
reality is also affected by her awareness of the audience who will read this material. Therefore
every narrative is socially interactive in multiple ways; an event is described but interpreted in
the context of a relationship with clients as well as with supervisors (Payne, 2005). For it is the
worker’s direct supervisor who will review the documentation, communicate her feedback, and
the narrative will be constructed so as to be in accordance with organizational rules, regulations
and culture. In the context of child welfare practice, the act of supervision, designed to improve
workers’ productivity and expertise in working with families, often becomes a routine procedure
of reviewing adherence to bureaucratic policies rather than enhancing workers’ effectiveness and
efficiency (Samantrai, 2004).
Furthermore, the record is also accessible to administrators from governmental agencies such as the New York City Administration for Children’s Services (ACS) and the New York State Office of Children and Family Services (OCFS) that monitor the case practice of contracted agencies. For programs such as the one in the current investigation, the Division of Quality Assurance within ACS engages in ongoing monitoring and periodic audits with significant implications; agencies that perform poorly in the reviewing process are subject to disciplinary action, loss of funding or program closure.

Accountability and credibility are paramount as the worker must demonstrate that sufficient documentation supports the agency’s stance about each case. For example, if the agency is supporting family reunification, the worker must illustrate the mothers’ progress toward resolving the problems that triggered the children’s removal from the household. This narrative could include reports detailing consistent attendance to mandated services such as therapy, parenting classes, anger management counseling and family visits, as well as mothers demonstrating insight that their actions were wrong and that they are remorseful. In social constructionist theory such a narrative is identified as a progressive narrative, a story in which individuals are described as progressing toward their goals or failing to do so. Other narrative types applicable to the analysis of foster care case records include stability narratives that describe individuals in unchanging circumstances and digressive narratives in which people are veering away from their primary objectives (Payne, 2005). The foster care case record functions as a storytelling apparatus by which professionals communicate socially constructed information about the family to others in positions of authority.

A social constructionist analysis compels readers to question conventional ways of understanding the world and ourselves. “It challenges the view that unconventional knowledge
is based upon unbiased observation and that we can therefore easily separate subject and object, the perceived and the real” (Parton & O’Byrne, 2000, p. 25). Of particular interest to this study is the social construction that all abusive parents are mentally ill as purported by the field of psychiatric medicine. Medicine, with its foundation in biological science, assumes a significantly influential role as the authority of “truth” in society, determines what is discovered and observed and therefore what is constituted as scientific knowledge. Science has emerged as the dominant way of knowing and has facilitated the perspective of maltreating parents as sick and in need of treatment. Therefore, the etiology of child abuse is constructed as stemming from mental illness rather than a broader, contextual understanding that parents are raising children in a society that deprives parents of sufficient resources to adequately care for their children (Bell, 2011).

Perspectives toward child abuse do not exist in a vacuum but as part of a shared belief system. In turn, the validity of the belief that maltreating parents must be mentally ill is relative to one’s social and cultural context. There are those, however, who exercise more power than others in the construction of knowledge. Narratives concerning motherhood have been continually subjected to this process.

Over the centuries discourses surrounding mothering and mothers have idealized, scrutinized, and denigrated mothers’ roles and behaviours. While mothers and mothering have, at times, been romanticized, there have also been many patterns of control over and judgment of mothers, exercised by patriarchal systems of law and custom (Reid, Greaves, & Pool, 2008, p. 211).

Therefore, the social construction of abusive parents as mentally ill is further propagated by foster care workers referring them for mental health evaluations. The privileged knowledge of the clinician is sought to detect the presence and impact of mental illness.
has emerged as the definitive text and pre-eminent story on the classification of mental disorders as purported by the American Psychiatric Association. Since it is the most widely utilized diagnostic system, the DSM exerts significant influence over what is considered mental illness and how it is treated. At this writing, the latest edition of the DSM, the DSM-5, has been released by the American Psychiatric Association (APA, 2013). According to a critique by Lacasse (2014), this edition has been embroiled in controversies much like its predecessors. These debates include different definitions of what constitutes a mental disorder, referring to mental disorders as medical diseases and a lack of reliability. There is currently no set date as to when clinicians will be utilizing the new diagnostic system in practice (Munson, 2015).

In the process of diagnosing, however, psychologists, psychiatrists and social workers are reflecting their own perceptions in how they conceptualize participants’ behaviors (Eriksen & Kress, 2005). Clinicians’ theoretical approaches can significantly influence diagnosis. Family therapists that are trained systematically will focus on problematic thought, emotional and communication patterns among family members rather than a singular focus on the symptom-bearing individual (Strong & Busch, 2013).

In their survey of psychologists in New York State, Woodward, Taft, Gordon and Meis (2009), found a relationship between a clinician’s theoretical orientation to practice and choice of diagnosis. The authors compared posttraumatic stress disorder (PTSD), an anxiety disorder experienced as the result of a traumatic event and borderline personality disorder (BPD), an enduring pattern of behavioral instability affecting mood, self-concept and relationships (APA, 2000). After reading a vignette that described a client’s symptom presentation, those with a cognitive behavioral theoretical orientation were more likely to diagnose PTSD than BPD or
other disorders, and psychodynamic clinicians were more likely to diagnose BPD or other disorders than PTSD. The potential real-life implications are compelling; the BPD diagnostic label is typically stigmatized by clinicians due to its chronic and debilitating nature. Conversely, symptoms of PTSD can be connected to an external stressor which may have a positive impact on the therapist’s level of empathy (Woodward et al., 2009).

Furthermore, the DSM inherently espouses the core tenets of the medical model; the assumption is that mental health disorders exist within an individual rather than considering the family or wider social context. According to Eriksen and Kress (2005), the medical model has been disparaged as being overly simplistic; in that complex personal information is compressed into a few words. Eriksen and Kress also critique how this perspective views human beings as constant variables rather than dynamic individuals engaged in continuous change and development. Government entities such as the National Institutes of Health and Mental Health use the DSM classification system to determine eligibility and program funding depending upon the diagnostic label assigned. Nearly all environments in which mental health professionals work require a diagnosis in order to obtain reimbursement for services. Although the DSM wields significant power in the context of mental health diagnosis, the extent of its influence has not been studied in the context of foster care practice.

The child welfare worker must grapple with how to make meaning of, prioritize and utilize clinical information in the absence of an empirically validated knowledge base to guide this process. Ultimately, utilization depends on many factors including but not limited to the worker’s previous exposure to and knowledge regarding mental health treatment as well as her understanding of how the mother’s mental illness impacts her parenting ability. This complex process is especially volatile when professionals are also required to weigh the political
consequences of their decision-making. No child welfare worker or family court judge wants to see his or her name in the newspaper connected to a child’s death. In this context of heightened anxiety it is plausible that professionals in such circumstances will consistently make the most conservative and self-protective decisions. Equally important, risks that a mother’s mental disorder may affect the stability of reunification can also promote cautious decision-making. The intersection between these contextual factors and the decision-making of professionals is of particular interest to this inquiry. It should be clear, however, that none of this analysis is intended to minimize the immense child-protective responsibilities that child welfare workers shoulder on a daily basis and that child welfare agencies are mandated to perform.

**Research Methodology**

The purpose of this study is to construct a theoretical framework that describes and explains how mothers’ mental health evaluations function in the context of foster care practice, specifically with regard to their impact on children’s permanency outcomes. The following research questions frame this investigation: 1) What are the demographic profiles and psychosocial characteristics of mothers referred for mental health evaluations, and are there differences based on whether the mothers abuse substances? 2) Are there differences in how the mental health evaluation functions for mothers who acknowledge versus those who do not acknowledge their mental illness? 3) What are the parenting qualities and mental health symptoms identified as having an impact on children’s permanency outcomes? 4) What other service and/or case factors affect case outcomes (i.e. service plan adherence, visiting, etc.) for mothers that have been referred for mental health evaluations?

As evidenced by the literature review, few empirical investigations have analyzed this phenomenon. The dearth of information limits the investigator’s capacity to either name
pertinent questions or specify critical variables, and this paucity of knowledge is but one factor that recommends qualitative inquiry as a most suitable approach for this investigation. This fit is in part a consequence of the need for discovery. In contrast to quantitative research designs that are informed by a deductive process of specified variables and hypotheses, qualitative inquiry relies on an inductive process that supports the surfacing of novel assertions and constructs regarding the study’s subject matter (Patton, 2002). Qualitative inquiry allows the researcher to grasp and reconstruct the meanings currently ascribed to a topic and to support novel interpretations over the course of the data collection process (Guba & Lincoln, 1994).

In addition to gaining a more comprehensive understanding of a phenomenon of interest, qualitative methods are appropriate to study sensitive topics (Padgett, 2008) and to generate empirically “grounded theory” about complex social processes (Oktay, 2012). The initial research question aims to describe characteristics of mothers who have children in foster care and are referred for mental health assessments; because of the stigma and shame associated with mothers’ involvement in mental health and child welfare systems (Wells, 2011a), this is an essential first step in defining the population of study. Furthermore, the inquiry intends to illuminate the multifaceted process by which mental health assessments affect children’s permanency outcomes and how that process is impacted by mothers’ substance abuse and acknowledgement of mental illness. Finally, the analysis is concerned with exploring the impact of other individual, service or case factors such as mothers’ mental health symptoms, type of foster care placement and frequency of visiting with children.

This investigation utilizes a grounded theory approach for the purpose of focusing the inquiry. Oktay (2012) describes grounded theory as a method “designed to create theories that were empirically derived from real-life situations” (p. 4). The term theory has been defined as an
organized set of interconnected statements that serve the purpose to explain some component of social reality or enhance our sense of how individuals function and find value in their existence (Rubin & Babbie, 2001). In addition to the objective of constructing rather than empirically validating theory (Patton, 2002), grounded theory is based on concepts derived from symbolic interaction theory. From this theoretical perspective, reality is considered to be dynamic rather than a fixed constant (Oktay, 2012). Continuous exchanges between individuals and their environment mold and significantly affect the other over time (Gitterman & Heller, 2011), and the nature of self is in constant flux as a result of social interactions (Oktay, 2012).

Grounded theory requires researchers to incorporate theoretical sensitivity into the conduct of their studies. Theoretical sensitivity refers to a combination of the investigator’s understanding of extant theoretical concepts and perspectives regarding the phenomenon of interest and personal and professional knowledge that shapes the researcher’s ability to generate theory. Since qualitative studies are driven by genuine curiosity as opposed to obtaining proof of one’s hypothesis, it is critical that the investigator is able to suspend her preconceived notions, reduce bias and create novel perspectives that arise directly from the data (Oktay, 2012). For the current investigation, the study’s design is informed by the researcher’s clinical practice experience of providing mental health services to mothers with children in foster care, collaborating with child protective and foster care workers in creating service plans for families involved with the child welfare system and promoting policy change as part of a parents’ advocacy organization.

In the course of data collection and analysis, constant comparison and theoretical saturation are essential to the process of grounded theory development. Contrary to other research approaches, grounded theory involves constant comparison between data collected and
analyzed in an effort to search for similarities and differences. Therefore, data collection and analysis are occurring simultaneously as the researcher begins to formulate concepts that become the theory’s foundation. Insights, hypotheses and questions generated from the researcher’s experience with the data refine decision-making regarding further data collection (Charmaz, 2008). Theoretical saturation is achieved when there are no new constructs emerging from the data, and there is a goodness of fit between the core categories and the data (Oktay, 2012).

Grounded theory is a method reliant on emerging logic that combines explicitness and flexibility. It is predicated upon concurrent utilization of deduction, induction and verification for the purpose of developing theoretical analyses. The grounded theorist’s continual interrogation of the data functions to elucidate, advance and develop intuitive strategies to illuminate the process (Charmaz, 2008). As the researcher details theory creation, there is an opportunity for other investigators to replicate the study’s methodology, enhancing the study’s level of rigor.

In many ways, clinical data-mining (CDM) and grounded theory are complementary approaches with regard to the investigation’s conceptual framework and methodology. Both approaches rely on induction to generate theory from study results. Furthermore, CDM and grounded theory can be equally applicable to quantitative and qualitative research designs. In their seminal 1967 work *The Discovery of Grounded Theory*, Glaser and Strauss considered the prospect of grounded theory in the analysis of original and available data (Glaser & Strauss, 1967 as cited in Epstein, 2010). Mirabito (2002) exemplified the linkage between CDM and grounded theory. First, the researcher conducted qualitative interviews with clinicians in an effort to create a grounded theory to explain why some clients abruptly terminate from mental health treatment. Then, the grounded theory was strengthened and supported by a CDM analysis
of case records that indicated that clients often terminate services without acknowledgment. Another illustration of a study combining CDM and grounded theory is that of Cordero (2000). The researcher utilized a sampling framework of having participants that varied by maltreatment (neglect, substance and domestic abuse) and placement (foster and kinship) type. Cordero utilized the stage model of the psychosocial stages of helping (exploration, assessment, intervention and termination) to frame a grounded theory approach to coding the data relevant to describing successful foster care casework practices leading to family reunification. The current investigation aims to add to this developing knowledge base and demonstrate the utility of generating grounded theory through the use of CDM.

**Study Site**

The study site is a non-profit, multiservice organization in New York City that encompasses community-based and out-of-home care services offered at more than 70 programs in the Bronx, Brooklyn and Manhattan. A strengths-based, youth development focus that supports the development of individuals’ and families’ independence structures the organization’s approach to providing comprehensive services to vulnerable families. The agency is accredited by the Council on Accreditation for Children and Family Services, has been the recipient of the New York Times Nonprofit Excellence Award for overall management excellence and has been ranked highly in terms of performance ratings when compared to other agencies engaged in similar work. The investigation’s focus is on the agency’s family foster care program that is contracted by the Administration for Children’s Services (ACS), the public child welfare agency of New York City. In fiscal year 2009-2010, approximately 1,334 children, young people and families were served through the program’s family foster care and adoption departments.
Clinical Data-Mining: Preparation for Sampling and Data Collection

The current investigation utilizes a CDM research approach and, the ensuing steps in the methodological process are determined by the data sources available. Gaining access to the information is critical to the success of any CDM investigation. The researcher must resolve any political or technical concerns that could jeopardize data access. As the investigator begins to survey the information, she is seeking data about persons served by the organization, services rendered and results. In the initial stage of this process, it is essential that the researcher is engaging in as thorough a survey as possible, thereby not limiting herself to focusing only on social service data. Informational sources vary from computerized databases to handwritten case notes and log books (Epstein, 2010). For the present study the researcher began assessing data sources while employed at the study site. In order to gain access, permission was obtained from a variety of authority figures including the program director, deputy director, executive director and the director of program evaluation and planning. Upon completion of the study, the researcher will present the findings to management and staff at the organization.

Following the preliminary assessment of information, the researcher is to further structure the study by establishing the unit of analysis and cataloging variables within the data. In CDM studies, the unit of analysis is determined by the research questions and the manner in which data is organized (Epstein, 2010). Since the current study primarily focuses on mothers and how their mental health evaluations affect permanency outcomes, mothers as individual cases function as the study’s unit of analysis. The case records and computerized databases are entitled with the mothers’ names and will serve as the informational sources by which to extract variables for analysis. In keeping with the aforementioned survey model, variables are identified and grouped into categories such as characteristics of persons served by the organization, program services
and outcomes. In order to begin conceptualizing the breadth and depth of variables, a sample case record was utilized to compose an exhaustive list of client characteristics, services and outcomes present in the data. The foster care case record yielded a substantially large number of variables, and data emerged that was particularly relevant to the current inquiry. For example, hard copies of mental health evaluations provided information regarding mothers’ psychosocial histories, specifically with regard to family experiences, prior mental health treatment and substance abuse. See the data collection section for further discussion of variables targeted for qualitative analysis.

Finally, the researcher is to choose a time span or a “window” within which data collection will occur, especially since this CDM study is retrospective in nature. Because this investigation aims to develop theory regarding the function of mothers’ mental health assessments in the context of foster care practice, a longitudinal design is indicated to capture this process over time. In studying foster care casework practice, it is recommended that a minimum time frame of one year of data is to be collected. Prior to one year it is believed that individual court mandates exercise more power over family reunification than casework interventions (Cordero & Epstein, 2005). Mothers whose children were in foster care as of February 2011 define the end point of data collection so as to provide a current reflection of agency practice. Mothers’ length of involvement with the foster care system ranged from 18 months to 5 years. The emergence of the mental health referral and its ultimate impact on permanency outcomes interact with critical time junctures that shape the life of the case. Following children’s placements, family conferences occur at least every six months for all concerned parties to review progress toward the children’s permanency goal. As stated in the introduction, the Adoption and Safe Families Act dictates timeframes for families involved with
the foster care system. After a year in placement, the initial permanency hearing takes place, and for children in care for 15 of the most recent 22 months, the court is to proceed with terminating parental rights (ASFA, PL 105-89).

**Sampling**

Qualitative and quantitative research designs vary considerably in their underlying sampling logic. Quantitative research prioritizes randomization of study samples in accordance with statistical probability theory. Therefore, each member of a specified population has the opportunity to be selected for participation in the investigation, thus protecting the study against selection bias. In utilizing randomized sampling procedures, the researcher strives for external validity, that the results of the study can be generalized from the study sample to a larger population. With qualitative research, the investigator is conducting sampling with another rationale. The inherent strength in this model is the purposeful selection of information-rich cases that provide a depth of understanding and insight regarding a particular phenomenon (Patton, 2002).

Although purposive sampling may initially guide a grounded theory study based on the desired characteristics of participants, theoretical sampling is informed by the concepts generated from the process of constant comparison. Additional subjects are chosen based on the developing theory (Padgett, 2008). Ultimately, the researcher endeavors to identify a target population of sufficient depth and richness for the exploration of emerging theoretical constructs (Oktay, 2012). Furthermore, with CDM studies, the investigator is to determine a sampling framework that takes into account the availability of data, standard research practices, the investigator’s personal commitment of resources and the investigation’s organizational context.
(Epstein, 2010). Therefore, in grounded theory and CDM studies, it is counterintuitive for the sampling strategy to be established in advance of prospecting the data (Oktay, 2012).

In the initial stages of developing the research design and sampling framework, the investigator obtained a list of parents (both mothers and fathers) that had been referred for mental health evaluations. The data indicated that the agency had referred 27 parents in 2008 and 31 parents in 2009 for a grand total of 58 parents. Following approval from critical stakeholders (i.e. deputy director, program director, etc.), the researcher reviewed program files. At this juncture, criterion sampling, or the inclusion of cases with specific characteristics (Patton, 2002), was utilized to target particular cases to be analyzed. The criteria for this round of sampling included mothers who had completed both psychiatric and psychological evaluations.

Fathers were eliminated for several reasons. There was extensive missing data about them; although 6 out of 8 of the fathers had completed psychiatric and psychological evaluations, there was only 1 complete case record available. That case record was removed because the researcher had supervised the case. The study's focus is limited to mothers. Mothers’ names typically identify the title of each foster care case record, a practice identifying the mothers as both the primary caregivers and recipients of child welfare services. Mothers are more likely than fathers to perpetrate child maltreatment (USDHHS, 2010), and women are at an increased risk of developing mental illness in comparison to men (Riecher-Rossler, 2010).

In addition to having completed both psychiatric and psychological evaluations, mothers whose children were still in foster care as of February 2011 were selected so as to reflect contemporary casework practice. Twenty-three cases met the inclusion criteria. For the final round of sampling, subgroups of mothers were identified to support the development of grounded theory. Specifically, the inquiry is concerned with how the function of the mental...
health assessment may vary depending on mothers’ substance abuse and whether they acknowledge their mental disorders. For the purposes of the current investigation, mothers identified as drug abusers had substance abuse (i.e. cannabis abuse, alcohol abuse, etc.) listed among their mental health diagnoses. In keeping with CDM methodology, the following 16 cases were also chosen based on sufficient richness of available data. See Table 1 for further detail on the study’s subgroups.

Table 1

<table>
<thead>
<tr>
<th></th>
<th>Acknowledgment of Mental Illness</th>
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<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Substance Abuser</td>
<td>3</td>
</tr>
<tr>
<td>No Substance Abuse Indicated</td>
<td>3</td>
</tr>
</tbody>
</table>

Missing data poses significant challenges to the CDM researcher. Epstein (2010) defines missing data as “variables for which not all clients have data recorded” (p. 207). For the eliminated cases, missing data was prevalent. Since qualitative methodology frames the investigation, missing data limits the researcher’s ability to provide rich description and compromises the analytic objective of generating grounded theory. Of the 7 cases eliminated, 3 had such limited documentation that the researcher was unable to address the investigation’s research questions, especially with regard to identifying the parenting qualities and mental health symptoms that affect children’s permanency outcomes. Also, sparse documentation restricts the inquiry’s aim of capturing this process over time. The remaining cases did not have current
documentation; exclusion of those cases allows the analysis to focus on cases representative of contemporary practice. In two of those cases, most of the available documentation predated the actual mental health evaluation; therefore, it would have been impossible to explore the assessment’s function and ultimate impact in the life of the case.

**Data Collection**

With regard to data collection, the researcher gathered all information contained within each participant’s case record. Hard copies of the mothers’ charts were photocopied; additional data within the agency’s computerized database was printed out with the assistance of the executive director’s administrative assistant. This included progress notes, evaluations, reports, letters and all documentation regarding the mothers’ services. As stated above, it is critical that the investigation is not limited to collection of social service data (Epstein, 2010). Data concerning other aspects of mothers’ lives such as their medical and legal status hold the potential for illuminating additional factors contributing to the utilization of the mental health evaluation in the context of foster care practice. The case documentation has been organized into folders bearing an identification number for organizational purposes.

Initial organization of case record data involved the researcher’s completion of data extraction forms for each participant. In order to answer the study’s first research question, demographic profiles and psychosocial characteristics were prioritized at this stage of data collection. Demographic information includes the mothers’ gender, age, race/ethnicity, marital and socioeconomic status. Psychosocial characteristics have been operationalized according to Axis IV (APA, 2000) of the mothers’ mental health diagnoses. Axis IV is for recording contextual factors that may impact the assessment, diagnosis and treatment of mental disorders (Pierce, 2013). Psychosocial characteristics affect the mothers’ functioning within
their personal lives in the context of work, school and interpersonal relationships. In addition, psychosocial characteristics impact how mothers interact with their environments (Ro & Clark, 2009). Axis IV categories include: problems with primary support group, problems related to the social environment, educational problems, occupational problems, housing problems, economic problems, problems with access to health care services, problems related to interaction with the legal system/crime and other psychosocial/environmental problems that do not fall into one of those categories (APA, 2000). Other significant variables recorded include: family composition, the mothers’ mental health diagnoses, substances abused, presence of cognitive impairment and whether or not they acknowledged their mental disorders. See Appendix A for the sample data extraction form. For the remaining research objectives, the investigator applied grounded theory analytic methods (e.g. memoing, open coding) to the case record data.

Data Analysis

At the beginning of grounded theory analysis, the researcher has read each case and engaged in line-by-line coding of the raw data. Open coding, or the process of ascribing data to codes in which words are utilized to communicate meaning is critical to establishing the study’s overall direction (Oktay, 2012). For the current investigation, however, this is where the researcher departs from classic grounded theory. At the outset of classic grounded theory studies, the research focus is still under construction, and through the process of open coding, the study’s scope narrows and takes shape. Clearly, this is an inappropriate approach for the current study because the researcher is entering into the analysis with an articulated objective of generating theory to explain how mothers’ mental health evaluations function in the context of foster care practice. In keeping with the investigation’s conceptual framework of social
constructionist theory and the client career perspective, grounded theory analytic approaches have been employed to make meaning of the available data.

Due to the voluminous nature of the foster care case record, chunks of data are broken down and split up into smaller pieces for analysis. It is essential for the researcher to attend to data sections with emotionally laden content, word phrases and sentences that illustrate action and material that exemplifies symbolic interaction ideas such as interpersonal relations, the self, meaning making and process. Portions of the data are clearly recovered and organized, so the researcher can easily locate and group the segments related to a specific line of research inquiry or theoretical construct.

Codes are then differentiated and categorized. For descriptive codes, the researcher labels a class of phenomena to a portion of the text. Such description may be of specific conditions, interactions among individuals, actions and outcomes. Interpretive codes surface as the investigator becomes more knowledgeable about the phenomena under study. Pattern codes are labels that surface as the researcher infers an emerging theme or pattern in the data (Miles & Huberman, 1994). Substantive codes use words quoted from participants; when the code’s title is directly derived from the data, it is referred to as an in vivo code. For example, if the respondent says, “She is frightened of elevators, subways, and the like because she needs air.” Then, the sentence may be coded as “BM’s reported symptoms of anxiety.” In vivo codes demonstrate a close connection and reflection of the study’s raw data (Oktay, 2012). The statement, “BM has many trust issues and does not get along with family members” could be coded as trust issues. Theoretical codes are created in the mind of the researcher whose background will inform her worldview. A quote such as, “BM stated that she is willing to do anything asked of her, in order to get her kids back,” could be coded under level of commitment
to reunification or compliance with service plan. It is critical that the researcher is not forcing her own perspective onto the data and that codes are derived closely from the data. Code development continues until the researcher has achieved “theoretical saturation, the point in category development at which no new properties, dimensions or relationships emerge during analysis” (Strauss & Corbin, 1998, p. 143 as cited in Patton, 2002, p. 490). Memoing occurs throughout the coding process as the investigator is recording the reflections and questions evoked by the data; ideas need not be fully conceptualized, rather the researcher is making external her brainstorming process. Memos are to be dated, titled and occur throughout the course of analysis (Oktay, 2012).

In the transition from early to later stages of the analytic process, the researcher has developed an initial version of the study’s codebook comprised of preliminary codes derived from the data. As the researcher has reviewed the codebook, it has become evident that certain codes are similar and can be combined into concepts and categories. The continuation of this process has involved the identification of elements and properties of concepts and categories. For example, the researcher has generated a category entitled “mental health symptoms that affect parenting.” In order to further refine and develop elements and properties of this category, the investigator has explored types of symptoms such as depressive, anxious or psychotic and levels of severity such as acute, episodic and chronic mental health symptoms that impact the ability to parent. For example, chronic depression affecting a mother’s ability to clean the home is markedly different from psychotic behavior that warrants hospitalization.

Axial coding represents the next level of grounded theory analysis and is comprised of the recognition of various conditions, interactions, and effects related to a category, linking a category to its subcategories and the researcher’s search for hints in the data about how
significant categories may connect to one another. In addition, the investigator seeks to uncover the context, circumstances and consequences of what is occurring in the data. In addition, memoing is utilized to reflect the researcher’s thought process of utilizing constant comparison and noting down emergent ideas about associations among categories, concepts and contextual factors. Focus on relationships between categories and concepts is essential to theory generation.

In the selective coding phase, the researcher endeavors to integrate and fully conceptualize the theory that has developed in the prior phases of coding. This is achieved through the identification of one or more core categories and then relating other significant categories to this core category. Core categories are distinguished by their recurrent appearances in the data, their abstractness and relevance to other categories. Identification of the core categories dictates the focus of the analysis and theory generation (Oktay, 2012). See chapter 8 for further discussion of theory generation and visual representation of the grounded theory demonstrating how mothers’ mental health evaluations function in the context of foster care practice.

**Methodological Strengths and Limitations**

In the aforementioned study, one must balance the strengths and limitations of the qualitative grounded theory design utilizing the CDM research approach. Primarily, this CDM study was carried out in an unobtrusive manner; that is, data collection did not interfere in any way with the practice environment since the practice under investigation has already concluded (Epstein, 2010). The researcher was able to independently gather information from the agency’s file room and with the assistance of the executive director’s assistant prior to and after business hours. With the investigation’s utilization of CDM techniques, the analysis is dependent upon the quality of data entered by foster care workers. Although case record analysis provides the
opportunity of extracting rich illustrations of clients’ needs, services provided and the results of those interventions (Epstein, 2001), the reliance on existing data renders the researcher vulnerable to the possibility of missing, illegible or inaccurate data due to the possibility of human error or intentional distortion. Since the researcher had been able to survey the data prior to data collection, it is apparent that the amount of missing data is limited to information irrelevant to the current analysis.

In an effort to assess the quality and scientific rigor of qualitative investigations, a multitude of concepts and techniques have been offered to replace quantitatively derived concepts such as reliability and validity. A study’s transferability concerns whether the study’s results are applicable to other environments. Auditability or dependability indicates that research methods are clearly described and logical such that the procedure could be replicated by other investigators (Lincoln & Guba, 1985 as cited in Oktay, 2012). An audit trail is particularly applicable to grounded theory studies in which the researcher is memoing and discussing each aspect of the data collection and analytic process (Padgett, 2008). For the current investigation, the researcher has a binder with all memos, data extraction forms and coding sheets that outlines the evolution of the analytic process.

Confirmability is demonstrated through a clear linkage between data and research outcomes, leaving no doubt as to genuineness of the results (Lincoln & Guba, 1985 as cited in Padgett, 2008). In keeping with postmodern perspectives of qualitative research, however, Oktay (2012) had the following critique for the aforementioned terminology.

If all knowledge is constructed, or co-constructed, then the application of criteria designed to challenge the ‘subjectivity’ of the researcher does not apply. In the constructivist worldview, there is no single ‘truth’ or ‘reality’ out there that is being discovered by the researcher (p. 105).
Therefore, Lincoln and Guba expanded their perspective to include fairness and authenticity that allows for the inclusion of participants as fellow researchers, alternative ways of knowing and that the investigator rejects the notion of a knowable reality (Lincoln & Guba, 1985 as cited in Oktay, 2012).

For grounded theory studies specifically, it is important for researchers to consider the state of practice knowledge regarding the substantive field being studied. Whether the theory can be clearly understood by practitioners and achieves an adequate fit with professional realities is essential in determining both the quality of the grounded theory and its usefulness to social service professionals (Oktay, 2012). Peer debriefing has assisted the author in achieving this goal. In June 2014, the researcher had the opportunity to present preliminary study findings at a conference attended by fellow researchers and social service professionals. The researcher gathered feedback that nurtured a transparent analytic process.

In the next three chapters there will be an exploration of how mothers’ mental health evaluations function in the context of foster care practice. Each chapter will focus on a different aspect of the factors shaping their pathways through services, specifically with regard to their demographic profiles and psychosocial characteristics and any differences based on substance abuse, acknowledgment of mental health problems and additional variables including mental health symptoms, foster care placement type and service plan adherence.
CHAPTER 5: DEMOGRAPHIC PROFILES AND PSYCHOSOCIAL CHARACTERISTICS

In considering the demographic profiles of the mothers referred for mental health evaluations, all mothers identified as female, and the ages range from 18 to 40, with a mean age of 30 years old. African-American \((n = 8)\) and Hispanic mothers \((n = 5)\) are the predominant racial groups represented in the sample. For the remaining mothers, one is biracial (half Polish, half African-American), and two are of unknown racial background.

For mothers who abused substances \((n = 9)\) versus those who do not \((n = 7)\), there are subtle differences with regard to demographic characteristics. Substance abusing mothers ranged in age from 18 to 40, with a mean age of 29. Mothers who did not abuse substances exhibited an age range of 19 to 39 with an average age of 28 years old. The majority of African-American mothers \((n = 7)\) abused substances, in addition to 1 biracial and 1 Hispanic mother. One African-American, four Hispanic and two mothers of unknown ethnicity comprised the group of non-substance abusing mothers.

Drugs of choice varied across the group of substance abusing mothers. The majority of the mothers \((n = 7)\) smoked marijuana and abused alcohol \((n = 5)\). Cocaine was used by four of the mothers, while at least one mother abused PCP, LSD and crack. Five of the nine substance abusing mothers used more than one type of drug.

**Socioeconomic Status/Educational Attainment**

Low educational attainment was a recurrent theme among all sixteen mothers in the study sample. Similar to demographic characteristics, however, there is slight variance between the two subgroups with regard to number of school years completed. Mothers who abused substances completed fewer years of secondary education; most of them had an 8\(^{th}\) grade
education ($n = 3$), with the remainder completing 9th grade ($n = 2$), 10th grade ($n = 2$) and 11th grade ($n = 2$). For non-substance abusing mothers, the level of educational achievement skewed slightly higher with one mother earning an associate’s degree, one GED recipient, and the others finishing 11th grade ($n = 1$) and 10th grade ($n = 3$). One mother’s exact educational attainment was unknown as the file indicated that the mother dropped out of a special needs high school, but it was unclear as to the highest grade completed. The mothers provided an array of reasons for not completing their high school education including pregnancy, following the poor choices of others and family conflict. The mothers’ educational histories were often intertwined with the traumatic and chaotic nature of their lives.

Educationally, [BM] reports that she did not complete the 10th grade and had been enrolled in special education classes. The client reports that she had behavioral problems and did not listen and simply chose not to continue her schooling as she was weary of bouncing around from various foster care and group homes. (Mother 1612-65, substance abuser)

Educationally, the client reports that she completed the 11th grade and had been enrolled in regular classes. She was held back once in the 9th grade. She claims that she made good grades if she made a suitable effort, but did not always make the effort. Her negative behavior was related to being influenced by friends, which included truancy. An ex-boyfriend in high school beat and raped her in the 10th grade. She then met the father of her 8 year old son, who denied paternity. The client states that he tried to get girls to beat the baby out of her. The client does not have a GED. (Mother 4135-62, substance abuser)

Educationally, she completed the 10th grade and was placed in regular classes. She denies being aggressive in school, but did allow that she was a smart child although she was cited for talking too much and blamed the attendance lady for not crediting her with having been present. She threw a paper at a woman in her school in the school office and received a superintendent’s suspension and never went back to school. She does not have a GED and failed to pass it in the past. (Mother 5336-55, non-substance abuser)

All 16 mothers exhibited significant financial struggles affecting their ability to care for themselves and their children. The majority of the mothers received some form of public
assistance such as cash payments and food stamps \((n = 12)\), comprised of six substance abusers and six mothers who did not misuse drugs. Of the three remaining substance abusing mothers, two had no documented form of income, and one was employed in a low-wage position. The remaining mother who did not abuse drugs supported herself financially by receiving monthly payments from a past lawsuit. Mothers who did not abuse substances were slightly more likely to have a prior work history \((n = 5)\), versus drug users \((n = 3)\). For many of the mothers, the problems stemming from their low socioeconomic status significantly affected their child welfare involvement.

[BM] reported that she couldn’t pay the rent, and then said that she was refusing to because the conditions of the bathtub were terrible and the landlord didn’t repair it. She says housing called ACS not because she was neglectful, but because of the rent being in arrears. She agrees that the house was a ‘mess’ but that she was just behind on the laundry, sweeping, and mopping. (Mother 1002-88, substance abuser)

[BM] reported that she voluntarily gave up custody of her two children in 2007. She reported that her apartment ‘started to get nasty’ and that rats were present in large numbers and eating through the food. She stated that she did not want the children to be in the apartment and called ACS asking the organization to find her children a home until she could find a more suitable place to live. She reported that her landlord began charging $1000 per month for rent and that she subsequently went to live in New Jersey with her then-boyfriend’s family. (Mother 2137-12, non-substance abuser)

**Family Composition**

With regard to family composition, there were more similarities than differences across the two groups of mothers. Substance abusing mothers had an average of 3 children with a range from 1 to 5, and their children’s average age was 8, with a range of 3 months to 21 years old. For mothers who did not abuse substances, they also had an average of 3 children with a range of 1 to 6. The children’s average age was 8.5, with a range of 9 months to 21 years old. For both groups, a substantial proportion of the children were characterized as having special needs.
classified as emotional, behavioral or cognitive impairments. There were 11 out of 28 children with special needs born to substance abusing mothers and 10 of 25 children born to mothers who did not abuse substances.

One mother had a 12-year-old daughter and 10-year-old son in foster care, and their difficulties are described in the following excerpt.

[The son] is a young boy with chaotic upbringing, neglectful care who was admitted into residential care for stabilization of aggressive and impulsive behaviors. In the past, [the son] has dealt with frustrated states with aggressive acting out or impulsive behaviors such as dangerous running, which poses serious safety risks to himself and others. [The son] has a diagnosis of Mood Disorder, ADHD, Asthma and Vitamin D deficiency. [The daughter] has PTSD, ADD, emotional disturbance, and a learning disability.
(Mother 0132-25, substance abuser)

Another mother (9333-27, substance abuser) had five children, 14 and 17-year-old daughters, a 16-year-old son and 11-year-old twin sons. Four of the five children experienced mental health, emotional and learning problems.

She [14-year-old daughter] was placed in a DRC [residential facility] due to mental health and behavioral concerns. There were several behaviors that [the daughter] was displaying that lead to her placement at the DRC, such as violations of curfew, sexual acting out in the community, aggressions towards peers and teachers, bring[ing] male peers into the house without permission, and inability to follow household rules. [She] was hospitalized at Bellevue Hospital for visual and auditory hallucinations. In addition, [she] had expressed suicidal ideation.

The youth [16-year-old son] is in the 9th grade. He was left back as he was absent almost every day the previous academic year. Youth is basically the class clown and constantly serving as a distraction. He is also being very disrespectful towards the staff and is not doing any work in class. He was diagnosed with ADHD Combined Type and R/O Oppositional Defiant Disorder.

[1st twin son’s] learning disabilities need to be addressed. [1st twin son] will continue to receive speech/language and occupational therapy at school. [2nd twin son’s] behavior issues and learning disabilities need to be addressed. [2nd twin son] will continue to receive related education services and a special education support teacher five periods per week. [Both twin sons’] bed wetting needs to be addressed.
In considering father involvement, both groups had an average of 2 fathers of their children, with a range of 1 to 4. All 16 women were single mothers, with minimal involvement of the children’s fathers. For the children of substance abusing mothers, 5 out of 21 fathers were noted as having any kind of involvement in their children’s lives. There was little difference for the children of mothers who did not abuse substances; only 3 of 17 fathers were documented as having any contact with their children. A multitude of factors were reported as negatively affecting father involvement including fathers being deceased, incarcerated, experiencing their own drug addiction or mental illness or being lost to contact. Domestic violence was a common occurrence for the substance abusing mothers; 7 of 9 mothers experienced abusive relationships with their significant others. Mothers who were not drug abusers were slightly less likely to be involved in abusive relationships \((n = 3)\).

The oldest child’s father [has] no current involvement. [BM] is now separated from the father of the two younger children after a 10 year relationship. Her 6-year-old son claims that his mother cut his father with a knife, which the client says is not true at all. She says that she and [her younger children’s father] were in a relationship for 10 years, and that it ended when the children were taken and an Order of Protection was placed between them. She reports that the Order of Protection has since expired but they still have very little contact. She says that she ‘needs to stay away from him’ and would not consider resuming their relationship until he enrolled in a program and ‘got help.’ (Mother 4135-62, substance abuser)

She reported that she is not certain of the identity of [her son’s] father and that her daughter’s father ‘disappeared.’ (Mother 2137-12, non-substance abuser)

She has never been married and has no involvement with the father of her daughter. In her view, he is irrelevant to the situation since he is not present. They had a relationship ‘for a while’ and separated about 3 ½ years ago when she moved out secondary to issues around domestic violence. (Mother 5336-55, non-substance abuser)
Psychosocial Stressors

The entire sample experienced a multitude of psychosocial stressors within all nine Axis IV categories. Many categories are overlapping as occupational and educational problems could have a direct impact on economic and housing problems. What is clearly indicated in the following section is that the mothers of the study sample have experienced complex family dynamics, severe trauma and compromised environmental contexts that have affected their ability to parent.

Problems with Primary Support Group

For the category of problems with primary support group, the mothers’ stressors involved severely dysfunctional relationships with their families characterized by abuse, neglect, dissolution of the family through divorce or estrangement and deaths of family members (Pierce, 2013). The entire sample experienced some degree of problems within their primary support group, specifically with regard to the dissolution of their families through removal of the children into foster care. In the excerpts below, the following themes emerged: the mothers’ own experiences of being in foster care, the mothers’ being survivors of trauma and exposure to family members’ substance abuse.

Foster Care Experiences

Unfortunately, many of the mothers are continuing the cycle of trauma and child welfare involvement they encountered in their own childhoods. The majority of the sample (7 substance abusers, 5 non-substance abusers) experienced a foster or kinship placement at some time during their childhoods. Thus, these mothers have an intimate knowledge of what their children are experiencing in being away from their immediate families.

At age 13, she left home due to severe physical punishment by her mother and went to her boyfriend’s home. Thus, she entered a repeated cycle of living in
group homes after her mother obtained a PINS case against her, and living intermittently with her mother with whom she had a strained relationship. (Mother 1418-14, substance abuser)

[BM] reported that she was born in Brooklyn and raised by her mother. At age 3 she was placed in foster care but came back one week later and then went to Jamaica, West Indies until age seven. After that she was with her birth mother until age 13. She was then in foster care for many years due to her mother’s negligence in her care. (Mother 7717-37, substance abuser)

She was raised by her maternal grandmother after age eleven. Prior to that age, she had been raised by her biological mother, and cannot identify the reason for the move. She said her mother gave her custody to her grandmother. She has never had any contact with her father. (Mother 4732-25, non-substance abuser)

[BM] reported that she had a happy childhood until her mother killed herself in front of [BM] when she was a child. [BM] reports that she was raised by several aunts as the result of her mother’s suicide. She claims that she has never had contact with her father. (Mother 6257-12, non-substance abuser)

She was born and raised in the Bronx. Her father is incarcerated and her mother was unstable and often absent, so she was raised by her paternal grandmother (the mother of her siblings’ father. (Mother 8881-03, substance abuser)

In addition, many of the mothers, (5 substance abusers, 2 non-substance abusers), are survivors of abuse themselves.

[BM] has had a very complex family background. Her mother died when she was very young and she was raised by her older sister who was very mean to her. She ultimately, was abused in the home of that sister and no-one believed her claim of abuse. She is very angry and committed now only to her daughter. (Mother 3114-99, non-substance abuser)

At age 4 she reports physical abuse with fists, slaps, belts, and being twice sexually molested by her half-sister’s father. These episodes would occur when her mother went to the Laundromat. She recalls trying to tell her mother about these episodes but felt that she did not want to hear about it. (Mother 1418-14, substance abuser)

[BM] described a chaotic childhood characterized by severe physical trauma, sexual abuse, and neglect. She reported that her father ‘did not want to take care of me’ and that her mother left her at a young age. She reported that she was shuttled between the homes of various cousins, aunts, and uncles and that she ultimately lived with the same uncle [for a 10-year period]. She stated that she was raped by her uncle’s brother when she was 14 years old and that the uncle
with whom she lived also molested her and continues now to proposition her for sex. (Mother 2137-12, non-substance abuser)

[BM] reported that she was born in Brooklyn and reared by her step-grandmother. She ran away because of physical abuse by her step-grandmother. She also reports sexual abuse by her aunt’s boyfriend (rape) when she was 18 years old. She described very sadistic behaviors by her grandmother, who put roach spray in her food, bit her, threw things, stabbed her in her back twice, and threw boiling water on her. The abuse started when she got into her teens (if she didn’t sweep the floor correctly or talked to her friends too long). (Mother 9333-27, substance abuser)

Furthermore, slightly less than half of the mothers, (3 substance abusers, 2 non-substance abusers), were exposed to their family members’ substance abuse.

[BM] was born in Bronx, NY and was raised by her grandmother and her aunt, mainly by her aunt. In response to the question why she was not cared for by her mother, she reluctantly (and only after a few inquiries) responded that her mother had a drug problem. (Mother 2700-42, non-substance abuser)

Mother – history of crack cocaine, and ‘probably everything else but I’m not sure.’ She reported that she was removed from her care when she was 11 months old. (Mother 3279-09, substance abuser)

The client describes a tumultuous childhood and reports that her mother, grandmother and uncle all abused crack cocaine. (Mother 1612-65, substance abuser)

**Problems Related to the Social Environment**

For the category of problems related to the social environment, mothers’ stressors encompassed challenges in creating a support system such as losses of friends, lack of support, residing alone and difficulties with adjustment such as acculturation and prejudice (Pierce, 2013). Although each mother had professional support such as foster care workers, therapists and other service providers, the mothers were not universally accepting of or felt that they were in need of help. See Chapter 7 for a more detailed discussion of how case factors such as mothers’ adherence to service plans, children’s length of stay and types of foster care placements affected permanency outcomes.
It is significant, therefore, that she has no support systems, any social infrastructure being all but non-existent. When things do not proceed well in her life, there is a revolving door to the shelters, despite claiming to have five friends. In terms of services, the client is in need of parenting and anger management classes. But the stark reality, given her long time dysfunction, is that the results could be highly questionable. (Mother 0132-25, substance abuser)

She described several recent losses in her life including two deaths that occurred in her home in the last year. Her mother died in 2007 from AIDS related complications. In 2008 a male friend was sleeping in her apartment one night when he fell out of the bed they were sharing. She found him dead in the morning. Finally, in 2009 her uncle’s infant also died in her apartment. (Mother 1612-65, substance abuser)

Socially, [BM] seems to have few friends, only those whom she parties with in clubs as a regular outlet. Her social functioning is limited by her diminished intellectual capacity. She is underdeveloped in her social skills of negotiating with others, advocating for herself, resolving conflicts, and forming healthy, stable relationships. (Mother 7717-37, substance abuser)

**Educational Problems**

As discussed in the beginning of this chapter, the study sample is characterized by low educational attainment. More specifically, educational problems on Axis IV of the DSM diagnosis (APA, 2000) encompass learning disabilities, such as not being able to read or write, conflict with school staff as well as an inadequate learning environment (Pierce, 2013). In considering the aforementioned problems related to the social environment, the mothers also seemed to struggle with their academics due to a lack of support.

Educationally, [BM] reports that she completed the 11th grade and was registered for both regular and special education classes. She stated that she was good at reading and writing when she was younger, but was mischievous in elementary school. She was held back once, and eventually dropped out due to pregnancy, difficulty caring for her child and meeting the demands of academics simultaneously. To date, she has not earned a GED. (Mother 3114-99, non-substance abuser)

[BM] completed the 11th grade and she was in regular education. She was held back once. [BM] stated that she was a good student who had good behavior, though she was once suspended and expelled for fighting. [BM] does not have a
GED. She stated that she was in a program but had to stop due to ACS demands. (Mother 3884-92, non-substance abuser)

Educationally, she states that she completed the 8th grade and had been enrolled in regular classes. She was an average learner and reports that she was quiet and had friends. She sustained one suspension and later dropped out due to pregnancy, and has never earned a GED. (Mother 1418-14, substance abuser)

**Occupational Problems**

Occupational problems encompass a wide variety of employment challenges such as stressful or difficult work conditions, unemployment, dissatisfaction with the position and conflict with co-workers and supervisors. Although unemployment and reliance on public assistance characterized the majority of study participants, locating affordable child care options and being able to manage daily stressors proved to be significant obstacles to the mothers being able to work on a consistent basis.

Regarding sustenance, the client indicates that she was most recently employed in retail for one month in March 2009, but had child care issues. Her longest job was 7 months at a movie theatre in 2004. She stopped due to the hours. The agency records show that the client worked in retail and customer service in the past. She now receives public assistance. (Mother 3114-99, non-substance abuser)

The client has a tendency to see the errors of her volatile behavior after the fact. An example being her dismissal from a job with Target due to a verbal altercation with a supervisor, allegedly with racial undertones. After the fact, she said that she regretted ‘telling him off’ (the boss) due to her feeling degraded by him. While her charge may have some merit, the illogicality of her thinking is her assertion that she can move to New Jersey and reassume the same job position at Target. She also regrets leaving Target because she ‘would have been wealthy’ if she kept her customer service job. (Mother 5336-55 non-substance abuser)

**Housing Problems**

Homelessness is the predominant housing problem affecting the study sample. Housing problems included landlord/tenant disputes, inadequate living conditions and an unsafe community (Pierce, 2013).
[BM] feels that the agency’s description of her history is inaccurate. She also said that she was not ‘kicked out’ of the shelters. She left only because she was ‘not built for the shelter.’ She was not keeping the hours the shelter required and therefore was asked to leave. She did not follow the shelter’s hours because she wanted to stay in her home and, in addition, her mother became ill and she was at the hospital a lot. (Mother 0132-25, substance abuser)

BM reports that she currently lives with her grandmother and is unemployed. She is working to get her own apartment which she said she needs to do in order to get her daughter back. (Mother 4732-25, non-substance user)

The SCR received a report stating that mother does not have a home. Mother is in the habit of dropping her children at various family members’ homes for days and not returning for the children. (Mother 3279-09, substance abuser)

**Economic Problems**

Financial problems are one of the prevailing issues affecting the mothers in this investigation. Coping with severe poverty affected nearly every mother in the study sample. As evidenced by the excerpts below, the family’s financial strain often precipitated child welfare involvement.

Her loans to many persons seems to imply that she may seek to buy the affections of others. In any case, this is illogical behavior in the face of her dire financial circumstances. It would imply a lack of the sensibility of priorities when her children should come first. She has admitted that ACS took her children due to poor living conditions and lack of stable finances. The fact that she can reclaim her loans any time she pleases and that she made them in the first place because she is ‘nice’ is then made irrelevant. (Mother 7717-37, substance abuser)

The referral states that there was allegations of ‘inadequate guardianship, no food, lack of medical care. (Mother 3279-09, substance abuser)

All of the children were removed from BM’s care because of allegations of inadequate clothing, food, shelter and BM’s drug use. It was reported that BM had not paid her electric bill and owed over $10,000 in back payments. The power was shut off and there was not light or gas in the home. (Mother 9333-27, substance abuser)
Problems with Access to Health Care Services

Challenges in maintaining access to health care was another theme that emerged from the data. Many of the mothers had difficulty maintaining coverage, which had a direct impact on their ability to complete their service plans since the entire sample was mandated to engage in services such as mental health and/or substance abuse treatment, parenting skills and anger management groups.

BM at present does not have medical coverage, making a treatment referral impossible. The CW asked her if she has Medicaid, she said no. The CW told her to get Medicaid as soon as possible for her health and so she can refer her to services. The BM said that she will do so. (Mother 3279-09, substance abuser)

Birth mother Medicaid not working at the moment. Birth mother to engage in services once Medicaid is working. (Mother 2700-42, non-substance abuser)

CW then asked the BM if she brought the documents about her Medicaid being open, BM told the CW that she did but then just received a letter that it is going to expire but she doesn’t understand because she just got her Medicaid open. BM told the CW that she is going to go personally to the office to find out what is going on, CW told the BM that she is going to continue to communicate with her and the mentor to get updates. (Mother 3884-92, non-substance abuser)

Problems Related to Interaction with the Legal System

As for the legal system, every participant in the study sample has a problem with the legal system since each mother is engaged in family court proceedings. In addition, this category includes any history of arrest, incarceration or being a victim of a crime (APA, 2000).

[BM] states that she has a legal history of arrest several times for cannabis possession and fights with her mother, but denied being incarcerated. Most recently in 2008, she was arrested for scratching her baby’s father and violating an order of protection. (Mother 1418-14, substance abuser)

She also reports a number of arrests for second-degree assault, harassment arrests. At age fifteen, she was arrested for physically assaulting her uncle with a golf club, and was subsequently sent to Spofford and Horizons for 6-8 months. (Mother 4732-25, non-substance abuser)
She reported that she was arrested when she hit a woman who was her daughter’s baby sitter, in her apartment. She had told the woman to get out and had hit her, knocking her out. Her daughter was sleeping at the time. Therefore, she was arrested and incarcerated six days, but the charges were dropped to a misdemeanor. (Mother 5336-55, non-substance abuser)

**Other Psychosocial Stressors and Environmental Problems**

The final Axis IV category refers to all circumstances not covered by the aforementioned categories such as natural disasters, war and conflict with individuals who are not family (APA, 2000). Some of the mothers reported tension with their ACS or foster care workers, which is to be expected given the power differential between mothers and workers. See Chapter 7 for further exploration of factors at the personal, family and case level that affect children’s permanency outcomes.

As for ACS she states that their allegations concerned her lack of finances, poor living conditions and that she had a history of moving to shelters. Also one of the children’s schools reported that one of her daughters smelled like urine and was dirty and unkempt. She denies all of the allegations and claims her daughter has clean clothes, and that the ACS worker is ‘nasty’ and wants to cause trouble. (Mother 7717-37, substance abuser)

During the home visit, CW asked BM to put the dog in her bedroom because CW felt a little uncomfortable that the dog was barking. BM’s two older children started to become very disrespectful. [BM’s daughter] told BM that she should not honor CW’s request to put the dog in the bedroom until CW leaves the home. [BM’s daughter] tried to incite the dog to bite CW and told CW to leave the home if CW did not like what was taking place. CW observed that BM did nothing to stop the dog from barking and stood by when the older siblings were trying to incite the dog to attack CW. At the same time, the older siblings started to approach CW and that’s when CW felt threatened and told BM that she had to leave the house. (Mother 9333-27, substance abuser)

In summary, the subgroups of mothers who abuse substances versus those who do not exhibit only slight differences in terms of their demographic characteristics and psychosocial stressors. Substance abusing mothers were more likely to be African-American and an average of 29 years old. Mothers who did not abuse substances were more likely to be of Hispanic or
unknown racial background and an average of 28 years old. Alcohol and marijuana were the
recurring drugs of choice for substance abusing mothers, with some individuals also abusing
crack, cocaine and LSD. Mothers who abused drugs had slightly less years of education, and
they were less likely to have a work history or documented source of income. The family
compositions of both groups were nearly identical down to having an average of 3 children, with
an average age of 8, and there was a significant proportion of children with special needs. Also,
absentee fathers was the norm for the sample. Domestic violence was slightly more common for
substance abusing mothers. Although severe psychosocial stressors including childhood abuse,
family dissolution and poverty are recurrent themes for the entire sample, substance abusing
mothers were slightly more likely to experience childhood trauma and an out-of-home placement
with relatives or non-kinship foster parents.

In chapter six, the group of mothers will again be split into two subgroups to compare
whether acknowledgment of mental health problems affects the utilization of the mental health
evaluation in the context of foster care practice. That chapter will also include discussion of the
family’s permanency outcomes, specifically with regard to whether mothers who acknowledge
their mental health problems are more likely to reunify with their children than those who do not.
CHAPTER 6: ACKNOWLEDGMENT AND UTILIZATION OF MENTAL HEALTH EVALUATIONS

As discussed in chapter two, forensic mental health evaluations significantly differ from client driven assessments in which individuals seek services of their own accord. The foster care service plans have been the driving force behind mandated mental health evaluation referrals for the mothers involved in the current investigation. Over the course of the assessments clinicians pose a wide range of questions, especially with regard to the mothers’ experiences of emotional problems. It is unclear, however, whether mothers’ acknowledgement of their mental health disorders affects how the evaluation is utilized, especially with regard to permanency outcomes.

What has emerged from the data is that mothers are referred for mental health evaluations due to the concerns of others. The mothers are not requesting mental health assessments, but rather they are compelled to participate due to the recommendations and mandates of their service providers. As will be discussed in the following sections, workers within preventive, child protective and foster care services identified the mothers as in need of assistance due to a wide variety of difficulties that ranged from their behaviors and attitudes to their self-disclosure of past trauma and prior mental health problems. Therefore, the mental health evaluation becomes a mechanism for service providers to verify their concerns, gather information regarding the mothers’ functioning level and obtain guidance on how to effectively work with these mothers.

Preventive Services Involvement

For many of the mothers, the foster care agency’s referral was not their first encounter with mental health services. Four of the mothers had been clients of preventive services prior to their children’s foster care placements. That is, after the initial allegations to child protective
services, workers determined that although the children were susceptible to future maltreatment, the situation did not warrant an out-of-home placement. Monitoring the family in addition to providing referrals for mental health, substance abuse and domestic violence treatment and other services comprise the range of supports offered by preventive services (Chemtob, Griffing, Tullberg, Roberts, & Ellis, 2011).

One mother had been involved with preventive services for over a year, and she had not completed the recommended services, including a mental health evaluation. Perceived barriers to engagement are in the following excerpt.

[BM] has made very little to no progress in areas of goal achievement. Her participation/involvement in services being offered has been very sporadic since signing [for services] with this agency therefore, making it difficult in providing assistance in areas of needs. It has been assessed that [BM] is illiterate. [BM] being illiterate makes it difficult for her to understand and process things being said to her. She also seems to have issues with trust and this may be the reason she tends to avoid people, places, and things geared towards helping her. (Mother 0132-25)

Although there is an apparent awareness of the mother’s challenges, preventive services workers need to document their efforts in supporting the mother’s completion of recommended services.

Agency consultant referred [BM] for mental health services after an assessment on 2/27/07, of the following diagnosis: Posttraumatic Stress Disorder, Chronic/Cyclothymic disorder, Alcohol Abuse, Cannabis Abuse, Cocaine Abuse, Deferred, and R/O Personality NOS. Referral was made at the [mental health service provider] three times. Due to her failure in keeping the last appointment, the [mental health service provider] refused to reschedule her a fourth time. [BM] wasn’t happy with the referral and she seems to be having a difficult time adjusting to this new setting (saying this is a place for ‘CRAZY’ people) for she was very disrespectful to both CP and [the agency consultant], after her initial visit. It’s obvious that [BM] is in denial of her mental health issues by her fighting treatment and the people trying to help her. (Mother 0132-25)

This mother, who is also one of the nine substance abusers in the study, is clearly not receptive to the referral as indicated by the number of appointments missed, her apparently negative attitude toward the case planner and consultant and the emphasis placed on the mother’s use of the word
crazy, all in capital letters. Clearly, this mother is distinguishing herself from others who receive mental health services, but the workers involved are not convinced that she does not need treatment. This is evidenced by the consultant’s description of the mother as being “in denial of her mental health issues” and “fighting treatment and the people trying to help her.” This assessment occurred over a year prior to the mandated evaluation from the foster care agency. Since the mother’s mental health concerns were not addressed, the problems only escalated as the family moved from preventive services to the children being placed into foster care.

For another mother, initial assessments by child protective services indicated the mother’s compromised emotional state and need for ongoing support via preventive services.

Mother appeared disheveled, talking in tangents and making no sense to her surrounding. Caretaker(s) has a serious mental health problem. According to mother she was the victim of a car accident and as a result the court deemed her incapacitated. Mother is willing to engage in services. [Preventive] services will be implemented for services. (Mother 2137-12)

As the mother and family began receiving preventive services, she was observed to have difficulty in being able to accept her mental health condition.

She has limited insight into her cognitive impairments, and feels she is capable of caring for herself and her children. She does not feel that she is ‘mentally incapacitated’ and thinks that ACS’s current involvement is unjustified. She lacks the problem solving and coping skills to implement interventions on her own. [BM] is cognitively limited and has exhibited poor judgment in some of her decision making, which could have placed her children at risk. She is socially isolated, and not receptive to interventions. [BM] needs to participate in outpatient mental health services. (Mother 2137-12)

In contrast to the aforementioned mother (0132-25), this mother followed up with mental health services despite her disagreement with the preventive worker’s assessment.

Though [BM] lacks insight into her illness, she reports a willingness to comply with recommendations in order to keep her children. She has been seeing a mental health specialist through the shelter on a bi-weekly basis and she complied with a psychological evaluation. She is waiting for a psychiatric appointment. (Mother 2137-12)
This mother was one of the seven non-substance abusing mothers in the sample, and she maintained adherence to her preventive services plan for a year and a half. Ultimately, however, this mother chose to voluntarily place her children into foster care due to inadequate housing.

Following an allegation of excessive corporal punishment, another non-substance using mother was referred to preventive services. Similar to the aforementioned mothers, workers identified mental health concerns to be addressed.

\[BM\] appears to be overwhelmed. She is young, alone and seemingly at times afraid in this big world. Her family system along with her life experience have been traumatized by the repeated acts of physical and psychological violence. \[BM\] seems to believe that if she would avoid talking about her family that it will all go away. She has a strong feeling of detachment cutting herself off from other people. She also appears to be depressed, this is when she has the feeling of irritability and anger. She is watchful and on guard checking out what everyone is doing and then reacting. (Mother 3114-99)

The worker’s assessment focuses on how the mother’s trauma history and isolation contribute to her depressed mood and avoidance. The worker’s language of describing the mother as “young, alone and afraid in this big world,” however, is infantilizing. The mother is construed as a young woman who is avoidant, distrustful, agitated and in need of help. Although there is emphasis on this woman’s strained family relationships and interpersonal distress, the preventive services worker appears to espouse a negative perspective when this mother has difficulty establishing a working relationship with the service providers involved in her life.

The family view at this time is that things are not going so good for the family. \[BM\] is very aggressive. She does not follow shelter rules and blames everyone else for whatever is wrong in her life. She appears to want services handed over to her without herself doing any work. She feels she has all of these service providers and that they should get her an apartment. Her most pressing need is that she must realize that she is an important component in her future and that she is not only a client but a partner in her case. \[BM\] on the other hand has become her own strongest advocate but needs guidance with getting information. \[BM\] needed to learn strategies that will help her promote best interest and empower herself. (Mother 3114-99)
The mother’s defiance is depicted both positively and negatively as she is referred to as “her own strongest advocate” and as an individual that does not follow rules or take an active role in her own services. The worker emphasizes that the mother neither acknowledges her role, nor does she take personal responsibility for her circumstances, a theme that will be explored in greater depth later in this chapter. Mental health services were a prominent component of the mother’s service plan.

[BM] needs evaluation for mental health services to help control her anger from her past history of abuse. [BM] will learn how to let go of some of her anger and use her strong survival skill and drive to satisfy her needs to help her through her therapy. (Mother 3114-99)

Due to a finding of physical abuse, however, this mother’s 2-year-old daughter was placed into foster care before she engaged in therapy.

Although the mothers engaged in preventive services had been reported for maltreatment services, they were given the opportunity to address the reasons for referral while the children remained in their custody. Engagement in mental health services was one of these expectations, so not attending coupled with increased safety factors to the children resulted in foster care placement. Clearly, the preventive workers have an awareness that the mothers’ trauma histories have affected them significantly, specifically with regard to their ability to trust others and form healthy relationships. Unfortunately, however, the mothers do not appear to share that insight as three out of four of the mothers did not acknowledge their mental health problems.

**Concerns Raised by the Administration for Children’s Services (ACS)**

Similar to the mothers involved with preventive services, the need for mental health services was identified early in the majority of cases. Twelve of the sixteen mothers had their evaluations completed within the first six months of the children’s placement. The other four
mothers completed assessments at a later date. See Table 2 for further information regarding the timeframe of the mental health evaluation referrals for all of the mothers in the sample.

For five of the mothers, mental health problems were recognized from the very beginning of the child protective services investigation. A variety of concerns prompted workers to consider the mothers as potential recipients of clinical support. At one 72-hour post placement conference, the child protective services worker reported on the mother’s strange presentation and delusions.

Worker indicated that she suspects that the BM has mental health issues. Worker indicated that BM is very bizarre. Worker indicated that the BM prayed with the child in Hebrew language while in her presence. Worker indicated that the BM told her that she had psychic powers. Worker indicated that BM said that she gave away all of the children’s clothes to ‘Puff Daddy’ (rap star) because he took all of the children’s clothes. (Mother 1022-88)

For another family, hygiene and the mother’s partner led child welfare staff to believe that untreated mental health problems played a role in the neglect allegations.

There was a conference held on the above case. Present was caseworker, caseworker supervisor, CES, and CPS. During the conference CPS explained some concerns as birth mother’s home was unsanitary, and the children were not well kept. Birth mother’s paramour was smoking marijuana in the home and birth mother saw nothing wrong with that or that the children didn’t have to shower every day. Birth mother’s mental state is being questioned. The following service plan was discussed: Birth mother is to undergo mental health eval. Birth mother is to receive parenting class. Birth mother is to enforce OOP against paramour. [Daughter] is to be referred to early intervention. (Mother 2700-42)

A third example is of a mother who became involved with child protective services due to leaving her daughter unsupervised. Again, mental health concerns were readily apparent to the workers from the beginning of the investigation.

Caretaker(s)’s apparent or diagnosed mental health status or developmental disability seriously affects his/her ability to supervise, protect or care for the child(ren). Mother is aggressive toward the child. Mother left child in the home alone while she went outside and engaged in a physical altercation. An elevated
risk conference was held and a service plan was developed. Mother is to take mental health evaluation, parenting and anger management. (Mother 5336-55)

Table 2

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<thead>
<tr>
<th>Number of Mothers</th>
<th>Time for Referral</th>
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<tbody>
<tr>
<td>12</td>
<td>Within 6 months of placement</td>
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<tr>
<td>1</td>
<td>Within 8 months of placement</td>
</tr>
<tr>
<td>1</td>
<td>Within 9 months of second placement</td>
</tr>
<tr>
<td>1</td>
<td>Within 1 year of placement</td>
</tr>
<tr>
<td>1</td>
<td>Within 1 ½ years of placement</td>
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Similar to the findings for the mothers in preventive services, the mothers identified by their child protective services workers presented with behaviors, attitudes and verbal statements that triggered significant concerns, specifically with regard to how those mental health problems affected parenting capacity. Results were mixed on whether the mothers acknowledged their mental health problems (Yes = 2, No = 3). This is understandable given the context of custody loss and the power differential between the mothers and the child protective workers. The remaining mothers were referred by their foster care workers.

**Concerns Raised by the Foster Care Agency**

For the seven other mothers whose evaluations were completed within the first six months of their children’s placements, the referrals emerged as part of their service plans due to concerns raised by the foster care agency.

The specific questions are to assess her mental health status, emotional/behavioral functioning, problems with postpartum depression and her experience stemming...
from being a ward of foster care, and a recommendation concerning treatment. (Mother 7717-37)

Agency would like us to assess the client’s current mental health status, personality functioning including emotional/behavioral problems or strengths, and the client’s ability to care for her children. Agency would also like to know if [BM] is a danger to herself or others, and whether she is in need of therapy and/or psychotropic medication. (Mother 4732-25)

The court ordered a psychiatric and psychological evaluation to know if the birth mother is at a functional level to properly supervise her children. The agency and court would like to ensure that the biological mother is capable of taking care of her children. (Mother 6257-12)

As evidenced by the aforementioned examples, the foster care agency is utilizing the mental health evaluation for gathering a wide range of data including mental health symptoms, parenting capacity, risk to self and children and treatment recommendations. Later in this section, there will be further discussion as to how this information affects children’s permanency outcomes.

With the four mothers whose evaluations occurred later in the life of the case, the referral questions were similar to those evaluations completed more rapidly. The foster care agency continued to inquire about mental health status, parenting skills and whether the mothers were in need of clinical interventions such as therapy and medication. The difference for these women was that personal and structural circumstances proved to be barriers to their timely participation in mental health evaluations. As discussed in Chapter 5, the mothers experienced a wide range of environmental stressors, especially with regard to being poor women of color. One mother had problems with access to health care services, due to lack of transportation and difficulty maintaining her insurance coverage.

There was a referral done for BM to [mental health service provider] for drug treatment and mental health; however, BM did not follow through to complete intake due to the long distance from her home to the program. BM then self enrolled herself to [drug treatment provider] for drug treatment but was
discharged due to non-attendance. According to BM they did not accept her health insurance, and she was trying to change it but was discharged before she was able to fix the problem. (Mother 1418-14)

For another mother, maintaining her recovery from drugs and the importance of healing family relationships were the impetus in the foster care agency’s referral for the mother’s mental health evaluation that occurred nine months after the children’s second placement. In the context of the first failed attempt at reunification, it would seem that the foster care agency is utilizing the mental health evaluation for additional information regarding the appropriateness of reunification for a second time and what services may assist in that process.

Continued child welfare intervention is necessary until drug treatment is completed and housing is secured. During the visitation, the interaction between all family members is still portraying the roles that lead to care. The older siblings are still controlling and assuming parental roles while the younger siblings are used as the scapegoats. While this occurs, mom has a tendency to not intervene and allow these roles to continue. When addressed with mom, she states that the children are uncontrollable and has a defeated attitude. BM will complete drug treatment and mental health evaluation for any additional services. (Mother 9333-27)

The mother whose evaluation took the longest to complete (2 ½ years from the time the children were placed) was referred for mental health evaluation as part of her initial foster care service plan. As stated below, the barriers are considerable and continuous throughout the family’s involvement with the foster care agency.

[BM] is a young mother, and does not have permanent housing or financial support. [BM] also has a history of drug abuse. [BM] is a foster child who has reached the age of release. BM was given an appointment to apply for Medicaid. She did not show up for the appointment. This makes it difficult for the caseworker to refer her for mental health evaluation. (Mother 3279-09)

Furthermore, this mother’s foster care worker spoke to her sternly about her options of participating in her services or considering other alternatives for the permanent care of her
When the children had been in care for approximately six months, the worker shared the following concerns with the mother.

The caseworker called the BM to find out what she wants to do, either surrender her rights to her sister or start complying with her services. The BM said that she wants to start complying with her services and she gave birth to a baby boy. The CW asked where she is currently residing. BM said that she is staying with her sister in the Bronx. The BM is coming into the agency today before 1:00 p.m. The CW will refer the BM for parenting, mental health, and random drug testing. (Mother 3279-09)

Mental health evaluations are a mechanism for the foster care agency to gather information as well as structuring the mothers’ service plans with the evaluators’ service recommendations. For one mother whose initial reunification had been unsuccessful, the foster care agency appeared to use the evaluation for ascertaining the appropriateness of attempting family reunification a second time. In another case, the mother’s mental health evaluation referral was part of agency pressure to motivate the mother to complete her service plan in a more timely manner. The mental health assessment timeframe is also affected by the mother’s belief in whether mental health services are something from which she could benefit as well as the agency’s stance that the evaluation is integral to the permanency decision making process. See Table 3 for a summary of mothers’ referral sources. In the next section, there will be further description regarding nuances of acknowledgment.

**Continuum of Acknowledgment of Mothers’ Mental Health Problems**

As discussed above, child welfare workers such as preventive services, child protective and foster care workers often recommend or mandate mental health evaluations as an instrument of information gathering. A critical component of the assessment is the mother’s own report of mental health symptoms, specifically with regard to whether she acknowledges her emotional struggles. According to Mizock and Russinova (2015) women’s acceptance of their mental
health diagnoses are complicated when they are also experiencing oppression, sexism and mental health stigma.

Table 3

<table>
<thead>
<tr>
<th>Referral Subgroups</th>
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<tbody>
<tr>
<td>Number of Mothers</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>7</td>
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Furthermore, the authors reported that women’s awareness of the impact of structural problems such as oppression, prejudice and discrimination can enhance their ability to feel empowered and accepting of their mental health disorders. The findings of Mizock and Russinova (2015) resonate throughout the current study of poor women of color experiencing mental health problems.

What was discovered in the study’s analysis of 16 mothers is that acknowledgment is not a constant variable in which mothers indicate that they do or do not acknowledge their mental health problems. In fact, acknowledgment exists on a continuum. Acknowledgment is defined as the “act of admitting the existence or truth of something” (The Free Dictionary, 2014). Continuum refers to a connection across points; when applied to a mental health disorder, it suggests that the elements along the continuum may differ with regard to severity (Kaplan et al., 2006). See Figure 1 for a visual representation of the mothers’ continuum of acknowledgment.
This was the case with the mothers’ level of acknowledgment. Although the sample of mothers is split into two discrete categories as those who acknowledge their mental health problems ($n = 6$) versus those who do not ($n = 10$), two additional categories emerged from the data analysis. This included mothers who denied the presence of mental health problems but saw a therapist at some time in their lives ($n = 3$), and mothers who reported mental health symptoms such as suicidal thoughts and had interactions with a service provider, only to later deny their experience of those symptoms ($n = 5$). Finally, there were 2 mothers who clearly denied the presence of mental health problems. For the six mothers who did acknowledge, they reported a range of experiences that varied from the childhood onset of mental health problems, to a dual diagnosis of substance abuse and emotional difficulties to challenges that occurred in conjunction with their child welfare involvement.

![Figure 1. Continuum of Acknowledgment of Mental Health Problems.](image)

**Childhood Onset of Mental Health Problems**

All six of the mothers who acknowledged their mental health problems had been coping with mood instability, anxiety, depression and experiences of trauma since childhood.

[BM] reported that she had a happy childhood until her mother killed herself in front of [BM] and her brother when she was a child. She reported that she has been depressed at different times in her life and attributes this to her mother’s suicide. She reported that she made a suicide attempt by overdosing on medication when she was fifteen years old. She stated that she was hospitalized from the ages of 15-17 and that she was treated as an outpatient following her discharge. In addition to feeling depressed, she reported that she has euphoric
mood and decreased need for sleep in the past for months at a time. She stated that she has been treated in the past with the mood stabilizer Lithium, the antidepressants Prozac and Zoloft, the antipsychotic Risperdal, and the sedative Ambien. (Mother 6257-12)

During her youth, [BM] was psychiatrically hospitalized at Holliswood Hospital due to a history of self-harm, namely she used to bang her head and punch herself. She reported, ‘I used to do that because I was always angry, but didn’t know why I was angry.’ When she was released, she was prescribed a medication regimen of Depakote, but she only took the medication until her prescription ran out. She only received one session of outpatient psychotherapy after her discharge from the hospital. (Mother 4732-25)

As a child, she reports that she used to see a social worker for counseling in school for ‘being shy and crying all the time’ but was coached by her mother before the sessions on what to say or not say. The client reports that she has a previous psychiatric history [as] an outpatient and inpatient in 1998 secondary to a suicide attempt via ingest of pills. The mother has disclosed her mental health history and has admitted to being previously diagnosed with bipolar disorder. (Mother 1418-14)

She did report that she was in counseling for anger management at the age of 13. [BM] reported that she has a history of panic attacks. [In the context of a domestic violence relationship with her older daughter’s father], she was hospitalized twice, and often experienced panic attacks due to the violence. (Mother 3884-92)

In addition, five of the six mothers abused substances during childhood or throughout their lives.

Per drug usage, the client states she began using cannabis and alcohol during the ages of 13 and 14. She began using cocaine at age 15 and used LSD during her teenage years only, and denied using cocaine since her early 20s. She last used PCP April 7, 2009 during the incident involving the present case and only used it with her boyfriend. The client also states that she last used cannabis 2 days ago and had ‘a few shots’ of hard liquor on Labor Day, September 7, 2009. The client affirms that cannabis is her drug of choice and she smokes it daily. The client also admitted that she used cannabis during her pregnancy. (Mother 1418-14)

[BM] reported that she has a past history of cocaine dependence. She stated that she used to ‘fight in the street’ while under the influence of cocaine and that she spent one year in an inpatient rehabilitation facility in 2000. She reported that she has been sober for nine years. She is not in any substance abuse groups but stated that church is her source of support. (Mother 6257-12)
She started smoking marijuana at 14 and smoked 4-5 times per day. She stopped now when they were removed and has been sober eight months.  
(Mother 9333-27)

At age thirteen she began to abuse marijuana after she was raped. She also abused ecstasy and alcohol for one year. She discontinued all substance use [at] age fourteen due to a bad experience with marijuana.  
(Mother 4732-25)

**Exacerbation of Symptoms Due to Foster Care Placement**

Five out of six of the mothers reported that their symptoms and overall functioning further deteriorated in the context of children’s removal from their homes into foster care placements.

She stated that she is very emotional now and often cries. [BM] constantly thinks about her children and dreams about them daily. [BM] reported that she is depressed. She stated that she feels sad all of the time. She cries frequently, sleeps too much, and does not eat well. When feeling depressed, [BM] tries to distract her mind by spending time with her best friend. She stated that she worries a lot about her daughters and whether they are being well cared for by their foster parents.  
(Mother 3884-92)

As a child, her mother took her to see a psychiatrist ‘when I was young’ and she was prescribed an unrecalled medication at that time. She said that there have been different episodes in which she did not sleep for several days and first occurred when she was in her twenties. During these episodes, she experienced racing thoughts and spoke at a rapid rate, and observed that ‘people said I did not know what I was talking about.’ She believed that she could read the thoughts of other people. [BM] also described symptoms of depression, the other half of Bipolar Disorder. She said that she currently feels overwhelmed, under pressure and depressed. She complains that her appetite, energy level, concentration and sleep patterns are poor.  
(Mother 1612-65)

The client states that she has experienced some bad dreams, replaying of things from her troublesome past, and complains that her mind is always running. She also drifts off while people are talking. As per her mood, she says that cannabis keeps her calm and mellow, otherwise, she is moody, irritable and sad. She says that she cries a lot due to anger and can be explosive and threaten people verbally, and has also been known to break things.  
(Mother 1418-14)
Engagement in Treatment Despite Denial of Mental Health Problems

Of the 10 mothers who did not acknowledge their mental health problems, three of them participated in clinical services. For one mother who exhibited cognitive difficulties, it may be inferred that she sought out help in the aftermath of surrendering custody of her children. Despite her denial of symptoms, the evaluator does not appear to be convinced of the mother’s stability and overall wellness.

[BM] reported that she saw a therapist in the Bronx after giving her kids to ACS custody. The [foster care agency] report states that she stopped seeing that therapist after moving to New Jersey. [BM] denied symptoms of depression or other psychiatric disorders. However, there were some indications during the interview of psychiatric difficulty. She had some difficulty at times giving a coherent history, but was able to do so with redirection. In addition, her range of emotional expression was flat. Both symptoms may be due to sequelae of her brain injury as a child, but can also be seen in depression. In [BM’s] case, it is likely a combination of both. (Mother 2137-12)

For the two other mothers, they reported being brought to therapy as children due to the concerns of their caregivers.

She denied any history of psychiatric problems. She was sent for counseling by her adoptive mother when she was 12. She stated that the therapy ‘helped a little,’ and she went for a couple of years. She did not receive treatment with medications, although she reported having been diagnosed with depression. She was hospitalized at age 16 at Elmhurst hospital after running away and not ‘talking to anyone.’ She reported that ‘they tried to give me medications, but I didn’t think there was nothing wrong with me and didn’t take the medications.’ She was prescribed Abilify but was non-compliant taking it or following up as an outpatient. She denied history of suicide attempts. [BM] also reported a history of multiple rapes and she claims that she never received support services related to these assaults. (Mother 3279-09)

She has seen a therapist in her pediatrician’s office many years ago because her grandmother wanted her to talk to someone. She is not currently receiving outpatient psychiatric treatment. She denies current or prior symptoms of depression, mania, anxiety, and psychosis. She has never been treated with psychotropic medication before. She has no history of suicidal or self-injurious thoughts or behaviors. (Mother 8881-03)
Mental Health Symptoms Reported and Later Recanted

Although they did not identify themselves as having mental health problems, half of the mothers who did not acknowledge reported symptoms of anxiety and depression. Two of them had been assessed in a psychiatric emergency room after reporting suicidal thoughts. Both mothers concluded that their crises had been externally triggered by environmental stressors rather than mental illness.

She was once in the psychiatric emergency room for alleged suicidal ideation, when she was in the ‘program.’ She was going through ‘changes’ and rethought things after a few hours. [BM] said she would like therapy, but is unwilling to go. She feels it’s too much bother to commit to being at particular places at particular times. She does not like making commitments; she’s ‘not good at it.’ She feels it makes her look bad to commit and not go—so she’d rather not commit. (Mother 0132-25)

However, she reports that she was taken to the psychiatric ER on one occasion last year after she told police that she would ‘kill’ herself in the context of their intervention in a domestic violence dispute with [her paramour at the time]. As per the police taking her to a psychiatric ER last year after she threatened to kill herself, she said that she ‘did not mean it’ and only said it because she was angry and overwhelmed. She says that she was discharged quickly from the ER after assuring them that she had no intention of hurting herself. (Mother 4135-62)

For two ambivalent mothers who initially did not acknowledge their psychiatric problems, both eventually disclosed depressive symptoms over the course of their assessments.

However, she reports that she is never depressed although she felt suicidal about three years ago due to discord with her birth father whom she is only in touch with if she needs money. She described her suicidal feelings as just a thought, not an overt action or plan. (Mother 7717-37)

[BM]’s sister reports that she has a history of psychiatric issues, though she denies it along with any history of psychological/psychiatric treatment. As well, she denied any history of self injurious behavior or eating disorders. The client was not receptive to mental health services. Her only concern and wish is for stable housing and income. The client denies depression, suicidal ideation or gestures. However, she states that she may be a little in denial regarding feelings of depression related to missing her daughter, and if she is depressed she will eat. She admits to having small bouts of sleep disturbance. (Mother 5336-55)
Guarded Presentation during Assessment

Clinicians raised concerns for the final two mothers who did not acknowledge their mental health problems during their assessments. The mothers’ guarded presentations led evaluators to suspect underlying difficulties.

There is no history of substance use, domestic violence, or mental health treatment for [BM]. She seemed guarded but was fairly pleasant and was superficially cooperative and was somewhat oddly related. [BM] evidences limited insight into her own psychological functioning and that of others. She tends to externalize blame onto others or circumstances and takes limited responsibility for her own actions. She presented as somewhat guarded and seemingly indifferent to the process, denying/minimizing the agency’s concern. Although she denied drug use, and there was no obvious signs of drug use in her, it is important to rule out the drug use in mother as the reason for neglect and her poor judgment. (Mother 2700-42)

She denies a psychiatric history of treatment, hospitalization or psychotropic drug prescriptions. The agency is concerned that [BM] appeared depressed especially right after the case was received. Her affect was of limited range, intense and irritable. Due to reticence with giving information (on the advice of her lawyer, she claims) the client was not fully comprehensible due to poor content. Her verbal style was therefore evasive and global as well as abrasive. (Mother 3114-99)

See Table 4 for a summary of mothers’ acknowledgment and associated concerns.

For the mothers in this investigation, acknowledgment of mental health problems is intertwined with ambivalence. Ambivalence refers to the phenomenon of having multiple and divergent feelings about people, objects or ideas (Stehn & Wilson, 2012). This is clearly indicated for the eight out of ten women who initially did not acknowledge the presence of mental health problems. In the course of their assessments, they revealed their experiences of depression, anxiety and other stressors whether they identified those feelings, or the concerns were recognized by someone else. Typically, they attributed symptoms to their environmental circumstances and experiences of crisis.
For the mothers who clearly did not acknowledge mental health problems, another perspective is considered. With Mother 3114-99, the clinician documents that she is guarded with regard to sharing information and that she “claims” it is “on the advice of her lawyer.” In considering the gravity of the situation, however, what would make this statement so outlandish?

Table 4

<table>
<thead>
<tr>
<th>Level of Acknowledgment Subgroups</th>
<th>Childhood Onset of Mental Illness Subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Full Acknowledgment</td>
</tr>
<tr>
<td></td>
<td>Childhood Onset of Mental Illness</td>
</tr>
<tr>
<td></td>
<td>Substance Abusers ($n = 5$)</td>
</tr>
<tr>
<td></td>
<td>Exacerbation of symptoms due to</td>
</tr>
<tr>
<td></td>
<td>Foster care placement ($n = 5$)</td>
</tr>
<tr>
<td>3</td>
<td>Saw therapist, did not acknowledge</td>
</tr>
<tr>
<td></td>
<td>Brought to therapy as children ($n = 2$)</td>
</tr>
<tr>
<td>5</td>
<td>Initially reported symptoms, later recanted</td>
</tr>
<tr>
<td></td>
<td>Assessed in emergency room for suicidal</td>
</tr>
<tr>
<td></td>
<td>thoughts ($n = 2$)</td>
</tr>
<tr>
<td></td>
<td>Initial report of depression ($n = 2$)</td>
</tr>
<tr>
<td>2</td>
<td>Fully Denied</td>
</tr>
<tr>
<td></td>
<td>Guarded Presentation</td>
</tr>
</tbody>
</table>

This woman may justifiably be devastated with the custody loss of her children, but at the same time she is being advised by an attorney and considering how to present herself appropriately to reunify with her children. As stated above, however, the mother’s silence regarding her emotional struggles led the evaluators to perceive her behavior as noncompliance and further evidence of mental health problems. It is not the assessor’s purpose to work with the client’s resistance, to accept where she is in her process and to patiently work with her until she achieves her treatment goals (Stehn & Wilson, 2012). As stated in the beginning of the chapter,
the referral questions are clearly stated for the foster care agency to attain an understanding of the mothers’ emotional functioning, mental health status and capacity to care for their children. In the next section, there will be further exploration regarding the relationship between mothers’ acknowledgment of their mental health problems and whether and how that affects children’s permanency outcomes.

**Permanency Continuum**

Similar to the aforementioned discussion of the continuum of acknowledgment, the data indicated that children’s permanency outcomes also exist on a continuum ranging from family reunification to adoption with non-relatives. See Figure 2 for a visual representation of the children’s permanency continuum. Since the majority of the mothers still had children in foster care \( (n = 12) \) at the close of data gathering, the continuum is best illustrated with the children’s permanency planning goals. Results illustrated only slight differences between mothers who had acknowledged their mental health problems versus those who did not.

![Permanency Continuum](image.png)

**Figure 2. Permanency Continuum.**

**Family Reunification**

Family reunification was the most likely outcome to occur for mothers who did acknowledge their mental health problems \( (n = 3) \) and the second most likely outcome for those who did not \( (n = 3) \). For those six mothers, however, the manner of family reunification varied
significantly. Only two of the mothers who did not acknowledge their mental health problems had all of their children returned to their care.

[The children] are final discharged from foster care to bio-mother. Effective date is 9/10/10. The team determined that there are no safety factors and deemed safe and appropriate for final discharge. Action Steps: BM, continue with counseling at [service provider] as soon as Medicaid is active. Family will continue to receive preventive services. RM (respondent mother) makes admission to all allegations in petition. Court enters a finding of neglect as to all allegations based on witness testimony. Neglect finding for both RM and RMGM.  
(Mother 2700-42)

The child [daughter] is trial discharged to the mother. [She] appears comfortable and happy with her mother. [She] interacts appropriately with her mother and appears to have proper attachment levels with her mother and sibling even though she appears to request a lot of attention and affection from her mother at times. RM makes 1051; a submission finding of neglect is entered. Release of [son] to RM to comply with: 1) anger management; 2) attend individual counseling and group counseling; 3) no corporal punishment. (Mother 3114-99)

What can be gleaned from both excerpts are several important factors that appear to be critical to family reunification: 1) the mothers’ admission of neglect and taking responsibility for maltreating their children; 2) ongoing monitoring via preventive services and trial discharge in which the foster care agency continues to follow-up with the family; 3) the expectation that the mothers will continue to attend mental health services.

For the last mother who experienced family reunification and did not acknowledge mental health problems, she was able to regain custody of her youngest daughter approximately two weeks after she gave birth due to the progress she had been making toward completing her service plan to reunify with her three older children who remained in foster care with permanency goal of return to parent.

On 11/30/10 the child was placed in non-kinship foster care on a remand status with foster care agency. On 12/16/10, the judge paroled the child to the respondent mother at the conclusion of the 1028 hearing. A finding of neglect was made. The current goal is return to parent. The agency has begun unsupervised visitation and will continue to expand as needed. Birth mother has
come a long way in terms of the supervision of her children, at this time birth
mother has been able to attend visits and be more interactive with her children.
Birth mother has been compliant in terms of completing her service plan, she has
been attending anger management and has completed parenting classes at the
single resource center. Birth mother is also visiting consistently with her children
on a weekly basis. (Mother 3279-09)

Results are similar for the mothers who did acknowledge their mental health problems. Two of
the mothers had all of their children returned to their care.

RM and BF make admission. Finding of Neglect. The children have been
returned to the care of their mother with 12 months supervision, mother has
agreed to random drug testing in which she tests negative, to continue with her
mental health services and all other referrals made by ACS, she will allow ACS
into her home for supervision with her daughter attending counseling. Mother
stated that she is receiving [mental health] services twice a week. Mother stated
that she gets counseling, therapy and medication management as well. Mother
stated that sees a psychiatrist and psychologist. Mother stated that she also takes
the medication Trazedone for depression. (Mother 1418-14)

Respondent mother made an admission to the neglect petition. A finding of
neglect was entered against the respondent mother in regards to [the] child. The
respondent mother did inflict the injuries to [the child] causing serious physical
harm to her. The birth mother was approved for a final discharge. The case
planner explained that she could not conduct the final discharge until daycare was
put in place and the birth mother was able to locate housing. The judge stated that
once the services were put in place a final discharge could be conducted. [BM]
would continue to receive supportive services from foster care, ACS and GEMS.
(Mother 4732-25)

The aforementioned components critical to family reunification are exemplified with these
mothers that have acknowledged mental health problems, specifically with regard to the
mothers’ admission of maltreatment, ongoing monitoring and support services.

For the remaining mother who both acknowledged her mental health problems and
reunified with her children, she had three of her five children home on trial discharge by the end
of the data collection period. Her circumstances were complicated by the fact that three of her
children were teenagers who experienced their own ambivalence in going home after years spent
in foster care.
The children have been on trial discharge in the home since 10/2010. BM is providing adequate supervision to the youth in her home. BM stated that she continues to have difficulties with [her oldest son]’s behaviors in the home. She stated that youth continues to be blatantly disrespectful and rude to her. [BM’s 16-year-old son] was removed from his mother’s home after a failed trial discharge and returned to his previous foster home. BM reported that her son allegedly choked her after getting into an argument. She was asking for youth’s immediate removal as she felt his continued presence in the home would put her younger children in harm. During the transfer to the foster home, youth mentioned that he had already envisioned that he would return to care. He stated that he never really wanted to return home in the first place and only did so because he thought it would have prevented his younger siblings from returning home. (Mother 9333-27)

In addition, this mother had a 14-year-old daughter who was unable to return home due to her own emotional and behavioral problems that required hospitalization and residential treatment programs. At the close of the data gathering period, this mother was still very much on the agency’s radar.

Until BM fully participates in her after services and children’s therapy, the agency cannot move forward with a final discharge. (Mother 9333-27)

**Goal Remaining Return to Parent**

Another outcome along the permanency continuum was families where the permanency goal remained return to parent, despite the children being in care longer than the 15 of the last 22 months standard purported by the ASFA law. For two mothers who acknowledged their mental health problems, it appeared that the foster care agency had confidence in their abilities to complete their service plans.

A permenancy hearing and fact finding was held. BM made an admission and a finding of neglect was made. BM admitted to abusing alcohol during her pregnancy but the child did not come out positive. The current foster mother stated that should it come to an alternative plan, she would not mind planning with the agency. Birth mother stated that she does not wish for the case to come to adoption as she will do all she can to reunite with her son. Birth parent insists on planning for son and is not contemplating a surrender at the moment. (Mother 1612-65)
When BM was asked what the progress was with obtaining her parenting skills certificate that she claimed she completed, BM stated that she was unable to obtain it because the program has it in storage. Supervisor informed BM that she has been referred for a new parenting skills class that is scheduled to begin on February 3, 2011. BM stated that supervisor was not giving her a chance to breathe and was starting her right away with classes. Supervisor explained that it is time BM starts to feel the sense of urgency explaining to her that her children have been in foster care for two years and it’s time that she really start focusing on their permanency and getting them out of the system. (Mother 6257-12)

As stated in Chapter 1, mandatory termination of parental rights (TPR) proceedings can be prevented in exceptional circumstances such as the mothers not being provided with sufficient resources to complete their service plans (Green, Rockhill, & Furrer, 2006). For mother 1612-65, a relapse of alcohol use as well as the young age of the child (1 ½) caused the foster care agency to be cautious in discharging the child back to her care. In a February 2011 note, the foster care worker noted, “Birth mother has remained compliant with service plan and has been sober since September.” In the second example, the supervisor is endeavoring to inspire a ‘sense of urgency’ for the mother to complete her service plan, specifically her parenting class.

**Concurrent Planning**

For four of the mothers (3 who did not acknowledge and 1 who did), the foster care agency utilized concurrent planning in the permanency decision making process. Concurrent planning is an approach in which multiple permanency goals, such as reunification and adoption, are considered simultaneously (D’Andrade, 2009).

The planned permanency goal is currently return to parent, however the courts have ordered the agency to also plan for an adoption in case the birth mother fails to complete her service plan by December of 2010. [FM] has been identified as an adoptive resource for the children in the event that they are unable to return home. The BM is planning for the return of the children. However, she is constantly in and out of services because her Medicaid case has been closed and reopened so many times. This has caused delays in achieving the PPG of return to parent. (Mother 3884-92, did acknowledge)
A goal change conference was held for this case as a result of BM’s failure to plan. BM and foster parents shared their concerns about the goal change at this time they are in disagreement with the goal change to adoption. Supervisor explained that in the last court hearing the judge ordered a concurrent plan of adoption due to BM’s failure to plan for the return of her children. The agency shared/expressed concerns regarding permanency as BM continues to test positive for marijuana. BM’s physical safety was also addressed as she was recently assaulted by the children’s father, resulting in a missed court appearance. BM’s safety and well-being is directly related to the children’s safety and well-being and therefore must be addressed before she can be considered as a discharge resource. (Mother 4135-62, did not acknowledge)

Currently the goal is return to parent with a concurrent plan to place with fit and willing relative. On the above date a discharge conference was held for the above case. The case was placed directly with ACS supervision. MGGM continues to care for [child] and is waiting on custody petition. The agency expressed concerns regarding the biological mother’s failure to comply with her service plan. The agency also expressed concerns regarding the biological mother failure to visit with her child. (Mother 8881-03, did not acknowledge)

Currently there are some concerns as [BM] is not showing any motivation to work towards reunification with her children. [BM] informed the case worker that she was not interested in surrendering her parent rights. [BM] informed the case worker that she will plan for her daughter. The team came to a consensus that the goal for [the children] will be changed from the primary goal of Return to Mother (01) to Adoption (04) with a concurrent/back-up plan of Return to Mother. (Mother 7717-37, did not acknowledge)

Although each mother faces unique challenges in regaining custody of her children, they all struggle in completing their service plans. For mother 3884-92, she is clearly “planning for the return of the children,” but “she is constantly in and out services.” As discussed in Chapter 5, consistent maintenance of medical coverage is a common obstacle to the mothers’ completion of their foster care service plans. Furthermore, mother 4135-62 continued to abuse marijuana and engage in a domestic violence relationship, problems that endangered the mother and her children. In addition to concerns regarding service plan compliance, the foster care agency expressed concerns regarding visitation for mother 8881-03. In the last excerpt, the worker emphasized the mother’s lack of “any motivation to work towards reunification.” Concurrent
planning was court mandated due to their children’s extended length of stay in care versus the mothers’ progress toward addressing risk factors that precipitated placement. In contrast to the mothers whose permanency goals remained returned to parent, these three mothers have clearly not earned the confidence of the agency that they will make changes in a timely manner.

**Adoption**

The most common permanency outcome for mothers who did not acknowledge mental health problems was adoption \( n = 4 \). Within the category of adoption, each family is at a different phase of the adoption process. The common theme, however, is that the foster care agency had petitioned the court for the mothers’ termination of parental rights (TPR), and the focus had shifted from the mother’s completion of her service plan to the children’s permanent placement with kinship or non-kinship caregivers.

Two of the mothers withdrew from services once they learned that the permanency goal had been changed to adoption, and a TPR petition had been filed.

BM still denies that she need[s] to plan for the return of her children according to her service plan and to why her children were placed in care. BM said that she will not enter drug treatment and said that she would fight to have the children back somehow. Because of BM’s noncompliance with her service plan, the agency will proceed with a goal change to adoption and termination of BM’s rights to have [the] children. The current FM has been identified by the agency as the pre-adoptive resource. (Mother 1002-88)

RM arrived at the agency this morning with a black suitcase. She stated that it contained toys for her children. She requested that the toys be given to the kids because she was leaving and not returning. She stated that she is tired of all this and that she is leaving. She stated that [FM] can just adopt the children because she is done and leaving and not coming back. RM signed a notarized letter stating that she no longer wishes to plan for her children and left the agency. (Mother 2137-12)
Another mother who had intermittently engaged in her services tragically died while her children were in foster care. Also, the children’s fathers were not able to care for them, causing them to be freed for adoption.

BM passed away due to medical complications. The goal of adoption is approved for both children. At this point, [BF] has played an inconsistent role in the child’s life and his parental rights were terminated. [The son] has been freed for adoption. [The daughter] is officially freed for adoption. (Mother 0132-25)

Severe mental health problems and aggressive behavior proved to be contributing factors to another mother’s loss of parental rights and her daughter’s adoption by out-of-state relatives.

FM stated that recently BM had taken to calling her home and making physical threats. She stated that BM would call everyday and threaten to ‘come down to Virginia and cut everyone’s heads off.’ FM stated that she was very scared for herself, [the mother’s daughter] and her own children. She stated that BM was calling on a daily basis and beginning to cause a disruption in her life. CW advised FM to file police reports to record these threats. CW also told FM to consider filing an order of protection for herself. TPR already filed. Goal for adoption approved. Reasonable efforts found. Mental health provided and it does not recommend return to parent based on BM’s behavior/diagnosis. Agency to continue to make efforts towards goal of adoption. (Mother 5336-55)

The relationship between mother’s acknowledgment of mental health problems and children’s permanency outcomes is complex and multifaceted. As discussed above, the concepts of acknowledgment and permanency lie on a continuum with various points of demarcation. Although the analysis yields clear examples of mothers who recognize their emotional challenges, the category of mothers who do not acknowledge their mental health problems is complicated by the fact that several of them engaged in mental health services \((n = 3)\), and half of the group \((n = 5)\) reported symptoms of distress, only to recant them at a later time. It is important to consider how the mothers construct their own perspective of mental illness and engagement in clinical services. As indicated by the mothers who utilized the psychiatric emergency room, mental health problems are episodic and arise in a time of crisis. Others
appeared to normalize their stressors in the context of environmental circumstances such as poverty, homelessness and losing custody of their children. See Table 5 for further detail on the study’s subgroups of acknowledgment and permanency outcomes.

In Chapter 7 there will be further exploration regarding other elements that affect the permanency decision making process for mothers that have been referred for mental health evaluations. This will include discussion of the mothers’ mental health diagnoses, cognitive functioning and parenting qualities on an individual level, children’s feelings and maltreatment type on a family level and case factors such as type of placement and quality and quantity of visitation.

Table 5

Acknowledgment and Permanency Outcomes

<table>
<thead>
<tr>
<th>Number of Mothers</th>
<th>Acknowledgment</th>
<th>Permanency Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Yes</td>
<td>Reunification</td>
</tr>
<tr>
<td>3</td>
<td>No</td>
<td>Reunification</td>
</tr>
<tr>
<td>2</td>
<td>Yes</td>
<td>Goal Remaining Return to Parent</td>
</tr>
<tr>
<td>3</td>
<td>No</td>
<td>Concurrent Planning</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
<td>Concurrent Planning</td>
</tr>
</tbody>
</table>
CHAPTER 7: MOTHERS’ MENTAL HEALTH SYMPTOMS, PARENTING SKILLS AND OTHER FACTORS AFFECTING CHILDREN’S PERMANENCY OUTCOMES

Eradicating children’s exposure to continuing maltreatment is the fundamental objective of permanency planning. To that end, each case record assembles information from various sources to determine the mothers’ progress toward family reunification. In addition to discussion regarding the impact of the mothers’ specific mental health diagnoses, the following chapter will explore factors at the individual, family and case level that affect permanency outcomes for mothers that have been referred for mental health evaluations.

Mental Health Diagnosis

In addition to gathering the mothers’ self-report of their symptoms and history, the evaluators utilized a variety of assessment tools to diagnose the mothers’ mental health disorders. Every mother in the sample \((n = 16)\) completed the Wechsler Abbreviated Scale of Intelligence (WASI), a brief assessment of general intelligence focusing on verbal and reasoning abilities (Canivez, Konold, Collins, & Wilson, 2009). The clinicians administered the Thematic Apperception Test (TAT) to nearly every mother in the study \((n = 15)\). The TAT is a projective assessment method in which individuals are asked to construct narratives based on picture cards; the narratives are meant to reveal the individual’s psychic functioning and defense mechanisms (Verdon et al., 2014). The Draw-A-Person Test was administered to more than half of the mothers \((n = 9)\), and three mothers were asked to make figure drawings. Both are projective assessments in which individuals are asked to draw themselves according to their perceptions (Handelzalts & Ben-Artzy-Cohen, 2014). One mother was assessed via the Rorschach Inkblot Test, another projective assessment method in which a set of 10 inkblots of various shapes are presented to assess an individual’s level of psychopathology in areas such as depression, coping
strategies and hypervigilance (Mihura et al., 2013). Seven of the mothers completed the Parent-Child Relationship Scale that assesses the mothers’ relationships with their children, and three of the mothers were asked the 3 Wishes question. That is, the evaluators inquired as to what the mothers would wish for given the option to wish for anything at all.

As stated in Chapter 4, the DSM-IV-TR provides the nomenclature and classification system for the determination of mental health disorders in the United States (APA, 2000). For the mothers in the current investigation, each assessment conducted aims to substantiate the concerns of the foster care agency. Five axes or categories comprise the DSM-IV-TR (APA, 2000) diagnostic method. Axis I includes clinical disorders that are typically the primary reason for referral. Axis II refers to more enduring and chronic problems such as mental retardation and personality disorders. The third axis is for listing physical ailments such as diabetes or high blood pressure. Axis IV denotes psychosocial/environmental stressors as discussed in Chapter 5. The fifth and final axis is the global assessment of functioning or (GAF) score which assigns a numerical value from 0 to 100 to describe the impact of mental illness on an individual’s life, specifically with regard to mental health symptoms and difficulty in school, occupational or social functioning (Zalaquett, Fuerth, Stein, Ivey, & Ivey, 2008).

**Axis I: Clinical Disorders**

What emerged from the analysis was that the majority of the mothers (n = 13) were diagnosed with an Axis I mental health disorder. That included all six of the mothers who acknowledged their mental health problems and seven of the mothers who did not acknowledge. For the three mothers who did not receive an Axis I diagnosis, two of the mothers were assigned rule-out diagnoses. The Rule-out (R/O) code is utilized when clinicians assess that a client exhibits signs of a disorder without meeting all of the diagnostic criteria. The R/O code is a
recommendation for a future evaluator to consider that diagnosis upon receipt of further information (Rudlin, 2015).

A wide variety of Axis I diagnoses were represented among the mothers in this study. Two of the mothers who acknowledged were diagnosed with bipolar disorder. Individuals with bipolar disorder experience alternating episodes of depression and manic episodes. Mania typically occurs over a week or longer and involves persistently elevated or irritable mood, rapid speech, reduced need for sleep and increased engagement in pleasurable activities with negative consequences such as sexual promiscuity or excessive shopping (APA, 2000).

She has a history of exhibiting poor judgment and she has a history of affective struggles that have impacted how she parents her children. She reports struggling with depression and many symptoms indicative of manic episodes. Her affective lability appears to significantly impact her ability to care for her children and needs to be addressed by mental health professionals. (Mother 6257-12)

She reported that in the past she had experienced euphoric mood for months at a time, which coincided with a markedly decreased need for sleep, but denied having those symptoms currently. (Mother 1612-65)

Two other mothers received a diagnosis of posttraumatic stress disorder (PTSD), a mental health condition triggered by severe trauma and characterized by flashbacks, nightmares, avoidance of stimuli related to the trauma, irritability and an amplified startle response (APA, 2000). One mother admitted to self-medicating with marijuana to manage her symptoms, while the other reacted to past trauma with anger and irritability.

Regarding her psychiatric history, the client states that she has experienced some bad dreams, replaying of things from her troublesome past, and complains that her mind is always running. She also drifts off while people are talking. As per her mood, she says that cannabis keeps her calm and mellow, otherwise, she is moody, irritable and sad. She said that her mood fluctuates and is not related to external events but internal thoughts. (Mother 1418-14)

On a good day, her mood is outgoing, but on a bad day she is withdrawn. Her mood is very variable. She gets frustrated easily and has a bad temper. She no longer thinks about her past abuse so much and used to hate her mother and
avoided the family because mom got her sisters back, but never got her back (she was in her late teens by then). (Mother 9333-27)

Another mother who acknowledged her mental health problems was diagnosed with both major depressive disorder and panic disorder without agoraphobia. Major depressive episodes are characterized by a continuous state of sadness occurring over a 2-week period. Accompanying symptoms include significant changes in appetite, poor sleep or sleeping too much, persistent suicidal thoughts, fatigue, feeling worthless and difficulty concentrating. Panic disorder is illustrated by ongoing panic attacks which include chest pains, sweating and heart palpitations. Agoraphobia involves one’s fear of being somewhere from which it would be difficult to leave or obtain help such as traveling by bus or train and being in a crowd (APA, 2000).

Now I am depressed because my daughter was taken away from me. I just don’t eat and don’t want to go nowhere. I am feeling sad. For three months before my daughter got taken away from me, I used to get mad and cry for no reason. I used to sleep a lot and felt really depressed. Additionally, [BM] reports symptoms of anxiety, including panic attacks. She describes her anxiety as discrete episodes during which she experiences weak legs, palpitations, blurry vision, and ‘feeling like something is going to happen to me.’ (Mother 4732-25)

The final mother who reported emotional distress was diagnosed with adjustment disorder with mixed anxiety and depressed mood. What differentiates adjustment disorders from other types of mental health disorders is that the symptoms develop within 3 months of exposure to an environmental stressor, and the symptoms are expected to dissipate within 6 months (APA, 2000). This mother’s predominant symptom presentation involved anxiety and depressed mood in response to having her daughters removed from her custody.

[BM] is able to acknowledge her feelings, yet she does not have healthy outlet to express them. [BM] reports that she currently does not get angry. However, she does feel angry that she does not have her daughters. [BM] stated that if she feels angry now, she just cries. She replays the incident (leaving children alone) in her head. She could not sleep in her own room for awhile. (Mother 3884-92)
As stated in Chapter 6, five out of six of the mothers who acknowledged their mental illness were also substance abusers at some point in their lives, and their drug use was indicated on their Axis I diagnosis. Substance use disorders included cocaine dependence, in full sustained remission, cannabis dependence with physiological dependence, alcohol abuse, cocaine abuse, phencyclidine (PCP) abuse in remission and alcohol dependence, in early full remission. For the purposes of sampling, three out of six of the mothers who acknowledged their mental health problems were not classified as substance abusers since they either reported no substance use or had maintained sobriety for 5 years or more.

Axis I disorders were less prevalent among the group of mothers who did not acknowledge their mental health problems. More than half of the group (n = 7) met criteria for an Axis I diagnosis. Two mothers were diagnosed with adjustment disorders, either with depressed mood or not otherwise specified, which means that the individual’s maladaptive responses to the environmental stressors did not fit into one of the existing subtypes such as depressed mood and anxiety (APA, 2000).Clinicians suspected that these two mothers were minimizing emotional distress as evidenced by their concern regarding ‘underlying’ symptoms.

Despite her assertion that she was ‘always happy,’ responses suggest underlying depression and anxiety reflecting her current circumstances and past history of separations, sexual abuse, foster care placements, and domestic violence relationships. (Mother 7717-37)

Per our examination, the client presented as defiant, irritable and hostilely guarded. The client may have hidden impulse control issues related to her anger problems. Due to limited information provided by her, it was difficult to assess her thought process comprehensively. (Mother 3114-99)

Mother 3114-99 was additionally diagnosed with parent-child relational problem. According to the APA (2000), this diagnosis refers to an impaired pattern of parent-child interaction as
evidenced by poor communication, ineffectual discipline and overprotectiveness that results in diminished individual or family functioning or significant symptomatology in mother or child. Another mother was diagnosed with major depressive disorder, despite her self-report of not experiencing any psychiatric problems. From the aforementioned discussion of the symptoms of major depressive episodes, however, this mother would appear to meet the diagnostic criteria.

She is in denial regarding her mental health struggles and does not believe that she needs mental health services. However, her unstable history suggests otherwise. She reported that she feels stressed, but denied feeling sad or depressed. She has some difficulties falling asleep and staying asleep. She reported having difficulty trusting people. She isolates a lot, and feels alone. Her appetite is ‘on and off. I don’t eat as much as I did before.’ She denied feeling hopeless, helpless or worthless. She enjoys doing things, but has stopped doing things she used to enjoy doing like going out to eat, movies, and the park.

(Mother 3279-09)

Symptoms of psychosis were detected in another mother who did not acknowledge her mental health problems. The clinical evaluators assigned her the diagnosis of psychotic disorder nos meaning that they recognized psychotic symptoms such as delusional thinking, disorganized behavior and flat affect but that there was not enough information for a definitive diagnosis (APA, 2000).

The clinical portrait, in summary, is suggestive of a thought disorder with features of paranoia and grandiosity. There is also evidence of mood disorder characterized by being overly cheerful in the face of serious circumstances. Her report that she ‘rarely sleeps’ (four to six hours) and at other times sleeps more than ten hours, particularly if sleep deprived, speaks overtly to the symptoms of active mood dysregulation by way of alternate depression activation.

(Mother 5336-55)

Claustrophobia, a specific fear of small spaces, affected another mother who both struggled with cocaine abuse and did not acknowledge her mental health problems.

She is frightened of elevators, subways, and the like because she ‘needs air.’ She never rides elevators and always takes stairs, which is at times problematic.

(Mother 1002-88)
For the remaining five mothers who did not acknowledge, one had no Axis I diagnosis, and two mothers had a primary diagnosis of substance abuse, including marijuana, cocaine and alcohol. Two mothers had rule-out (R/O) diagnoses; one was a R/O diagnosis of alcohol and cannabis abuse and the other a R/O diagnosis of major depressive disorder. As stated above, a R/O code is utilized when the evaluator assesses that a client presents with some aspects of a disorder without meeting all of the criteria (Rudlin, 2015).

With regard to permanency outcomes, results are mixed with regard to the Axis I diagnoses of the mothers who experienced some level of reunification. For the three mothers who acknowledged their mental health problems and reunified with their children, there were two mothers diagnosed with PTSD and concurrent substance abuse and one diagnosed with major depressive disorder and panic disorder without agoraphobia. For the three mothers who did not acknowledge and reunified, there was one mother diagnosed with adjustment disorder, another with major depressive disorder and the last with no Axis I diagnosis.

The two mothers who acknowledged and had permanency goals that remained return to parent were diagnosed with bipolar disorder and substance abuse either current or past. Concurrent planning was utilized for three mothers who did not acknowledge and were diagnosed with cannabis abuse, adjustment disorder with depressed mood and R/O diagnoses of cannabis and alcohol abuse. Adjustment disorder with depressed mood and anxiety was the diagnosis for the mother who did acknowledge and experienced concurrent permanency planning. Finally, the four remaining mothers who did not acknowledge and had permanency goals of adoption were diagnosed with cocaine abuse, claustrophobia, R/O diagnosis of mood disorder nos and psychotic disorder nos.
With the exception of the mother without a diagnosis, all of the mothers were either diagnosed with a severe mental illness or substance abuse problem \((n = 13)\), or exhibiting some symptoms for a R/O diagnosis \((n = 2)\). Therefore, it would appear from the results that an Axis I diagnosis alone does not dictate permanency outcomes, especially when considering that all but one of the mothers who reunified with their children had an Axis I diagnosis. The next section will explore the relationship between permanency outcomes and more enduring mental health and cognitive problems such as personality disorders and mental retardation.

**Axis II: Personality Disorders and Mental Retardation**

As stated above, Axis II diagnoses encompass more chronic and enduring problems such as mental retardation and personality disorders. Mental retardation is a condition that exists on a spectrum from mild to profound and is distinguished by an IQ that is 70 or below, the age of onset is before 18 years old, and there are concurrent challenges in functioning in at least two areas such as self-care, social skills and school or work functioning (APA, 2000). None of the mothers were diagnosed with mental retardation, but a number of them were diagnosed with a condition referred to as borderline intellectual functioning \((n = 5)\). That includes three mothers who acknowledged their mental health problems, and two who did not. Individuals with borderline intellectual functioning have an IQ range from 71-84 (APA, 2000), and they experience subsequent cognitive challenges as evidenced on their psychological evaluations. As can be seen from the excerpts below, borderline intellectual functioning did not automatically negate the mothers’ parenting skills.

[BM]’s verbal comprehension is in the low average range of intelligence. She has only an 11th grade education, thus her school based vocabulary is somewhat deficient. She is nevertheless, capable of expressing herself clearly and can converse with others with ease. [BM] appears to have adequate social and
interpersonal skills at this time. She appears to have the cognitive skills necessary to meet the basic demands of parenting. (Mother 6257-12)

Overall, [BM] presents with some cognitive deficits that will inevitably interfere with her ability to routinely meet the overall demands of parenting. However, she appears to have the ability to anticipate when she will need help and access services accordingly. As she currently presents, it appears that she has the ability to meet the basic demands of parenting as long as the proper support services are in place. (Mother 2137-12)

She seems to be emotionally volatile and somewhat cognitively limited but does love her children. (Mother 9333-27)

For the other mothers, however, borderline intellectual functioning coupled with the mothers’ mental health problems was a cause for concern.

[BM] presents with some cognitive limitations that suggest that she will struggle with caring adequately for her children. She does not appear to think about how her behavior impacts others and this warrants concern when considering her ability to parent. (Mother 3279-09)

Given that her attitude is resistive and somewhat cavalier, she will need some form of structure and limit setting in such a way that she is accountable for her actions, as much as she can be given her limited cognition, not to mention the ill effects of a multitude of life traumas. In that respect, the case should remain under supervision. (Mother 1612-65)

In considering permanency outcomes, only two of the mothers experienced reunification with their children. Both mothers, however, did not have all of their children returned to their care. Mother 3279-09 had one child out of four, and mother 9333-27 had three children out of five back in the household. Mother 6257-12 and mother 1612-65 had permanency goals that remained return to parent, and mother 2137-12 had children placed for adoption.

Although there are ten different types of personality disorders, the general criteria encompasses a continuous pattern of dysfunctional thought patterns, behavior, interpersonal skills, emotional response and impulse control that is a significant departure from what is typically expected in the individual’s culture (APA, 2000). Similar to Axis I disorders, there can
be rule-out (R/O) diagnoses, where the individual meets some but not all of the criteria for diagnosis (Rudlin, 2015), as well as the diagnosis being deferred on Axis II due to the lack of sufficient information (APA, 2000). The majority of the mothers received a deferred diagnosis on Axis II ($n = 6$). That includes two mothers who acknowledged their mental health problems, and four who did not. The remaining mother who acknowledged was noted as having no diagnosis on Axis II. For the four mothers who did not acknowledge their mental health problems, two were diagnosed with personality disorders, and two were assigned R/O personality disorder diagnoses.

Two mothers were diagnosed with personality disorder nos, and a third received a R/O diagnosis of this disorder. The nos dimension of the diagnosis means that the individual is clearly struggling with personality functioning as evidenced by the aforementioned general criteria but that she does not meet the definition of a specific personality disorder (APA, 2000). One mother struggled to accept her mental health condition over the life of the case, as the family was involved with preventive services and foster care dating back 11 years from the end of the data collection period. Her difficulties in the areas of cognition, impulse control, interpersonal functioning, behavior and emotional response are described, specifically with regard to how her condition puts her children at risk.

She is clearly impulsive and acts at cross purposes to the needs of both herself and her children without an awareness of the consequences of their health and welfare. [BM] demonstrated marked impairment in her social and perceptual judgment, which impacts adversely in her cognitive functioning. It is significant, therefore, that she has no support systems, any social infrastructure being all but non-existent. (Mother 0132-25)

The clinicians emphasized their concerns about the mother’s ability to benefit from services as well as her understanding of her children’s needs and her readiness to regain custody of her children.
In terms of services, the client is in need of parenting and anger management classes. But the stark reality, given her long time dysfunction, is that the results could be highly questionable. The client has admitted that she has not followed the directives of ACS in the past. She has been known to be oppositional. Both of her children, at this time, seem to have significant emotional difficulties, and she seems to not only deny this, but also deny that her behaviors could have had anything to do with this. She is struggling with her own abstinence and is not, at this time, in a position to care for her children. (Mother 0132-25)

Due to this mother’s lack of progress toward service plan completion and her tragic death, the children were ultimately placed for adoption.

In addition to the personality disorder nos diagnosis, the second mother’s evaluation noted that she exhibited schizotypal features. According to the DSM-IV TR (2000), schizotypal features involve the individual’s severe discomfort with and decreased ability to engage in close relationships as well as extreme social anxiety that tends to be linked to paranoid thoughts, distortions in perception and thought processes and odd behavior that occurs in a variety of settings, suspiciousness, and ideas of reference such as a person watching television and feeling there are messages directed toward him or her. As stated in Chapter 6, this mother’s presentation was so florid and bizarre that her mental health problems were a concern from the beginning of the child protective services investigation. The mental health evaluation confirmed these concerns with her thought process, speech and strange appearance.

[BM] evidences an impairment in her ability to think logically and coherently and is less capable than others of coming to reasonable conclusions about relationships between events, and her ideas do not always follow each other in a comprehensible manner. She presents with a rather flamboyant appearance, and her use of language and her thinking are odd. While her presentation is consistent with substance abuse (of which she has a past history) it is also consistent with character pathology (schizotypal thinking perhaps), which at times may be non reality oriented. (Mother 1022-88)
Despite this mother’s apparently severe mental health condition, the evaluator encouraged the foster care agency to consider reunification if the mother would engage in mental health services. She opted not to engage in services, and her children were placed for adoption.

[BM] requires therapy and medication and some period of time to be certain that she is not abusing substances, that she is compliant with medication and working in psychotherapy. After a reasonable period of time and the mental health professionals who are treating her are consulted and agree, then plans to reunite the family can be initiated. BM said that she will not enroll in mental health or drug treatment. BM said that God was going to vindicate her to get her children back. (Mother 1022-88)

The fourth mother who did not acknowledge her mental health condition received a R/O diagnosis of antisocial personality traits. Antisocial personality traits encompass a pattern of behavior originating in adolescence in which there is a disdain and violation of the rights of others. The individual typically exhibits impulsivity, engagement in unlawful acts that are the basis for arrest, aggressiveness, lack of remorse and deceitfulness (APA, 2000).

She also presents with a history of mental illness, poor anger management skills, and low frustration tolerance. Throughout this assessment she minimized or denied the allegations that resulted in her children being removed. As she currently presents, she seems incapable of routinely meeting the overall demands of parenting. (Mother 3279-09)

This mother was diagnosed with borderline intellectual functioning as well as a R/O diagnosis of antisocial personality traits. As stated above, this mother regained custody of her youngest child out of her four children, despite the evaluator’s negative opinion of the mother’s parenting capacity.

**Axis III and V: Medical Conditions and Global Assessment of Functioning (GAF) Scores**

On the whole, the sample is comprised of relatively healthy mothers with no reported medical problems for the majority of the sample ($n = 9$). For the remaining seven mothers, two had asthma, one was anemic, and one suffered from a traumatic brain injury as a result of being
hit by a truck at the age of 12. One mother was pregnant at the time of the evaluation, and another had both a sprained ankle and a past coma of unknown medical origin. One mother experienced severe medical problems as evidenced by being HIV positive and being diagnosed with toxic embryopathy, a congenital disorder that most likely occurred due to the alcoholism of the participant’s mother. Medical problems did not appear to be a barrier to positive permanency outcomes. Five out of six of the mothers who were diagnosed with mild to severe medical conditions experienced some level of reunification with their children. The mother with the traumatic brain injury had children ultimately placed for adoption, and the mother with a lengthy coma and sprained ankle had a permanency goal that remained return to parent. For the remaining eight healthy mothers, the families’ permanency goals ranged from return to parent to concurrent planning and adoption.

In terms of the GAF scores, the numbers ranged from a low of 40 to a high of 70. One mother had a score of 40, two mothers carried a score of 42, one received a score of 48, and three were assessed to be at a score of 50. Two mothers’ assessment of global functioning scores were 55. The common score was a 60 ($n = 4$). Two mothers had a 65, and one a score of 70. With more than half of the sample ($n = 9$) with GAF scores at 55 or above, the majority of the mothers were assessed to have mild to moderately severe symptomatology affecting their lives with regard to their functioning at work, school, home, self-care and interpersonal functioning. For the remaining seven mothers with scores of 50 or below, their functioning level was evaluated to be so poor that they evidenced serious symptoms such as suicidal thoughts and antisocial acts, as well as severe impairment in their daily functioning (APA, 2000). Although the mothers who reunited with their children tended to have higher GAF scores, five out of six with 50 and above, there is no evidence that higher GAF scores predict family reunification. There has been no
quantitative analysis conducted with this extremely small sample with great variance of GAF scores. For the remaining nine mothers who did not experience reunification, seven also had GAF scores of 50 or higher.

As stated above, the evaluators utilized psychological assessment tools and the mothers’ self-reports to diagnose mental health conditions and formulate clinical opinions and recommendations regarding the mothers’ treatment needs and permanency planning. The following section will further explore the direct impact on case outcomes.

**Service Recommendations**

The mothers were referred for a variety of services including therapy, substance abuse and domestic violence treatment and case management services. The clinicians recommended a high volume of services with an average of four different interventions suggested for each mother. The majority of the sample was referred for individual therapy ($n = 14$). The evaluators purported a wide range of reasons as to how the mothers could benefit, especially with regard to addressing factors that led to the children’s placement, managing mental health symptoms and coping with their own traumatic experiences.

It is likely that the trauma she experienced continues to negatively impact her psychologically and that it impedes her ability to trust others and have safe, fulfilling, and healthy intimate relationships. [BM] appears to have some unresolved trauma related to the abandonment she experienced from her biological parents. She also appears to have some anger and lack of trust toward her adoptive mother for not revealing the truth about her being adopted until she was a teenager. These appear to be core struggles that she has not addressed in a therapeutic setting and it seems to workers that they continue wreak havoc on her psyche and affect her ability to have adequate relationships to others, including her children. (Mother 3279-09)

Her limited ability to make connections among past, present, and future does not bode well for her ability to learn from past experiences, develop reasonable insight and proceed toward goals in an efficient manner. She is underdeveloped in her social skills of negotiating with others, advocating for herself, resolving conflicts and forming healthy, stable relationships. [BM] would benefit from
individual therapy to be able to recognize and verbalize her feelings and to acquire coping skills for the management of her unpleasant emotions.
(Mother 7717-37)

Two of the mothers were recommended to attend group therapy. One mother was encouraged to address problems related to domestic violence in a group setting and the other “to improve her communication style to a more effective and [less] abrasive one.” Five of the mothers were assessed as being in need of medication due to severe symptoms of psychosis, bipolar disorder and depression. Two mothers were encouraged to consider medication if their therapeutic interventions proved ineffective.

Parenting support was also a highly recommended intervention with more than half of the sample (n = 11) being urged to engage in this service. The following mother was recommended to attend parenting services based on the challenges described by the clinician in terms of the mother’s psychological testing.

However, areas of relative weakness in knowledge were seen within the empathy, role reversal, and power independence subscales, suggesting a limited understanding of child development and needs, feelings that children should provide love, assurance and comfort to their parents, and may view power in children as threatening. The results also suggest that [BM]’s self concept as a parent is easily threatened, not surprising given her young age. [BM] is well-intentioned and appears to have [her son’s] best interests at heart.
(Mother 8881-03)

In general, the mothers were recommended to attend parenting for additional guidance, support and to learn about how to manage their children’s behavior.

It is significant that she voices a desire to be a better mother. She would do well by taking a parenting class and learn skills which will be even more greatly needed in her role as a single mother. She will need greater support and know-how as it appears that problems with her oldest son are already surfacing by way of poor academics and negative behavior. (Mother 4135-62)

Substance abuse treatment was recommended for almost half of the sample (n = 7), and drug screening was suggested for an additional four mothers. All but one of those mothers had
indicated current usage or a past history of substance use. For the one mother who denied any substance use it appeared that the clinicians were aiming to explore the underlying reasons for why she neglected her children.

[BM] acknowledged that her mother used substances, such as crack cocaine. She presented as somewhat guarded and seemingly indifferent to the process, denying/minimizing the agency’s concern. Although she denied any drug use, and there was no obvious signs of drug use in her, it is important to rule out the drug use in mother as the reason for neglect and her poor judgment.

(Mother 2700-42)

Other commonly recommended services included family therapy \((n = 2)\), assessments of the children \((n = 2)\), anger management \((n = 4)\), domestic violence counseling \((n = 5)\), educational assistance \((n = 2)\), vocational support \((n = 3)\) medical monitoring \((n = 1)\) and case management, including concrete assistance such as assistance in obtaining housing \((n = 2)\).

**Clinical Recommendations regarding Permanency Planning**

In addition to assessing the mothers’ functioning, presence of mental health disorders and making recommendations for treatment, the majority of the reports \((n = 15)\) advised the agency on how to proceed with regard to permanency planning, and all fifteen reports recommended that the agency continue to monitor the family. Similar to the discussion of the continuums of acknowledgement and permanency in Chapter 7, there was a continuum of clinical opinions that varied from the evaluators having grave concerns about the mothers’ parenting ability to the identification of the mothers’ strengths in their efforts to overcome adversity.

Evaluators described significant concerns for five of the mothers, specifically with regard to their ability to keep their children safe and benefit from services, as well as their children being at risk for their own mental health problems.

Even with parenting classes and other supports in place via drug counseling, domestic violence groups, and anger management classes, the overall impact cannot be weighted with any certainty. The prognosis may be doubtful as the
client has not voiced any insight or real thoughtful remorse for her behavior and continues to ingest various drugs during pregnancy. Given her long tumultuous history both with her own mother and with former boyfriends, plus her lack of ambition, the client does not presently seem equipped to address the responsibilities of motherhood. (Mother 1418-14)

She is invested in the well being of her children and is not at risk of harming them. She denies any thoughts of harming them. However, she is at risk of another suicide attempt if she does not receive the appropriate psychiatric treatment. Without this treatment she is also at risk of again becoming manic and depressed, further impairing her judgment. (Mother 1612-65)

She will need long term care to curb her issues with mood lability and impulsive outbursts that take on verbal as well as physical expression. Given the nature of the diagnosis of psychosis, it is not recommended that the child be returned to her care at this juncture. Long term psychiatric treatment and stabilization is paramount before this case can be revisited. (Mother 5336-55)

Three of the mothers received mixed evaluations in that concerns were raised and that the only recommendation was for the agency to continue to closely monitor the family. As discussed in chapter 7, two of these mothers neither acknowledged their mental health problems, nor did they speak openly with the evaluators. Therefore, there was little information for the clinicians to utilize in constructing their case formulations. As for the final mother, although continued monitoring was indicated, both positive and negative aspects of her parenting capacity were emphasized to illustrate her potential to reunify with her children.

[BM] only has good intentions in regard to her children. It appears that she would never cause them any kind of deliberate harm. She expresses regret for her behavior on the day of the accident. She says she made a mistake and should have taken the children out of the bathtub before answering the door. There was nothing to indicate that the children in her care would be at risk of being abused. However, it appears that at times, [BM]’s judgment is impaired. [BM] has the capacity to provide responsible parenting but first needs to complete parenting classes to improve her knowledge and awareness of appropriate ways to care for her children. (Mother 3884-92)

In some cases (n = 6), the clinicians assessed the mothers to have the potential for family reunification as long as they engaged in services.
[BM] needs to complete rehab and move into sustained full remission from substance abuse. [BM] needs to have therapy and to begin to examine the emotional issues which led her to use substances. She should not regain custody of her children until she demonstrates some understanding of their difficulties and the care they need. If she cannot commit to therapy for herself, would she be able to commit to care for her children if they warranted ‘extra’ care.

(Mother 0132-25)

She does not appear to be a menace to her children at this time. However, her impaired judgment and her history of affective lability warrant the need for ongoing psychiatric monitoring. It is in the best interest of the children that she be followed by a psychiatrist to assure that she is stable and capable of caring for her children. (Mother 6257-12)

For the final mother in which there was no recommendation regarding permanency planning, the evaluators opted to report her strengths, weaknesses, overall functioning and to aid the foster care agency’s determination of the child’s placement.

[BM] presents as generally passive and may not always assert herself to make her needs known. [BM] does not present as a risk for hurting herself or others. Her ability to inhibit aggressive impulses is adequate. She is not likely to initiate aggressive acts. There was no indication from the psychological testing or clinical interview that [BM] suffers from disturbances in reality testing, conduct disorder, or major affective disorder that would impact her parenting capacity. She views herself as positively bonded and attached to her son. (Mother 8881-03)

Agreement between Clinical Recommendations and Permanency Planning

Whether the foster care agency strictly adhered to clinicians’ recommendations for permanency planning varied widely across the sample. Slightly less than half of the participants (n = 6) experienced some level of family reunification, but only one of those mothers received something approaching a positive clinical assessment.

She has learned how to comfort her daughter when she cries and also how to understand her when she is crying. She also said she learned how to play with her and entertain her. When she is crying, she will pick her up and hold her tightly so she feels safe. She knows to check if her diaper’s wet, see if she is hungry or tired. If she needs to discipline her, she knows not to hit her. She has learned to give her time out for two minutes, to have her sit down. She reports she now has a better relationship with her daughter. Despite her feelings of depression, she is
completing all required tasks such as anger management and parent training so that she can try to have her daughter returned to her. (Mother 4732-25)

In addition to having an encouraging evaluation, the aforementioned mother attended a highly intensive infant-parent intervention program affiliated with a local university that works exclusively with family court clients. According to the organization’s website, evidence-based interventions such as child-parent psychotherapy are delivered to parents whose infants and toddlers under the age of 3 have been removed from their care due to maltreatment allegations. The program’s primary goals are to address issues related to trauma and attachment that are essential to strengthening parenting skills, ensuring children’s permanency, preventing recurrence of abuse and stopping the intergenerational cycle of foster care placement, court involvement and child maltreatment (Albert Einstein College of Medicine, 2015). The mother was reunited with her daughter approximately one year after her mental health assessment.

For the remaining five mothers, however, their evaluations ranged from nonspecific to mixed due to the clinicians having significant concerns. Although this group varied in terms of acknowledging their mental health problems (3 no, 2 yes) and substance abuse (3 yes, 2 no), what they all shared in common was their compliance with their service plans, making changes that address the reasons why the children were placed into foster care and strengthening their relationships with their children. A negative assessment may have provided motivation for these mothers to follow through with what was necessary to reunify their families.

BM has progressed in her overall functioning with all of her children. All children are well bonded with BM as BM has established a strong relationship with her children. BM has improved in her efforts in reestablishing her role as parent with all of her children. CP observed that BM is able to control children’s behavior, and the children are responsive and follow her instructions. (Mother 9333-27)
In following their service plans and making changes to ensure their children’s safety, the mothers who reunified with their children took responsibility for the circumstances precipitating foster care placement, and they took action to resolve those problems.

She appears to be remorseful for what she has done, and she wants to do what she can to get [her daughter] back. (Mother 4732-25)

The mother does not feel that she is at fault however she has stated that she is willing to do whatever she has to in order to have her children returned back to her care. The mother stated that she will do everything that is asked of her. (Mother 1418-14)

For the six mothers initially assessed to have the capacity for family reunification, however, only one mother (4732-25 mentioned above), actually regained custody of her children. Three mothers had permanency goals changed to adoption due to their refusal to engage in recommended services.

[BM]’s service plan included parenting skills, anger management, domestic violence, individual counseling and drug treatment. BM is not fully complying with these services. BM’s attendance in these programs is poor, and she continues to test positive for illicit substances. BM was dropped from her drug program because she was not complying with services and she was dating a man, which she has an order of protection against. BM has completed parenting and domestic violence. BM, however, has not been complying with the visiting schedule or the drug treatment program. (Mother 0132-25)

The director of [BM’s shelter] told CP that no one can even have a rational conversation with BM to even plan for her children. The director told CP that BM has a severe mental illness with a history of drug use and asked if the agency can commit BM to engage in drug/mental health. CP told the director that the agency cannot force BM to engage in services. CP told the director that the agency will proceed with goal change to adoption which is in the best interest of the children. (Mother 1022-88)

As for the other two mothers, one was engaged in concurrent planning, and the other had a permanency goal that remained returned to parent. In addition to their noncompliance with their service plans, several of the aforementioned mothers experienced strained relationships with their children who were aware of their challenges.
[Foster mother (FM)] stated that child does not want to be returned to her mother because her mother has a new boyfriend and she is only thinking about him. [Foster child (FC)] FC stated that she is doing great and that she wants to stay with her aunt. FC stated that she loves her mother, but she wants to be safe and she is not safe with her mother. (Mother 0132-25)

Both children explained that they are aware that BM is incapable of caring for them at this time because of her severe mental illness. [BM’s daughter] said that she was disappointed in the fact that BM did not want to visit her and her brother at the agency. Child said that if BM really cared for them she would make the sacrifice and visit with them anywhere. (Mother 1022-88)

CW asked the child if she still wishes not to return with her mother, and the child stated that she is willing to give her mother another chance. The child, however, remains fearful that if returned to her mother that her mother would get into trouble again, meaning that she fears that she and her siblings can land in foster care again. CW told the child that we are all working together to ensure that if she is returned to her mother, her mother would not get into trouble again, the child agreed. (Mother 6257-12)

For the remaining five mothers, continued agency involvement was the primary recommendation emphasized in their mental health assessments, which was adhered to by the foster care agency. Three out of five of the mothers encountered concurrent planning due to their lack of progress toward service plan completion. One mother’s goal was changed to adoption, and another mother maintained the child’s permanency goal of return to parent. The mothers purported a wide variety of reasons as to why they did not complete their services.

BM has difficulty trusting people and she does not like really to open up. From before the BM stated that she opened up to the social worker at the hospital when she gave birth and they took her child away. The issue with the BM being guarded comes from the incident and her past as well. (Mother 1612-65)

BM stated that it’s been three weeks since she’s picked up her daughters. BM stated that she sometimes does not have enough money to travel, and other times she and the FM cannot come to an agreement when BM can’t make it on time to pick up the children as scheduled. CW stated to BM that in order for the children to be returned into her care she has to follow the permanency plan. BM reported to CW that she is doing the best she can, and CW acknowledged her effort, however, CW reported to the BM the importance of building better communication between herself and those involved with the permanency plan. (Mother 3884-92)
[BM] has very reckless behavior and puts herself in danger often and makes it hard to assist her as she has not revealed her whereabouts. [BM] has great family support however at times some family members do not enforce boundaries and rules and allow [BM] to come and go, drink and smoke, and engage in other reckless behavior. (Mother 8881-03)

As described in the preceding section, consistently adhering to the foster care service plan and following through with service recommendations purported in the mental health assessment have emerged as factors that affect children’s permanency outcomes for this population of mothers. Further exploration is warranted with regard to other factors at the family and case level that could potentially impact children’s permanency outcomes.

Prior History with ACS

The majority of the mothers \((n = 9)\) had a prior history with child protective services such as indicated cases and children being placed into foster care. There was a wide range of maltreatment types, specifically with regard to neglect and some with older children no longer residing with the mothers.

The mother had a prior indicated case in 1999 after the birth of her daughter that is no longer in her care. The mother had left the child with the baby’s godmother and failed to visit or make future plans for the baby. The family went for custody of the child, in which the mother then went to their home with a knife and threatened to kill her if her baby was not returned. In 2008 the family had another indicated case in which the case was indicated against the mother for inadequate guardianship due to domestic violence. A report was called in due to the father being attacked by the mother while he was driving the car with the mother and 2 year old daughter. (Mother 1418-14)

She had another ACS case one year ago when [her eldest son] met with an after care worker and complained of there being no food. BM has a history of cocaine usage. In 1992 there was an indicated case against BM for parent’s drug misuse and BM was placed in an inpatient rehabilitation facility. During this time [BM’s eldest son] was sent to live with his father. (Mother 1002-88)

The family had three prior ACS cases and one resulted in the removal of the children. The bio-mother had problems with maintaining a clean home as prior case shows that in each home that she has lived has been in unsanitary conditions. (Mother 2700-42)
Prior history of child protective services involvement did not appear to have a direct impact on permanency outcomes, especially since four out of the six mothers who regained custody of their children had a prior history of indicated cases and their children’s foster care placement. As for the remaining five mothers with a prior history, two mothers had permanency goals changed to adoption, two mothers were engaged in concurrent planning, and one mother’s children had a permanency goal that remained return to parent. Another element to examine is whether type of placement such as kinship or nonrelative placement affects permanency outcomes for mothers who have been referred for mental health assessments.

**Placement Type**

Change, lack of stability and placement with nonrelatives characterized the foster care experience for the majority of the children of the mothers in this study. Twelve out of sixteen mothers had children with either multiple placements ($n = 7$) or non-kinship placements ($n = 6$) during their stay in foster care. For one family whose four children had a total of 16 different placements, the severity of placement instability revealed the numerous challenges to the children achieving permanency, specifically with regard to their mother not being equipped to resume her caretaking responsibilities.

As for her children, again, she is ambivalent. On one hand she claims to want custody, and conversely she is indifferent and has not made realistic plans for their return to her care. [BM] has admitted to wanting to leave the children with the current foster parent until she ‘gets her life together,’ yet she has no stable source of income and appears to be taking her time getting her life together. There are some concerns as [BM] is not showing any motivation to work towards reunification with her children. (Mother 7717-37)

In another family, the mother’s two young daughters, aged 4 and 5 years old, experienced five different placements due to the mother’s lack of progress toward service plan goals and the agency’s lack of appropriate foster homes.
[FM] is relocating, so her foster home will be closed. There is concern about how the girls will adjust to the absence of [FM] who has been like a mother to the girls since placement. [BM] is not attending therapy, a component of her service plan. The girls have been in care [for three years]. They need permanency. BM is planning to restart therapy, which is the only barrier to reunification. (Mother 3884-92)

In the two prior examples, the mothers’ inconsistency is reflected in their children’s placement instability. By the end of data collection, both were engaged in concurrent planning. The permanency outcomes were mixed for the remaining mothers whose children had multiple placements including two mothers who reunified with their children, one whose child’s permanency goal was changed to adoption and another whose children’s permanency goals remained return to parent.

Only three of the mothers had their children in a kinship placement, and just one of them experienced some level of reunification. Stability of placement appeared to have more of an impact on permanency than type of placement as half of the mothers who resumed custody (n = 3) had their children in one placement.

The children are in the non-kinship home of [FM]. The children have adjusted well to placement and are bonded with the foster family. There are no safety concerns regarding placement. (Mother 1418-14)

[FM stated] she is happy that the children are in her care and not going from home to home, because when the children were in the birth mother’s care, she would leave them with anyone to take care of them so she could go out. The foster parent is hard working and takes very good care of the children. (Mother 3279-09)

In addition to foster care placement type and stability, visitation quality merits further investigation in considering factors affecting permanency outcomes for mothers who have received mental health evaluations.
Quality of Visitation

Half of the mothers \((n = 8)\) visited their children on a consistent basis, including five out of six of the mothers who reunified with their children. Positive and consistent visitation was an integral component of the service plan. The typical process would include the family progressing from supervised visits to unsupervised and overnight visits to trial discharge. The children’s behavior before, during and after visits was also an indication of their attachment to their mothers and their readiness to return home.

All reported that the unsupervised visits are going well, and the children are happier with the quality of the visits. BM said the children respect her more as a parent and that they all as a family have fun together during the visits. BM said that she would take the children to the park or sometimes go shopping with them. (Mother 9333-27)

[BM’s sons] react negatively when BM leaves from their visits. The children cry out for BM and prefer her to stay with them. The children stated they love when BM visits them and hate to see her leave. ‘I want this to be over.’ Children are tired of having all the rules and regulations between them and their BM. (Mother 4135-62)

The remainder of the mothers were split between those with a negative quality and quantity of visits \((n = 4)\) and those who would inconsistently visit with their children \((n = 4)\).

Supervised visitation provides foster care workers with the opportunity to directly observe the interactions between mothers and their children, an invaluable assessment tool in the permanency planning process. Only one of the mothers with inconsistent visitation experienced some level of reunification due to her improvement in visitation over the course of the case. For the seven other mothers, inconsistent and/or negative visits were another indicator to the foster care agency that the mother was not ready to resume custody of her children.

The interaction during the visit was very negative. BM was ignoring [her daughter]. When BM did address [her daughter], she was yelling or putting [her] down. When asked ‘what’s wrong Mommy?’ BM said ‘YOU.’ BM told [her daughter] ‘I should smack you in the mouth.’ BM was talking out loud and said
that she does not want to come to the agency for visits anymore. BM also heated up food and [her daughter] said it was too hot and BM said ‘I don’t care’ and forced the spoon with hot food into [her daughter’s] mouth. [She] began to cry and BM took out a camera and began taking pictures of [her] crying and said ‘I like when you cry. It reminds me of when you were born.’ CW went to get a supervisor to approve ending the visit early but when CW came back, BM decided to leave early anyway. (Mother 5336-55)

This excerpt is difficult to read based on the cruelty exhibited by the mother toward her daughter in the context of a supervised visit. It causes one to think of how she would behave if she were alone with her daughter. This daughter was ultimately placed with relatives in another state. For another family in which a son was psychiatrically hospitalized due to his own behavioral and mental health problems, the family court judge initially banned the mother from visiting her son so as to give hospital providers time to assess his condition and how visitation would affect his treatment.

[The hospital social worker] reported that the previous day [he] had been acting out and therefore she had told him she could call his BM if he calmed down. When [he] calmed down he called BM who told him that she would see him tomorrow for a visit. BM never showed up to the visit. [He] sat there in silence as [his hospital therapist] asked him what he was thinking. [He] punched himself on the forehead and then started crying very loudly. [The hospital therapist] suggested that he should write a letter to his mother telling how he feels when she doesn’t come but he did not want to. (Mother 0132-25)

This narrative is also intense and presents a microcosm of this child’s experience as he had experienced significant emotional challenges, a long of period of time out of his mother’s care and ultimately his mother’s death which resulted in his permanency goal being changed to adoption. Before visiting plans are constructed and executed, the mothers have been found to be at imminent risk of harming their children due to findings of maltreatment. The next section examines how type of maltreatment affects permanency outcomes for mothers who have received mental health evaluations.
Referral Reason

As stated in Chapter 3, neglect is the most widespread type of child maltreatment in the United States (USDHHS, 2012a); this statistic was mirrored in the study’s findings. When including lack of supervision and children’s exposure to domestic violence, 15 out of the 16 mothers were reported for neglect. A broad range of neglect types were represented in the sample including lack of medical care, poor hygiene and living conditions and lack of food.

She has three children; however, they were all removed from her care. The referral states that there were allegations of ‘inadequate guardianship, no food, lack of medical care, parent’s alcohol use, [daughter] was born low weight and unable to keep food down. (Mother 3279-09)

ACS became involved after an incident in which [BM] accidentally left her daughters in a bathtub. She was living in the shelter at the time. She had been giving them a bath when she heard a knock at the door. She left the girls unattended and answered the door. When she returned, one of her daughters was found floating face down in the water. She called 911 and attempted resuscitation – eventually the child was brought to the hospital and revived. After four days at the hospital she was released into foster care. (Mother 3884-92)

In addition, more than half of the mothers ($n = 9$) were found to have committed multiple forms of maltreatment such as physical abuse, inappropriate responses to children’s reports of sexual abuse and neglect due to parental substance abuse.

It was reported that BM’s boyfriend tried to have intercourse with [daughter] prior to her turning 15 years old during the past year. It was reported that BM did not believe [her daughter] when she reported to her as [BM’s boyfriend] continued to reside in the home. It was reported that BM left the home for days at a time, leaving [BM’s boyfriend] alone with the children. (Mother 9333-27)

Initial report states that the mother swore at her 2 year old daughter and struck her in the face several times knocking her to the floor. A subsequent report states that the mother left the child with a woman with a history of drug use and she did not leave any provisions for her. CPS investigation found the child with a bruise under her eye and the mother stated that the child sustained the injury by hitting her head on the wall. The mother’s behavior is placing the daughter in danger. (Mother 3114-99)
Only one mother lost custody of her son due to her mental illness and substance abuse.

[BM] has a long history of alcohol use. [BM] gave birth to a baby boy, and she admitted to the hospital that she drank alcohol during her pregnancy and has a mental health history of being bipolar. [BM] has limited provisions for the baby. [BM] has another child who is in custody of an uncle due to her alcohol use and her not following up with ACS. The child was discharged from the hospital and placed into non-kinship foster boarding home. (Mother 1612-65)

With regard to permanency outcomes, there was no evidence for a direct relationship to maltreatment type, especially since nearly every mother neglected her children and engaged in multiple forms of maltreatment. Remarkably, the mothers who experienced some level of reunification with their children had some of the more disturbing narratives in this study. In one family, the mother’s boyfriend attacked her with a meat cleaver in front of the children. In two others, children of two years of age experienced excessive corporal punishment that resulted in bruising. In concordance with the discussion regarding clinicians’ recommendations and permanency planning earlier in this chapter, the mothers appear to have a capacity for change over the course of the case and that how they present themselves at case initiation and mental health assessment are but one juncture in their journey through mental health and foster care services. In one particularly profound statement, one mother spoke about ending the cycle of abuse and making essential changes to be reunified with her children.

Mother explained to CPSS that it has been hard because at first she wanted to drop the charges and take him back but then she realized that she has to be strong for the kids. CPSS spoke with mother about the duration of the abuse. Mother stated that the physical abuse went for some time maybe three years before BF cut her with the meat cleaver. Mother stated that he would beat her up all the time and each time she would take him back. CPSS asked mother what made this last time different. Mother stated that it was because her daughter witnessed the whole thing and saw her covered in blood. Mother stated that she felt so bad and she was so scared she just decided that enough was enough. (Mother 1418-14)

In Chapter 8, the study’s results are summarized and explored in terms of their relevance to current research literature. In addition, this dissertation study will conclude with a description
and explanation of the investigation’s grounded theory of how mothers’ mental health evaluations function in the context of foster care practice. Finally, there will be a discussion of the investigation’s implications for research, practice, policy and administration.
CHAPTER 8: SUMMARY AND IMPLICATIONS FOR RESEARCH, PRACTICE, POLICY AND ADMINISTRATION

This dissertation study has aimed to provide rich description and analysis to explain how mothers’ mental health evaluations are utilized in the context of foster care practice. The overarching inquiry has been structured by social constructionist and client career theoretical perspectives, as well as a qualitative, clinical data-mining approach to the investigation’s research methodology. The study has advanced the following research questions: 1) What are the demographic profiles and psychosocial characteristics of mothers referred for mental health evaluations, and are there differences based on whether the mothers abuse substances? 2) Are there differences in how the mental health evaluation functions for mothers who acknowledge versus those who do not acknowledge their mental illness? 3) What are the parenting qualities and mental health symptoms identified as having an impact on children’s permanency outcomes? 4) What other service and/or case factors affect case outcomes (i.e. maltreatment type, visiting, etc.) for mothers that have been referred for mental health evaluations? In the sections to follow, the study’s grounded theory will be presented as well as a summary of the dissertation findings and the investigation’s implications for research, practice, policy and administration.

Grounded Theory Construction

As stated in chapter four, this dissertation analysis is a significant departure from classic grounded theory whereby the investigation’s scope is shaped through themes that emerge in the open coding process. For the current study, the researcher entered into the analytic process with the specific purpose of constructing theory to elucidate how mothers’ mental health evaluations function in the context of foster care practice. The central phenomenon that emerged from the data is that mothers’ mental health evaluations function as a structuring force for the foster care
agency’s development of the mothers’ service plans. Therefore, since the mental health assessment typically occurs early in the life of the case, the evaluator makes recommendations that are resonant throughout the mother’s involvement with the agency. A theory of compliance was formulated around this principal category to describe and explain the processes and inner mechanisms of mothers’ pathways through mental health evaluations, involvement with the foster care agency and their children’s permanency outcomes. See Figure 3 for a visual representation of the study’s grounded theory.

Figure 3: Conceptual model of the utilization of mothers’ mental health evaluations in the context of foster care practice.

In considering the study’s social constructionist theoretical framework, the mothers are initially identified as individuals in need of mental health evaluations. As discussed in chapter
seven, there were a wide variety of documented reasons why these mothers were identified as such, including their attitudes, behaviors, reactions to losing custody of their children, the mothers’ disclosure of mental health problems and the foster care agency pursuing recommendations as to services and parenting capacity. Although it is not explicitly stated in the case record documentation, the referral process appears to apply the social construction of abusive parents as mentally ill as discussed in chapter four (Bell, 2011). None of the mothers requested the assessments, but rather they were compelled to participate through their service plans. Mental health concerns were always raised by workers at different levels of interaction with the family, including preventive services, child protective services and foster care services. There was only one mother who lost custody of her son due to her mental illness and substance abuse. Although her son was born with no birth complications, a combination of variables including the mother’s mental illness, substance abuse, lack of provisions for the newborn and her history of losing parental rights to an older daughter caused child protective services to construct this mother as someone not only in need of help, but also a mother that presents imminent danger to her son.

Once the mothers have been identified as individuals in need of mental health evaluations, the assessments occur, and the evaluators utilize a variety of assessment strategies to formulate clinical opinions and recommendations as to the mothers’ overall functioning, mental health diagnoses and treatment needs. Diagnosis of mental health disorders was nearly universal with 13 out of 16 of the mothers being assigned a clinical or personality disorder. Regardless of whether or not a diagnosis was given, the mothers were all recommended to participate in services, with an average of four services recommended per person, which included individual, family and group therapy, substance abuse and domestic violence treatment and parenting
classes. The services and recommendations were then incorporated into the mothers’ service plans; the level of service plan compliance had a significant impact on children’s permanency outcomes. Compliance involved following the court and foster care mandates, specifically with regard to making admissions of maltreatment, taking responsibility in a court setting and attending all services. This finding reflects current literature (Green et al., 2006) which confirms a relationship between service compliance and maintaining parental rights, especially with regard to substance abuse treatment.

As discussed in chapter four, the client career trajectory is shaped by how successfully individuals cope with environmental stressors and achieve a positive level of fit with their environments (Gitterman & Heller, 2011). The universal process of becoming an adult, for example, can be severely compromised by trauma, mental illness and dysfunctional family relationships as discussed throughout this study. Furthermore, client careers to dysfunction, such as mental illness, are profoundly affected by time of onset, with those exhibiting childhood onset tending to display more tenacious, chronic and persistent troubles than those whose difficulties arise later in life (Dandreaux & Frick, 2009). All six of the mothers who acknowledged their mental illness reported that they had been experiencing difficulties since childhood. As stated in chapter 6, however, childhood onset of mental health disorders did not automatically discount a mother from successfully navigating the foster care system as three of those mothers reunified with their children.

Sadly, the mothers’ mental health evaluations are occurring at a time of considerable vulnerability. Their identities as mothers have been compromised due to substantiated cases of child maltreatment and losing custody of their children. This outcome is a fundamental reason why many poor, mentally ill, mothers of color do not seek treatment (Copeland & Snyder, 2011).
Furthermore, in the discussion of psychological assessment tools, many mothers are “faking good” (Stredny et al., 2006) in an effort to present well and prove they are good mothers. There are considerable questions as to the validity of the projective assessment strategies and their applicability to mentally ill mothers seeking to regain custody of their children (Garb et al., 2005). Unfortunately however, as exhibited in the dissertation study, when the mothers do not acknowledge their mental health problems, the evaluators suspect there are underlying problems anyway. Guggenheim (2007) stated the following in relation to the inherent difficulties with parents’ experiences with service planning.

Child welfare process is all about family case planning: promptly identifying the barriers to the immediate return of foster children to their families of origin, agreeing upon appropriate services for parents, encouraging parents to take full advantage of these services, and working assiduously with parents to place them in a position to take back their children safely. Whether or not these things are done; how promptly they are done; and with what degree of compassion, empathy, patience, and respect they are done, will determine in most cases whether and when children are returned home. This is where child welfare practice tends to fail miserably. Agencies are too rarely facilitators, helping to solve problems with and for parents. Parents experience agencies and caseworkers as playing a game of "gotcha," pouncing when parents fail in some responsibility (p. 508).

Therefore, as discussed throughout this investigation, poor, mentally ill mothers of color are facing both personal and systemic challenges in their efforts to regain custody of their children. Although the description of the mothers’ client careers depicts a bleak perspective of the mothers who have been referred for mental health evaluations, providing a comprehensive description of this process is an essential step in designing effective models of service delivery. In the following sections, there is a summary of the dissertation findings, as well as implications for research, practice, policy and administration.
Summary of Study Findings

Substance abuse accounted for only slight variations in the demographic profiles and psychosocial characteristics of mothers referred for mental health assessments. Mothers who used drugs were more likely to be African-American, and the drugs of choice were predominantly marijuana and alcohol. Hispanic mothers were less likely to abuse substances. All mothers identified as female and were an average of 28-29 years old. Substance abusing mothers had less years of schooling, with an average of an 8th grade education; mothers who did not use drugs had an average of a 10th grade education. Furthermore, mothers who used drugs exhibited a decreased likelihood of a job history or verified income source in comparison to mothers who did not abuse substances. Both groups had nearly indistinguishable family compositions with an average of 3 children ranging in age from 3 months to 21 years old, and a substantial number of children coping with physical, cognitive and emotional challenges. The majority of the sample were single mothers, receiving minimal support from the children’s fathers. Although all participants experienced significant environmental stressors, intimate partner violence, childhood trauma and foster care placements were slightly more prevalent for mothers who abused substances.

In considering the participants’ demographic profiles and psychosocial characteristics, the findings add to current research. The majority of the sample were mothers of color with half of the sample identified as African-American mothers, and a substantial proportion of the sample (n = 6) categorized as Hispanic or biracial. The race/ethnicity of the mothers are consistent with recent statistics illustrating the disproportionate representation of African-American and Hispanic children in the foster care system in comparison to their Caucasian counterparts (USDHHS, 2012b). In terms of the mothers’ life stressors, empirical evidence has supported a
link between developing mental illness and abusing drugs (USDHHS, 2012c), being separated, divorced or single (Afifi et al., 2006) and living in poverty (Heflin & Iceland, 2009). With regard to race/ethnicity, however, Hispanic and African-American individuals exhibit a decreased risk for nearly all mental health disorders, with the exception of bipolar disorder (Breslau et al., 2006).

For the majority of the participant mothers who are of minority background (8 African-American, 3 Hispanic, 1 Bi-Racial and 1 of unknown racial background) and have mental health diagnoses, what then could more accurately explain this phenomenon? According to Benbow, Forchuk and Ray (2011), the term “intersectionality” refers to a theoretical understanding of “complex dimensions of oppression and privilege based on race, ethnicity, gender, religion, ability, sexual orientation and class as interactive forces rather than independently functioning categories” (p. 689). Therefore, since the mothers in this sample are experiencing cumulative challenges exacerbated by their race, gender and socioeconomic status, they appear to be more vulnerable to developing mental health disorders. Benbow et al. (2011) focused on mentally ill homeless women, many of which share commonalities with the dissertation’s participants such as housing instability and having difficulty changing behaviors. For the women in the dissertation study, their struggle to make changes was evident in their efforts to regain custody of their children. Furthermore, in their qualitative analysis of the mental health and substance abuse treatment experiences of African-American women, Jones, Hopson, Warner, Hardiman and James (2015) found a significant preponderance of barriers to effective engagement in treatment. Women expressed feeling stigmatized due to being labeled, that some service providers are biased and make assumptions that all African-American individuals are the same, that there is a disconnect between their service needs and what actually occurs in treatment and distrust due to
perceived cultural differences. Negative reactions to being diagnosed, as well as cautious
attitudes toward mental health services were common among participant mothers as well,
especially since their assessments informed service plan recommendations.

As discussed in Chapter 6, the relationship between acknowledgment of mental illness
and permanency outcomes was mixed. A continuum of acknowledgment emerged from the data.
That is, although six mothers affirmed and ten denied the presence of mental health problems,
there was more nuance within the group of mothers who denied mental health disorders. Of the
ten who denied, three had met with a mental health professional at some time, and five reported
symptoms but later recanted. As discussed throughout this study, mothers’ acceptance of their
mental health conditions are intertwined with their experiences of oppression, discrimination and
bias (Mizock & Russinova, 2015), and many did not seek treatment for fear of losing custody of
their children (Spreng, 2010). Only three of the mothers who acknowledged their mental illness
reunified with their children, while three mothers who did not acknowledge also reunified with
their children. The remaining mothers had a goal that remained returned to parent \( n = 2 \),
engaged in concurrent planning \( n = 4 \) and had goals changed to adoption \( n = 4 \).

As described in the study’s grounded theory, the single most influential factor on
children’s permanency outcomes was mothers’ adherence to their service plans. Furthermore,
mothers that reunified with their children shared the following characteristics: 1) admission of
neglect and taking responsibility for maltreating their children; 2) ongoing monitoring via
preventive services and trial discharge in which the foster care agency continues to follow-up
with the family; 3) the expectation of continued attendance to mental health services. Another
factor that emerged was that placement stability appeared to have more of an impact than
placement type since half of the mothers \( n = 3 \) who reunified with their families had children in
one placement during their length of stay. Also, the majority of mothers who reunified consistently visited with their children ($n = 5$) and had a history of ACS involvement ($n = 4$). Furthermore, trauma was a universal experience for all study participants, and the next section will explore the particular impact of trauma on the investigation’s results.

**Impact of Trauma on Study Findings**

Extensive, lifelong exposure to trauma could explain the increased rates of mental illness among this group of mothers since the entire sample experienced some level of family dysfunction, abuse, loss and traumatic events from childhood through adulthood. Twelve out of the sixteen mothers (7 drug abusers, 5 non drug abusers) personally experienced maltreatment as children, as well as out-of-home placements. Therefore, the cycle of trauma was perpetuated with their own families. Briere and Jordan (2009) reviewed research on the relationship between childhood trauma exposure and adult functioning. Their findings establish a consistent link between childhood maltreatment and negative mental health outcomes such as posttraumatic stress symptoms which include nightmares, flashbacks, sleep disturbance, anxiety, depression, cognitive distortions such as low self-esteem and helplessness, interpersonal difficulties and substance abuse. Furthermore, the researchers emphasized the cumulative effect of complex traumatic experiences, in which individuals are not exposed to just one type of abusive experience; victims of maltreatment are more likely to also experience neglect and to be abused in adulthood as well. Recent statistics indicate that children are likely to experience more than one type of maltreatment, with the majority being neglected (USDHHS, 2012a).

Similar patterns emerged in the dissertation study, as in many cases, mothers experienced complex trauma, or persistent traumatic exposure throughout their lives (Carolan, Burns-Jager, Bozek, & Chew, 2010). This traumatic cycle often led to the children being removed from the
family. For example, participant mother 1418-14 experienced numerous environmental stressors and traumatic events during her childhood and adolescence which included her father’s incarceration and death, physical and sexual abuse by her stepfather, her mother not validating her disclosure of abuse, being sexually assaulted as a teenager and multiple foster care placements. As this mother matured into adulthood not only did she develop severe mental health and substance abuse disorders, she also continued to experience abuse in her personal life by being in domestic violence relationships. The mother finally ended the cycle of abuse when her daughter witnessed the domestic violence, and her children were removed from her custody. This mother, however, eventually regained custody of her children as she completed her mandated service plan.

Implications for Research, Practice, Policy and Administration

Although the discussion of the demographic profiles and psychosocial characteristics presents a somewhat dismal impression of the study’s sample, presenting a complete narrative of this population is a fundamental component to effectively helping mentally ill mothers. An innovative approach of working with individuals that incorporates an understanding of their traumatic lives is referred to as trauma-informed practice. Knight (2015) describes trauma-informed practice as clinicians’ sensitivity of how individuals’ traumatic experiences affect their current functioning. The formulation of current functioning extends from the individual’s problem definition to how she behaves in the context of the therapeutic alliance, something that may be particularly difficult for trauma survivors given the possibility of cognitive distortions such as distrust of others and their challenges of developing healthy attachments.

Due to the severely traumatized population served by the foster care agency, trauma-informed practice is a framework espoused by the program from which I collected the
dissertation data. In their efforts to improve service delivery, executive staff members opted to espouse the Sanctuary model. In Bloom and Yanosy Sreedhar (2008), the Sanctuary® model is described as a trauma-informed approach for building and changing organizational culture. The organizational culture is guided by seven commitments that support a comprehensive treatment setting while also addressing persistent stress. The seven principles incorporate a culture that is nonviolent, socially responsible and characterized by shared governance, emotional intelligence, social learning, open communication and growth and change. This trauma-informed approach had been a relatively new initiative incorporated into agency practice during data collection.

In an effort to examine the implementation of the Sanctuary Model® in a child welfare agency, Esaki, Hopson, and Middleton (2014) conducted a survey of indirect care staff members. Findings indicated that indirect care personnel exhibited moderate openness to change and some success in program implementation. Furthermore, study participants were more likely to feel that the agency was committed to successfully executing the model when they perceived more support from executive leadership, supervisors and co-workers. In addition, Esaki et al. emphasized that subordinates of study participants were observed to be the best at exhibiting behavior consistent with the Sanctuary Model®, with supervisors and their colleagues also scoring highly. The program leadership scored the lowest which raised the question of impact of relationships in an organization. In Peacock and Daniels (2006), the Sanctuary Model® has also been applied toward work with children in residential care, specifically with a focus on anti-racist practice. The researchers gave examples of how the organization was incorporating aspects of the model, specifically with regard to nonviolence through the utilization of the children’s safety plans and using different language for behavioral description. Instead of referring to a child as sick or bad, staff members would use words such as hurt or injured.
Trauma-informed practice is consistent with the study’s social constructionist theoretical orientation, specifically with regard to how social constructions are formulated through language (Urek, 2005).

Solution focused casework is another innovative treatment approach that had been piloted at the agency after the close of data collection. Antle, Christensen, van Zyl, and Barbee (2012) summarized solution-based casework (SBC) as an evidence-based practice model for child welfare that has three underlying theoretical orientations including family life cycle theory, relapse prevention/cognitive behavioral therapy (CBT) theory and solution-focused family therapy. Furthermore, the authors emphasize three underlying assumptions of casework: 1) that partnering with the family is a fundamental objective for every family case, 2) focusing on the family’s routines of daily life, and 3) that solutions should be directed at enhancing prevention skills necessary to lessen risk in daily life situations. An SBC assessment incorporates the family life cycle to structure the problem narrative in terms of how typical developmental challenges can generate an unsafe situation such as in the context of supervision and household hygiene. The SBC casework approach categorizes those challenges into particular action plans for the whole family and individual family members to address. These particular action plans are behaviorally specific, co-constructed with the family, provider and case planner and are qualitatively different from typical service plans based on compliance. Antle et al. (2012) found that in a case review of 4,559 public child welfare cases in the state of Kentucky, cases that consistently followed the model’s tenets demonstrated significantly more positive outcomes in the areas of permanency, child safety, and well-being and surpassed federal standards, while cases that did not adhere to the model’s procedure failed to attain federal standards. In an earlier study of Kentucky data, Antle, Barbee, Christenson and Martin (2008) reported findings that
provide additional support for this model. When comparing an SBC intervention group with a control group that provided a traditional casework model, results indicated that the model had been successfully implemented and led to improved outcomes for service recipients, including workers having more collaborative relationships with families and engaging in less early legal action, children were less likely to be removed from the home, there was increased compliance with service plans, and families achieved more goals than the traditional model. Results are not yet available for the study site’s pilot SBC program, but the aforementioned studies present this intervention as a promising approach for forming collaborative relationships with families and improving permanency outcomes.

**Strengths and Limitations**

As discussed in Chapter 4, the study is subject to the strengths and limitations of qualitative grounded theory design utilizing the CDM research approach. The study was able to occur without causing distress to the study’s participants, and it did not interfere with the operational functioning of the study site. Additional strengths of the investigation are the researcher’s ability to provide rich description of the sample and processes underlying the utilization of the mental health evaluation in the context of foster care practice and adding to an extremely limited research literature. Furthermore, the researcher utilized an audit trail (Padgett, 2008) such that a binder was maintained in which all memos, data extraction forms and coding sheets were compiled.

Although missing data are problematic to the clinical data-mining research process, this was a minimally occurring phenomenon while the study was being conducted. Fortunately for the investigation’s mothers, the foster care charts were fairly comprehensive, with some exceptions. With regard to educational history, data was missing for one of the non-substance
abusing mothers, and race/ethnicity was not indicated for two of the mothers who did not use drugs. Furthermore, other identifying characteristics such as sexual orientation and religion were not documented in the case record. The missing data did not appear to compromise the analysis, however, since inferences can be made from the available information. For the mother whose educational level is not documented, the case record indicated that she had been in a special needs high school from which she did not graduate. Also, for the two women whose racial/ethnic backgrounds were not recorded, narrative data indicated they are of minority background. One mother’s children were identified as Hispanic, and when the mother stopped planning for the children she reported that she was leaving the country in order to reside in Mexico. In the other case, the mother referred to a situation in which she had been dismissed from her retail job due to verbal conflict with a supervisor; the mother had described the argument as having “racial undertones” (Mother 5336-55).

The investigation’s level of transferability (Lincoln & Guba, 1985 as cited in Oktay, 2012), or the applicability of the study’s findings to other environments, is an inherent limitation of this qualitative, data-mining study. The sample size was limited to sixteen mothers who had completed both psychological and psychiatric evaluations and had their children placed into foster care due to substantiated cases of maltreatment. Therefore, due to the small sample size, the findings cannot be generalized to other environments. Also, the study focused on the casework practices of one foster care agency in New York City, which may have its own idiosyncrasies. Despite those limitations, however, the study has provided a rich description of this population, and a crucial beginning for learning how to effectively service poor, mentally ill mothers of color. There has been recognition of the structural challenges facing this group of women, especially with regard to stigma, discrimination, oppression and trauma. The findings
are consistent with current research and practice realities, which is an essential objective for grounded theory construction (Oktay, 2012).
APPENDIX A: DATA EXTRACTION FORM

ID#: 

Age: 

Socioeconomic/Educational/Employment Status: 

Family Composition: (Include age, gender and birth order of children, marital status) 

Race/Ethnicity: 

Substance Use: 

Cognitive Impairment: 

Acknowledgment Statement: 

Mental Health Diagnosis:
BIBLIOGRAPHY


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