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Reunification Rates of Mothers With Mental Illness, Substance Abuse, and Co-Occurring Disorders

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This is to certify that the doctoral dissertation by

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Abstract

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MA, Argosy University, 2010

BA, Fresno Pacific University, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Mental illness is a problem that affects many people; however, little to almost no research relates to mental illness and reunification rates for mothers who have had their children removed from them by the child welfare system. The purpose in this study was to assess and compare reunification rates between mothers with mental illness, those with substance abuse, and those with co-occurring substance abuse and mental illness. The conceptual framework for this study was the use of the structured decision making (SDM) assessment tool in child welfare. The research questions addressed the differences in reunification rates among mothers with mental illness, substance use, and co-occurring mental illness and substance use in cases where children are removed due to neglect or abuse. This study also addressed the difference in timelines for reunification for mothers with mental illness in comparison with mothers with substance use and mothers with co-occurring substance use and mental illness in cases where children are removed due to neglect or abuse. In addition, this study addressed the dynamic assessment factors from the family assessment of needs and strengths (FANS) that predict reunification. This study used archival data related to the reunification status, reunification timelines, and the strengths and needs of the mother. A χ^2 analysis was used to determine whether a difference exists in reunification rates between the groups. In this study, no statistical significance was found; however, the study brought to light areas for further research. This includes using larger sample sizes that cover an entire state to compare reunification rates. This can assist in program development for reunification and decrease the number of children in care.

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Chapter 1: Introduction to the Study

This study was a quantitative study of archival data related to children removed from their mothers for reasons of substance use, mental illness, and co-occurring substance use and mental illness. Much of the current research focuses on programs to assist parents with substance use problems to reunify with their children, but research does not address the needs of parents with mental illness or co-occurring disorders. For this study, I studied only mothers because the child welfare system tracks cases by the mother and does not always include the father. In this chapter, I will introduce the study by discussing the background of the research. I will also explain the problem statement, research problem, and my purpose in this study. Furthermore, I introduce the research questions, the conceptual framework, the nature of the study, definitions of concepts relevant to the study, the assumptions of the study, the scope and delimitations, and the limitations and the significance of the study.

Background

In the United States, laws govern how long a child can remain in out of home care with a reunification goal remaining. The laws also provide states the ability to determine a parent will not benefit from services due to mental illness (Ackerson, 2003; Martin, Barbee, Antle, & Sar, 2002). Mothers with mental illness are at greater risk of having their children removed from their care than their nonentally ill counter parts (Ackerson, 2003). One study found that 6% of caregivers with children in their care had an emotional disturbance (National Council of Disability, 2012). Although substance use is diagnostically classified as a mental illness, as defined by the *Diagnostic and Statistical*

Manual of Mental Disorders, Edition 5 (American Psychiatric Association, 2013), in child welfare, it is treated and measured differently than other mental illnesses. Approximately 8% of child welfare cases include substance use as the sole problem (Nicholson, Hinden, Biebel, Henry, & Katz-Leavy, 2007) . Although data are tracked within the state systems regarding mental illness, it has not yet become readily available to the public, which makes it difficult to validate these estimates. The lack of available data suggests that no one is tracking mental illness rates in child welfare cases.

Although child welfare is an area of interest for researchers, often the studies are related to substance use specific programs or to the need for termination of parental rights for parents with mental illness. Not only are the data limited as to how many mothers are involved with the child welfare system, but no evidence-based practice exists for working with parents who have mental illness and are involved in the child welfare system. I compared the reunification rates of mothers with mental illness to mothers with substance use, and mothers with co-occurring substance use and mental illness. In addition, I assessed possible variables that may affect reunification rates in both a positive and negative light, building a foundation for future work in this area. In this study, I provided guidance for new program developments addressing mothers with mental illness involved in the child welfare system.

Problem Statement

Mental illness affects a large portion of the population. Almost one-third of American women have shown evidence of a psychiatric disorder within the last 12 months. In addition, 65% of these women were mothers (Kundra & Alexander, 2009).

Mothers with mental illness are at a greater risk than their nonmentally ill counterparts to have involvement with the child welfare system (Ackerson, 2003). This is due to several risk factors, including: high separation and divorce rates, lower family cohesion, and poor communication (Mayberry & Reupert, 2009).

The current research in child welfare has focused on why mothers with mental illness should have their parental rights terminated and how to assist mothers with substance use problems. (Ackerson, 2003; Martin et al., 2002). Currently, more than 400,000 children are in foster care across the nation each year (Child Welfare Information Gateway, 2016). In addition, only 55 % of those children have a goal of reunification and 25% have a goal of adoption. The rest of the children, approximately 20%, have no permanent goal, they have goals such as living with a relative, emancipate (or age out), long-term foster care, or guardianship (Child Welfare Information Gateway, 2016). This means that approximately 80,000 children in foster care have no permanence or stability.

Of the children that exited foster care placement in 2015, 51% were reunified with their family and 21% were adopted (Child Welfare Information Gateway, 2016). From that, 28% exited to live with a relative, emancipated, or had other outcomes. Furthermore, almost one-third of American women had evidence of a psychiatric disorder with 65% of them being mothers (Kundra & Alexander, 2009). However, despite the number of people in the population having a psychiatric disorder, laws exist that are not in favor of helping these people to recover or be able to safely parent their children. Several states have laws in place that allow the court to terminate parental rights of mothers with mental

illness with two psychological evaluations stating they are unfit to be a parent (Martin et al., 2002).

Even though substance abuse is a psychiatric issue it is often treated differently. Many programs and studies examine how to help parents overcome substance abuse to reunify with their children. Substance abuse is often viewed as something people can recover from whereas mental illness is not. A gap in the literature exists assessing whether parents with mental illness reunify with their children at all. The data are not being tracked or made available. It is important to know whether these parents do reunify, how long it takes them to reunify, and when they do reunify, to inform practice of what the typical looks like for mothers with mental illness. In this study, I addressed the gap in the literature by studying reunification rates specifically related to mothers with mental illness, in comparison to reunification rates of mothers with substance use, and those with co-occurring substance use and mental illness. I also looked at the variables impacting both positive and negative reunification rates.

Purpose of Study

This study was a quantitative study of archival data comparing reunification rates of mothers with mental illness, mothers with substance use, and mothers with co-occurring substance use and mental illness. I used numerical rating data from the structured decision making (SDM), FANS tool to compare reunification outcomes between three groups of mothers: mothers with mental illness, mothers with substance use, and mothers with co-occurring substance use and mental illness. The independent variable was the mothers' identified group (substance use; mental illness; co-occurring

mental illness and substance use). The primary dependent variables were reunification status and length of time to reunification.

Research Questions and Hypotheses

My purpose in this study was to compare reunification rates of mothers with mental illness, substance use, and co-occurring mental illness and substance use. The research questions for this study were as follows:

1. What is the relationship in reunification rates among mothers with mental illness, substance use and co-occurring mental illness and substance use in cases where children are removed due to neglect or abuse?

H_{01} — There is a no significant relationship in reunification rates for mothers with mental illness, in comparison to those with substance use, and mothers with co-occurring mental illness and substance use, in cases where children are removed due to neglect or abuse.

H_1 – There is a significant relationship in reunification rates between mothers with mental illness, in comparison to those with of substance use, and mothers with co-occurring mental illness and substance use.

2. What is the relationship in timelines for reunification for mothers with mental illness comparison to mothers with substance use and mothers with co-occurring mental illness and substance use in cases where children are removed due to neglect or abuse and are reunified?

H_{02} – There is a no relationship in timelines in reunification rates with mothers with mental illness, in comparison to those with substance use and those with co-occurring mental illness and substance use.

H_2 –There is a significant relationship between mothers with mental illness, in comparison to those with substance use or mothers with co-occurring mental illness and substance use.

3. What dynamic assessment factors from the Family Assessment of Needs and Strengths (FANS) predict reunification?

H_{03} – Dynamic assessment factors from the Family Assessment of Needs and Strengths (FANS) do not predict reunification.

H_3 – Dynamic assessment factors from the Family Assessment of Needs and Strengths (FANS) predict reunification

Conceptual Framework

This study was based in the conceptual framework of the SDM as an assessment tool in child welfare. The use of assessment systems such as SDM, which include actuarial and contextual assessments to determine risk level and to plan interventions, minimizes the risk of decisions made solely based on clinical judgment or actuarial assessment (Shlonsky & Wagner, 2005). Currently 25 states in the United States use SDM for child welfare cases (Children's Research Center, 2008).

Three types of risk assessments exist: consensus, actuarial, and contextual. Consensus-based assessments require the social worker to assess the client based on the consensus experts have determined is appropriate and use clinical judgment regarding

future risk of harm. Actuarial systems are based on empirical data, establishing a score of low, medium, or high risk to the family (Baird & Wagner, 2000). Contextual assessments assess the whole situation, looking at both actuarial facts and areas that change or make the situation different from others (Bolton & Lennings, 2010).

For many years, decisions in child welfare were made based on clinical decision or consensus-based assessment. This not only made life or death decisions dependent on a social workers' experience, but also made the social workers solely responsible if their decision was incorrect, especially when something went wrong (Baird & Wagner, 2000). This has shifted through the years and actuarial assessments have become more favored and have been found to be more accurate than consensus based systems, potentially improving the decision making process in child welfare (Baird & Wagner,2000). Although these assessments alone have great potential, some limitations exist due to the family not being completely truthful or missing information, which limits this assessment's ability (Baumann, Law, Sheets, Reid, & Graham, 2005).

I used the data from the FANS, a risk assessment identifying the dynamic needs of the family. SDM uses both contextual and actuarial risk assessments to provide a clearer picture of the situation. FANS assesses the static and dynamic needs. Static needs do not change, such as a parent sexually abusing their child (Bolton & Lennings, 2010). Dynamic needs change with time or can change, for example, housing, employment, current substance use, and other items related to current functioning. In this assessment, the factors are placed on a continuum from a strength to a severe need (Bolton & Lennings, 2010). These contextual assessments allow for individualized case plans

including services for the identified needs of the parent (Shlonsky & Wagner, 2005). This assessment is completed at regular intervals in the case, dependent on when case plans are required to be updated. This study used the FANS assessment as means of measurement to determine if reunification occurs and to assess both static and dynamic factors that may affect reunification. The use of FANS as a means for assessment allows for measurement of more than just static or dynamic factors and allows for the use of a conceptual assessment tool to be used.

Nature of the Study

I used archival data from an agency in Michigan. I was given permission from the agency's board of directors to use the data from 2004-2014. This study included all cases in the 10-year span meeting the qualifications for the study, which are that one parent showed a deficit on the assessment tool in substance use, mental illness, or co-occurring substance use and mental illness. The design choice to use archival data allowed the researcher to examine data from the field, without interrupting the lives of families who are going through or have gone through a difficult time. This method allowed for data to be gathered without bias from the individuals being studied and provided information from beginning to the end of the child welfare process.

This study had one independent variable. The independent variable was the three groups the mother belongs to: mental illness only, substance use only, or co-occurring mental illness and substance use. In addition, there were possible predictors that will be designated as a strength or deficit, including sexual abuse, parenting skills, domestic relations, social support, communication or interpersonal skills, housing, intellectual

capacity, literacy, resource management, physical health, employment, child characteristics. These possible predictors were collected to examine whether they mediate the relationship between the independent variable and the dependent variables. Reunification status and length of time to reunification were the dependent variables.

Definitions

I used the following in this study; the definitions follow.

Structured Decision Making (*SDM*): SDM is the name of the assessment system that is used in the study. SDM is a both an actuarial and contextual assessment (Shlonsky & Wagner, 2005). SDM is not a clinical assessment but is an assessment that comes from a social work perspective based on strengths and needs.

Deficit: A deficit is defined as an area of need on the SDM assessment tool. This means a numerical rating of less than zero as rated by the social worker or case worker completing the assessment (Children's Research Center, 2008)

Strength: A strength is defined as an area where there is not a deficit. This is based on how the word is used in the application of the SDM assessment. This means that a numerical rating of zero or high is a strength (Children's Research Center, 2008).

Mental illness: Mental illness is defined in this study when a mother has a deficit in emotional stability on the SDM FANS tool as rated by the social worker or case worker completing the assessment. This does not mean a *DSM 5* diagnosis. Case workers are often not qualified, for example have only a bachelor's level education, or are not licensed, or in the process of becoming licensed to make diagnosis (Children's Research Center, 2008). In this case, the case worker would rate the parents' behaviors as

appropriate responses becoming a strength or “some problems” or “chronic depression, severely low self-esteem, emotional problems,” which is determined based on the actions or observed behaviors and reported history of the mother by the case worker, other professionals and client self-report (Appendix A).

Substance abuse: Substance abuse is defined in this study as a mother having a deficit in substance abuse on the SDM FANS tool as rated by the caseworker. Substance abuse as a category has one strength. which is “there is no evidence of a problem.” There are three deficit related responses including “caretaker with substance problem/current treatment issues,” “caretaker with a serious problem” and “problems resulting in chronic dysfunction” (Appendix A).

Co-occurring mental illness and substance use: Co-occurring mental illness and substance use is defined as having a negative score in both emotional stability and substance.

Reunification status: Reunification status is defined as whether the children returned home to their parents after being placed in out of home care; this is a yes or no option.

Assumptions

In this study, there were two assumptions. First, I assumed that the mother wants to reunify with the child and has a relationship with the child. This may not be the case, because the mother may have only shown up for the first hearing but did not want reunification and was offered reunification for a statutory period. Second, the assumption that the data were accurate. Although the mother may not be honest, or the worker may

not observe certain behaviors, the assumption was that the data were as accurate as possible. These assumptions were necessary, because it was impossible whether the opposite was true based on the available data.

Scope and Delimitations

To gather the most complete information, all cases meeting the requirements were included. However, as information were gathered from only one agency, the generalizability is limited. This study compared the data from all cases that meet the minimum requirements of the mother falling into one of the three groups (substance use, mental illness, or co-occurring mental illness and substance use) and the case being opened during the time frame of 2004 to 2014. Cases with no data about the case closure were included and categorized as such (for example, children going to another agency due to a placement change). In addition, children that reunified with their father were included in the overall numbers and classified accordingly. Cases where the child was removed from a caregiver other than the mother were excluded.

Although I conducted this study using an agency in Michigan, the study may not be able to be generalized because the agency was not representative of the entire state or the nation. The agency covers some urban areas, but most the cases come from rural areas. Rural areas have their own distinct problems, such as problems with public transportation and availability of programs, which may not be consistent with larger areas.

I assessed the reunification rates specifically of the mothers with mental illness in comparison with mothers with substance abuse and those with co-occurring substance

abuse and mental illness. I assessed this area in this study because there is no other information describing reunification rates for mothers with mental illness.

Limitations

In this study, there were some limitations that may present concerns with both issues of internal and external validity. One area of concern to internal validity was attrition. Families are assigned to an agency based on placement ability. When the child needs to be moved and there is no placement within the agency, they go to another agency. One concerns with external validity include that data may not be representative of the whole of children placed in foster care due to variables outside the control of this study and the limited sample available. This data may not include children with more problematic behaviors or that have more severe medical needs as they would be placed in a higher level of care or would be more difficult to locate a placement within the agency. In addition, although this area covers multiple counties, these counties were more rural than others and the services available may be less than other areas. Furthermore, the weather in Michigan during winter months can be extreme and made it difficult for parents to access services. There may have be bias with the social worker completing the assessment that is not known to this study. In this study, there was an additional limitation in the sample size, which was significantly smaller than expected and below the threshold for statistical significance.

Significance

Current research in child welfare has focused on substance use services and the need for quick terminations for parents with mental illness (Ackerson, 2003; Martin et al.,

2002). The original contribution of this research does not focus on the quick termination of parental rights for these mothers. Rather, I assessed the reunification rates of mothers with mental illness to mothers with substance abuse and those with co-occurring mental illness and substance abuse. In addition, by analyzing archival data from 2004-2014, this research will help professionals working in the child welfare system better understand the needs of mothers involved in the child welfare system. In addition, I worked to inform program development, which will assist mothers in meeting their specific needs by providing services designed for them, to be successful in reunifying with their children. By analyzing the needs of mothers throughout their cases, at each assessment point (30 days, 120 days, and every 90 days thereafter), there can be a more focused approach in providing the services they need. In addition, by analyzing the needs at each point, it is possible to see where change occurs in those areas in the life of the case, for example a mother may have social support rated as a need at the initial assessment point but by the end of the case it is a strength due to supports the have been developed over the case.

By addressing the needs of mothers with mental illness, they may have a greater chance of reunifying. If they are unable to overcome their mental illness, they may at least learn to have a positive relationship and support their children and caretakers. The results may be more successful if other needs are addressed in a more global approach. If a mother is provided the services needed, and the support to complete these services, they may be able to understand themselves more and make better decisions regarding their own lives and their children's best interests. In this study, I provided a positive social change in many areas. The child welfare system has long been interconnected to many

other systems. When better outcomes are found for families this will be seen in a variety of settings and systems in the human services field. Those affected by child welfare often have roles within many other systems, including welfare, corrections, and mental health.

Summary

The child welfare system affects everyone, not only the children and families involved in it. Families involved in the child welfare system are found in all areas of life. However, often times mothers with mental illness are treated like second-class citizens who have no right to be parents, and as such their rights have frequently been terminated without offering any services (Ackerson, 2003; Martin et al., 2002). In this study, through comparison of archival data, I will assist child welfare stakeholders by establishing the frequency mothers with mental illness reunify with their children in comparison with mothers with substance abuse or co-occurring mental illness and substance abuse. This will allow services to be developed to assist mothers in parenting their children. In Chapter 2, I provide detailed information regarding the literature describing these issues, as well as the need for this study.

Chapter 2: Literature Review

Every year, more than 400,000 children are in foster care in the United States. Within this figure, approximately 250,000 of these children exit the system in a given year with close to that many coming into the child welfare system (Child Welfare Information Gateway, 2012). Most of the children in foster care are there due to neglect (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2012). Neglect often occurs in families with mental illness and substance abuse (Child Welfare Information Gateway, 2013).

In the United States, the tradition has been that parents' rights are paramount. This tradition has guided the policy in the United States regarding child welfare. Three primary pieces of legislation determine how family reunification is done in the United States: the Indian Child Welfare Act of 1978 (IWCA), the Adoption Assistance and Child Welfare Act of 1980 (AACWA), and the Adoption and Safe Families Act of 1997 (ASFA) (Wulcyn, 2004).

Both ICWA and AACWA legislation have strong language that require the states to provide families with "reasonable services" and "reasonable efforts" prior to removing the child from the home, whereas ASFA gives strong language and requirements about timelines for reunification and termination of parental rights (Wulcyn, 2004). ASFA also links funding to following the specific guidelines for reunification and if these are not met, the state or county agency loses federal funding. With funding being tied to this legislation, some agencies are focused on ensuring the timelines are met and, in some

cases, sending children home even if the family is not ready for reunification. In other cases, the use of “compelling reasons” to exceed the timelines, including the child being placed with a relative, are being used and children are remaining in care while parents are being offered services for longer periods of time (Wulcyn, 2004). For most children, their exit from foster care comes in the form of family reunification; however, during a 10-year period approximately, 20% to 25% of those children will re-enter foster care (Wulcyn, 2004). For children whose stay is brief, meaning under 6 months, the re-entry rate was around 35%, whereas those who are reunified for 18 to 35 months, the rate was 25% for re-entry (Wulcyn, 2004).

Regarding child maltreatment, a large proportion of mothers with mental illness are represented in the child protection system. Researchers have documented that mothers with mental illness are at a greater risk than their nonmentally ill counterparts to have their children removed from their care (Ackerson, 2003). Mental illness affects a significant percentage of the population and a large percentage of those, an estimated two-thirds, are parents (Hinden, Biebel, Nicholson, Henry, & Katz-Leavy, 2006). Within the last 12 months, almost one-third of American women have shown evidence of a psychiatric disorder; of those, 65% were mothers (Kundra & Alexander, 2009).

In some states, mental illness is a reason to terminate parental rights (Ackerson, 2003; Martin et al., 2002). When looking at mental illness and successful reunification there are not many studies that provide information regarding reunification and reentry rates and timelines. For child welfare professionals, knowing and understanding what

successful reunification looks like for families with mental illness could influence how they do case planning and what services they request from the community.

Not only does mental illness have a large intersection with the child welfare system, but substance abuse also intersects with child welfare. Although substance abuse is also a mental illness within *DSM-5* diagnostic criteria, it is often considered a separate category within child welfare, and so it is treated separately here. Approximately 8% of child welfare cases include substance abuse as the sole problem (Nicholson et al., 2007). However, the estimates of how often substance abuse is involved in child welfare range much more between sources. Some sources cite a range between 50% to 80% of child welfare cases involving substance abuse (Anthony, Austin, & Cormier, 2010; Niccols et al., 2012); however, these studies do not differentiate between substance abuse as the sole problem and substance abuse combined with other reasons that the family comes to the attention of child welfare professionals. Often substance abuse can co-occur with other issues that cause a family to be involved in child welfare.

I assessed the difference in successful reunification between mothers who have a mental illness (not including substance abuse disorders) and those who have a problem with substance abuse as well as mothers with co-occurring mental illness and substance abuse. In this chapter, I review the literature relevant to parental mental illness and substance abuse as they relate to child welfare cases. In addition, the conceptual foundation for the study, which is the use of SDM in child welfare decisions is included.

Literature Search Strategy

I completed a comprehensive literature review related to parental reunification, treatment of parents with mental illness and substance abuse, and the SDM model of assessment, which I relied on in designing this dissertation. I used the following databases to gather the literature: Thoreau, PsychARTICLES, ProQuest, Academic Search Complete, MelCAT and PsychINFO. The key search terms that I used included *parental reunification, parental mental illness, parental substance abuse, foster care, SDM, structured decision making,* and *actuarial assessments.* I conducted the search from November 2012 through November 2016 and included articles and books with articles primarily being written in the last 6 years. In addition, I reviewed articles older than 6 years and included those that applied to the development of the SDM tools in decision making. I read the articles and included articles I deemed to be applicable.

Conceptual Framework: SDM in Child Welfare Cases

Decisions regarding opening a case in child welfare, removing children, and subsequent reunification have been criticized as inconsistent or inappropriate. These decisions can be costly and at times tragic (Baird & Wagner, 2000). Reducing these errors in decision making has been the driving force behind the development and adoption of SMD tools. SDM is an assessment framework that utilizes actuarial assessment in conjunction with the contextual clinical assessment to determine risk levels and plan the interventions (Shlonsky & Wagner, 2005).

Despite the various opinions regarding how the child welfare system should work, there is a fairly standard system that 25 states use for assessing families involved in child

welfare, called a SDM assessment system (Children's Research Center, 2008). Currently half of the United States, several Canadian provinces, and several Australian states have implemented actuarial risk assessment tools (Shlonsky & Wagner, 2005).

Three types of risk assessments exist: consensus and actuarial and contextual. Consensus-based assessments require that the social worker assess the client by a consensus of what the experts have determined is appropriate and use their clinical judgment about the future risk or harm. Actuarial systems are based on empirical data and the system gives a score of low, medium, or high risk to the family (Baird & Wagner, 2000). When professionals use an actuarial system, they have a checklist that guides them through the assessment process and the score on that checklist determines the risk level. This risk level can be used to determine what services the family needs, and the level at which the interventions are to be implemented (Orsi, Drury, & Mackert, 2014). Contextual assessments are those that assess the whole situation and look not at only the actuarial facts but the areas that change or make the situation different from others. Contextual assessment in the case of SDM is used in conjunction with the actuarial assessment to provide a more complete picture of what is happening in that situation (Bolton & Lennings, 2010).

Prior to the use of structured assessments being used in child welfare, decisions were made based on clinical decision-making and similar assessment styles. Consensus based systems have been the historical method that social workers used. Individual decisions would depend on the social worker’s experience, intuition and interviewing skills to determine future risk to the child. One issue that has been addressed is

determining the validity of clinical and actuarial risk assessments (Baird & Wagner, 2000).

Currently actuarial studies have been favored over clinical decision making. For many years, the viability of using actuarial risk assessments has been the topic of discussion and research (Baumann et al., 2005). Baird and Wagner (2000) found that when they compared systems the actuarial system demonstrated a significantly higher level of validity than the consensus-based systems with all the outcome measures. They found that actuarial systems are more accurate than consensus based systems and had great potential to improve the decision making process in child welfare (Baird & Wagner, 2000).

Although actuarial risk assessments have a greater predictive validity than that of a consensus based assessments, they will never take over the role of clinical judgment (Shlonsky & Wagner, 2005). Clinical judgment will still be necessary because there are times that the person conducting the assessment does not have a full picture of the family and the situation. SDM allows for a risk level to be raised to high risk based on clinical judgment and allows for a high-risk investigation to not become a formal case. This requires the clinician to explain why and a supervisor also must agree.

Actuarial assessments have some limitations, as well. For these assessments, sometimes there is inadequate information to complete a thorough assessment. There are times that the files are missing information and/or the family is not truthful regarding the information they provide in an attempt to make themselves look better or fear of having their children taken away from them (Baumann et al., 2005). There is some caution

needed when using actuarial assessments without considering the weaknesses (Baumann et al., 2005).

SDM in Child Protection: The Family Assessment of Strengths and Needs

In child welfare, often people have a difficult time assessing risk and determining what level of services should be offered. For a social worker, this can be difficult and even scary because if they make a mistake it could cost a child their life. The use of a standard tool to determine risk helps the social worker to decide not based on feelings alone. SDM not only can determine risk level of future harm in Child Protective Services cases, it can also be used to establish the intensity of the service response and is also used in case planning (Shlonsky & Wagner, 2005). It was developed by the Children's Research Center (Children's Research Center, 2008). Key in the effectiveness of SDM is the use of assessments of multiple types, both actuarial and contextual assessments are used to make the decisions. Contextual assessments are those that assess the whole situation and look not at just the actuarial facts but the areas that change or make the situation different from others. SDM utilizes both types of assessments and guides the responses of the agency based on the levels determined through the assessment process (Bolton & Lennings, 2010).

An example of an actuarial assessment in child protection work would be the California Family Risk Assessment. California currently uses the California Family Risk Assessment in 45 of the 58 counties (W. L. Johnson, 2011). This is still being used in many states (under the name Family Risk assessment) and is the only actuarial assessment being used in Australia. This assessment uses 11 items for neglect and 11 for

abuse which produces a risk level from low to very high (Bolton & Lennings, 2010). One of the key factors to this assessment is that it allows for the social worker to override the risk assessment one level higher based on clinical impressions. This assessment is also intended to determine the service intensity for the family (Johnson, 2011). This is only one part of the assessment. In addition, the SDM safety assessment is completed prior to determining if the children should be removed from the care of the parents. When used in practice this allows for the social worker to ensure that the children who are high risk but that do not require out of home placement receive in-home services and priority over those that are lower risk (Johnson, 2011).

In addition , as part of SDM's system of assessment there is the contextual assessment, the Family Assessment of Needs and Strengths (FANS) is a risk assessment that looks at the dynamic needs of the family. SDM utilizes both types of risk assessments to provide a clearer picture of the family and the situation as well as to assist in future case planning. Dynamic needs are needs that change over time or can change, for example housing, employment, current substance abuse, and other items that are related to current functioning. The important thing in this process is to utilize contextual factors as they relate to child abuse. In this assessment the factors are placed on a continuum from a strength to a severe need (Bolton & Lennings, 2010).

A structured needs assessment much like the Family Assessment of Needs and Strengths (also known as Family Needs and Strengths Assessment) contributes to case plans that are individualized. Evidence based practice integrates risk and needs assessments into case planning (Schwalbe, 2008). It is used to inform case planning

(Shlonsky & Wagner, 2005). It assists in documenting a family assessment, screening families for more intensive services or specialized services, choosing the interventions for the family and developing the case plan. The clinical assessment portion of SDM helps workers develop the case plan for the family utilizing the most critical and important information available (Shlonsky & Wagner, 2005). This study will be utilizing data from Michigan, which uses the Family Assessment of Needs and Strengths.

Conclusion

Overall, the use of assessments that are a system of multiple types of assessments provides not only evidenced-based risk levels but also is able to put some of the family dynamics into perspective. SDM is used as a system for assessment in child welfare throughout the United States as well as in several other countries. This is the standard practice as it has been demonstrated that it is effective in providing not only actuarial risk assessments and safety assessments but contextual assessments of the families to assist with case planning.

Literature Review Related to Reunification

There are several key variables or concepts related to this study: overall reunification rates of children in foster care, reunification rates with parents that have a substance abuse diagnosis and reunification rates with parents that have a mental illness diagnosis. Additionally, a key variable to discuss is the assessment tool that is used in determining the level at which the parents are impacted by their diagnosis.

Overall Reunification

More than 75% of children in foster care in 2012, were victims of neglect (Child Welfare Information Gateway, 2012; U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau,, 2012; U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2012). In the 2012 fiscal year 51% of children exiting foster care did so through reunification. In the group of children exiting foster care, 27% of the children were in care less than six months. An additional 20% were in care between six months and a year (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2012). For this study, reunification is defined as the children returning to their parents. "Successful reunification" is the term used when the children return home and the case is closed without the children being taken back into care.

Mental Illness and Reunification

When children are removed from their parents because their parents' abilities are limited due to a mental illness, often the system works to terminate the parents' rights. Currently the sources that track reunification rates do not track if the parents have mental illness. Over the years, several states, 37 to be specific, have implemented programs that allow for parental rights to be terminated prior to services being offered based on a parent's mental health diagnosis (Kaplan, Kottsieper, Scott, Salzer, & Solomon, 2009; Kundra & Alexander, 2009). Although, some states do provide more protection and allow

for the parent to submit information on supportive services that would assist them. According to the National Council on Disability (2012), in one study it was found that 6% of caregivers with children in care had an “emotional disturbance.” Additionally within this grouping are the 2.6% that have multiple disabilities (National Council of Disability, 2012). Currently there appears to be a void in data related to reunification rates for parents with mental illness. There are no current studies that have assessed reunification rates for parents with mental illness or evidence-based practices for working with parents with mental illness.

Often the only thing that matters in termination trials of this sort is the parents’ diagnosis. The parents’ past behaviors and current behaviors are forgotten, excluded, or ignored by the courts (Kundra & Alexander, 2009). There are not many services geared to assist these parents in recovery from their mental illness and being good parents for their children. One thought is that the reason for moving towards termination quickly is that there are not services for the parents that will make them well and that at minimum the children will have permanency within a few months instead of several years. Nicholson and Deveney (2009) conducted a search of the Substance Abuse Mental Health Services Administration and found very few targeted interventions towards parents that have mental illness. The authors found one program that was targeted towards parents with “significant mood disorders” and most of the other interventions were targeted for parents whose children had behavioral and emotional problems (Nicholson & Deveney, 2009).

Despite policies that speed up termination in these cases, there is research stating that most parents with mental illness, when given effective support and treatment, can parent their children; however, the parents do not seek out the services for fear of losing their children (Kundra & Alexander, 2009). For example, Boursnell (2007) found that often parents with mental illness attempt to hide that they are parents because they have a fear that their children will be taken away solely because they have a mental illness. These parents have a desire to be parents and want to have their children in their care but they also want to receive the assistance that they need to be good parents (Boursnell, 2007).

Nicholson et al. (2009) described a program in which parents were given a family coach to assist them in making goals and modeling problem-solving in the family as well as developing relationships with the family members. At the end of the program the parents reported greater social support and a reduction in services needed but not available to them. (Nicholson, Albert, Gershenson, Williams, & Biebel, 2009). However, this program is not an evidenced based program, and was implemented on a small scale in one community. It is unclear if this program would work in other communities or on a larger scale. This would be a program that could be a promising practice and could become evidence based should it be tested in other communities and on a larger scale to determine if this impact is duplicable.

As suggested in the Nicholson et al. (2009) study, for parents who are mentally ill one area that has been found to assist them in being mentally healthy is having an adequate support system (Kundra & Alexander, 2009). Social support has been found to

help people without mental illness and correlates to an individual's performance at work and home as well as other social contexts. This research with regards to people without mental illness can be applied to people with mental illness. The mental health field has been developing intentional recovery communities, such as clubhouses where clients can build a social support network in a safe environment with others that understand where they are coming from (Carolan, Onaga, Pernice-Duca, & Jimenez, 2011). To assist the clients in building relationships, the emphasis of the clubhouse is to build interpersonal collaboration. For clients in these programs they report that the clubhouse helps to facilitate personal growth and is a safe environment for them to learn. These type programs are still in the early stages and more literature regarding the clubhouse as a means of assisting those with mental illness will arise as these programs continue to develop (Carolan et al., 2011).

Substance Abuse and Reunification

It has been estimated that substance abuse involvement in child welfare cases is 11-14% of investigations. With these statistics, it has been estimated that 8% of child welfare cases involve substance abuse as the sole problem (Nicholson et al., 2007). Other studies have found that substance abuse occurs in as many as 80% of child welfare cases (Anthony et al., 2010; Niccols et al., 2012). Reunification typically is most successful within the first six months of care, but in cases where substance abuse is involved children often have longer periods of out of home care. There are several factors that may impact the reunification. One mitigating factor may be whom the child is placed with. Often in cases of substance abuse the children are placed with relatives, which may ease

the parents' stress about the child returning home quickly. The children placed with family members return slower, however they reenter less frequently (Nicholson et al., 2007). This would imply that the children return home when the parent is ready instead of prematurely.

Nicholson et al. (2007) looked at the reunification time for children that were removed for alcohol, alcohol and other drugs, drugs and for no drugs or alcohol. The group with neither alcohol nor drugs had just over half of the group reunified within 9 months and 64% reunified by the 18-month mark. The group where the parents only had a problem with alcohol saw 60% of the group reunified between 9 and 12 months. At the 18-month mark, around half of the children in both groups with drug use were reunified (Nicholson et al., 2007). Children that were removed due to drug use waited 100 days longer to reunify than children who were removed because of alcohol use and 200 days longer than children removed without drug use or alcohol use; however, children removed because of parental substance abuse often have an increased likelihood that they will be placed in care with a family member which may account for some of the longer periods of time (Nicholson et al., 2007).

Family Dependency Treatment Courts and their impact on the reunification and reduction of substance abuse have been the topic of many studies, as the program now exists is 38 states (Moore, Barrett, & Young, 2012). The goals of these courts are to assist in motivating parents to address their addiction and increase parental participation in treatment. This approach includes several elements: frequent court hearings, frequent drug testing, intensive outpatient treatment as well as rewards and sanctions for the

parents based on their compliance.

Moore (2012) found that at the 6-month follow up in this study, 62.7% were still enrolled (program length is 9-12 months). Of the discharges, 17.3% were assigned to a more intensive program, 14.5% were transferred to another program, 2.4% quit and 1.2% were incarcerated. The average length of stay for those that left the program was three months. In the program 90% tested positive for drugs at least once. The average length from initial abstinence until a positive urinalysis was 36 days and the longest period was 57 days. At the 6-month follow up 6% reported using alcohol in the last thirty days and 11% reported illegal drug use in the last thirty days. This demonstrates that this program is impacting parental substance abuse (Moore et al., 2012). When parents can maintain abstinence from substances, they are more likely to reunify with their children.

In Baltimore, Burrus, Mackin and Aborn (2008) found that children whose parents were receiving services through the Family Dependency Court were in non-kinship foster care for 252 days versus their counterparts not involved in the Family Dependency Court who stayed approximately 342 days. They were also 1.5 times more likely to reunify and had a 70% reunification rate. Additionally, these parents were almost twice as likely to complete treatment and spent more time in treatment. It was found that this program actually saved over a million dollars to the state because of the reduced time children were in foster care (Burrus, Mackin, & Aborn, 2008). Additionally, Green, Furrer, Worcel, Burrus, and Finnigan (2007) found a similar result in that parents began treatment more quickly, stayed in treatment longer and were more likely to complete treatment. The children in this study were reunified much more quickly and

were less likely to have subsequent out of home care (Green, Furrer, Worcel, Burrus, & Finnigan, 2007).

It appeared that for parents with substance abuse as a primary issue, there are services that may assist them in reunifying and maintaining a new lifestyle after completing treatment. However, the studies regarding the family dependency court do not follow those that left the program for higher levels of treatment or those that left the program to find out if they had a similar success rate when they left. Those that left the program may have also reunified just as successfully as those that stayed in the program, however, they were not tracked and there is no data as to how well the individuals did in another program. The data may not be complete as to how well this program works in comparison to others.

Duffy and Baldwin (2013) assessed a person's recovery after completing substance abuse treatment and what factors were found to be useful in maintaining sobriety. This study found that one of the key factors that was an indicator of success was if the participant had social support. Additionally, this study found one of the other key predictors of success was if the participant had stable housing. This study found that most of the participants were residing in a supportive housing situation (Duffy & Baldwin, 2013). It is noted that in this study the participants had successfully completed a treatment program and were currently substance free. This study provided good information; however, it did not include those who had relapsed and used substances. A relapse is often due to a stressor and talking with those in a relapse could provide insight into what needs are highest priority and may cause the relapse. Relapse often hinders or

stops reunification or causes re-entry into the child welfare system if the child has been returned home.

Co-Occurring Mental Illness and Substance Abuse and Reunification

Co-occurring disorders are estimated to effect 5 million individuals (Choi, Huang, & Ryan, 2012). For those that have a co-occurring disorder, 53% percent never receive any type of treatment. 34.3 % receive treatment for mental health, 4.1% receive treatment for substance abuse and 8.5% receive treatment for both (Choi et al., 2012). It is thought that 20% of people that have a severe mental illness will develop a substance use disorder in their lifetime (Priester et al., 2016). Those with untreated co-occurring disorders often present with anxiety, depression and personality disorders. Also they are frequently homeless or have a history of incarceration (Priester et al., 2016). For those that have substance use disorders, 41% to 65% have a lifetime occurrence of mental illness and 51% of those with mental illness have a reported substance use disorder (Townsend, Biegel, Ishler, Wieder, & Rini, 2006). It has also been found that 25-35% of people with a mental illness have an active substance use disorder. Those who use substances while having a severe mental illness have a weakened ability to develop and follow a treatment plan as well as destroying the few social networks they may have. Women with co-occurring disorders are more likely to be diagnosed with PTSD, major depression and generalized anxiety (Townsend et al., 2006).

Choi and Ryan (2007) used data from Illinois Alcohol and Other Drug Abuse waiver program to determine if matching the parents needs to services affected reunification rates. In this study they found that in the sample 76% of the mothers had

more than four types of needs simultaneously (Choi & Ryan, 2007). The study found that co-occurring problems interfered with the likelihood of reunification. Choi and Ryan (2207) found in their study that 52% of the participants had co-occurring substance use and mental illness. Matched services increased the likelihood of family reunification (Choi & Ryan, 2007). Choi et al. (2012) found that mothers that were employed were 1.7 times more likely to reunify than those not employed. Mothers that had substantial progress in substance abuse treatment were 2.1 times more likely to reunify with their children (Choi et al., 2012).

Marsh et al., (2005) completed a study related to integrated service models with co-occurring substance use and mental health. It has been found that integrated service models have started to be used with reunification, specifically those with multiple issues such as substance use, mental health, domestic violence and housing (Marsh, Ryan, Choi, & Testa, 2006). One model of this is the recovery coach model in which a recovery coach is used to link clients with services in a manner seen as an intensive case management approach. While there was a significant improvement in reunification the rates remained low at 10% reunification (Marsh et al., 2006). Even with integrated case management services only 18% had completed substance abuse treatment. For families dealing with multiple concerns the reunification rate was 12% (Marsh et al., 2006). These rates are saddening to see that even with integrated services mothers are not likely to reunify and there is no further research to describe any possible ways to improve reunification status.

While there are some studies that have begun to look at co-occurring substance use and mental health, there are not many. Co-occurring problems were negatively

related to reunification rates (Choi et al., 2012). However, most of the studies have been conducted by the same core research group using the same data in one geographic location. The research is not complete and there is not any evidence-based practices that have been developed to assist mothers with co-occurring disorders. There continues to be barriers to treatment including that some mothers do not access treatment due to fear. One researcher found that 26.4% of single mothers that receive welfare did not access treatment due to fear. Additionally another barrier to completing treatment is the lack of availability of services to treat co-occurring disorders (Priester et al., 2016). The barriers for treatment are similar for those with co-occurring disorders as well as those with mental illness alone. One thing is constant, there are no programs or research that is comparing reunification rates with parents that have co-occurring disorders and those with those with just substance abuse or those with just mental illness. Additionally, the other factors that may be related to reunification are not assessed.

Structured Decision Making

As described earlier, SDM is the assessment technique that more than twenty states use for evaluating child welfare cases. These states use this assessment system to determine the risk and safety in the home as well as determining progress with ongoing cases. This tool incorporates both parents if there are two parents in one household or as two households if they are separate, as well as any needs or strengths that the children may have (Freitag & Park, 2008). If there is one parent with significant needs and the other does not have needs as significant, the family's overall needs are based on the overall priority needs of both parents as one unit (Scott & Dadds, 2009).

The use of structured decision-making came to have a standard way of assessing families that is not biased by the social worker. The federal government recommends four key general areas of assessment, which include patterns of social interaction, parenting practices, background and history and access to basic necessities (M. A. Johnson et al., 2008). Most of these assessments not only include these four areas but other specific risk factors for child maltreatment. Additionally, these four general areas are broken down into more specific questions to gain a better understanding of what needs arise within the group. As families navigate through the child welfare system, the SDM assessment is completed on a scheduled basis with some states at three-month intervals and in others at six month intervals. At each point that the assessment is completed a new case plan is developed and the case goes before the juvenile court to determine if the children should reunify. For example, in the SDM assessment there are several questions about basic needs, including housing, employment, and resource management. Each of these is rated individually to determine which part needs to be addressed first or given the most focus (Freitag & Park, 2008). This study measured mental illness and substance abuse and comparing if reunification happened at that point or not. When parents make progress on their case plan, are consistent with visitation and growth is seen in key areas within the family strengths and needs, then reunification is recommended. It is assumed that as the family is completing their case plan, caseworkers will see a decrease in the need level in areas such as parenting, mental health, substance use.

Summary and Conclusions

Throughout the literature review, there was no study that directly compares reunification rates for parents with mental illness and those with substance abuse. There are studies that discuss substance abuse as it relates to parental reunification and successful reunification. There were not many studies that discussed mental illness and successful reunification and more specifically not many recent studies. Most if not all studies discussed the need for a quick termination of parental rights. There are suggestions that some of the key tenets that are involved in substance abuse recovery may assist parents with mental illness if they have the same deficit. There are some substance abuse programs that are working well with child welfare and have increased the reunification and long-term substance free life of the parent. There are not studies showing the differences in the three groups when looking at the SDM tool. Additionally, there may be other areas where the parents overlap.

It is unclear how these two groups of parents compare to one another when rated on the same scale. When using the same rating scale, it is possible to see where one group has new strengths develop and where they continue to have similar deficits. This study utilizes archival data to compare closed cases with parents that have a substance abuse diagnosis or would qualify for one and parents with mental illness as a diagnosis. This study looked at the length of time the case is open, as well as if the child reunifies and how long this takes. This fills the gap by providing specific data between the three groups to assist in developing programs to assist in ensuring that the best outcomes for the

children are reached. The specifics of how the data were gathered and analyzed is further discussed below.

Chapter 3: Research Method

Introduction

My purpose in this study was to determine what differences there are with regard to reunification of parents with their children who are in the child welfare system when mental illness and when substance abuse are present both independent of one another and as co-occurring disorders. I hypothesized that parents with mental illness would reunify less frequently and over a longer period than parents with substance abuse or those with co-occurring mental illness and substance.

This chapter begins with the discussion of the research design and rationale for the research design. After that, I discuss the methodology including data collection and sampling procedures. Last, the possible threats to validity will be discussed as well as how the threats will be minimized.

Research Design & Rationale

This study was a quantitative research study in which I used archival data. This study was correlational, and I used an independent group design. I used the numerical rating data from the SDM FANS tool to compare outcomes between three groups of parents, parents with mental illness, those with substance abuse, and those with co-occurring mental illness and substance abuse. The independent variable was mothers' identified group (mental illness, substance abuse or co-occurring mental illness and substance). The primary dependent variables are reunification status and length of time to reunification.

For this study, I gathered archival data from old case files that fall between the years 2004 and 2014. Within the files the information regarding the SDM scores were gathered and put into SPSS software to be analyzed. The data that I gathered included the scores for all SDM assessments completed with the family as well as the reunification date and case closure date and whether the case closed while in reunification status, or if the date ends with termination of reunification services.

The design choice of using archival data allowed for the researcher to examine actual data from the field, without interrupting the lives of families that are going or have gone through a difficult time. This allowed me to analyze the data based on what is being done with families by local agencies without adding a potentially confounding factor of adding a researcher. In addition, by using archival data, the chance of triggers or poor reactions to the questions are mitigated. This allows for the researcher to observe the process that the family goes through in working to reunify without interruption or distraction. I analyzed the data from the mothers in a natural setting and allows the families' true outcome to be seen without any impact from the researcher.

Methodology

Archival Data

My purpose in this study was to investigate the relationship between parental mental illness and substance abuse and child protection case closure. Ideally, the findings would generalize to child welfare cases in the United States, which includes 415,129 which is the number of children in foster care as of September 30, 2014 (U.S. Department of Health and Human Services, 2015). However, I had access to child welfare data in one

state, Michigan, and from only one child welfare agency. This agency handles a portion of families in the child welfare system across multiple counties in the state of Michigan. According to the Children's Bureau, in 2014, Michigan had 13,452 children enrolled in foster care. Given that this sample is only one agency covering only a few counties in Michigan, the target population is less than half of that (U.S. Department of Health and Human Services, 2015).

Cases

For the study, I used a total population sample of families serviced by a specific agency. I was given permission by the agency's board of directors to use the data as far back as ten years: 2004 to 2014. This study included all cases in the 10-year span that meet the qualifications for the study, which are that the mother showed a deficit on the assessment tool in substance abuse or mental illness or both.

Cases in which reunification status is not known, as the child moved to another agency were included and classified as such. Cases that begin in timeframe, but do not end by the end of the timeframe were excluded. In addition, cases in which the child was removed from a caregiver other than the mother were excluded. Cases where the child reunified with the father were included and classified as such.

Cohen (1992) stated that a medium effect size for relationships is .30. The minimum acceptable power level for social sciences is .80 (Cohen, 1992). A sample size of 242 was required for an alpha level of .05 and a power level of .80. The sample size for this study was 87, which is less than the required sample size for statistical significance. The sample size was smaller than anticipated, due to inclusion criteria, as

well tracking the cases by the mother and not the children. For the purposes of the agency determining caseload, it is by the number of children, and although there were 87 cases, the number of children involved was significantly higher. All the cases that met the criteria were included. I moved forward with less cases, knowing that insights were still available in the data for future research.

Instrumentation and Operationalization of Constructs

Dependent Variables

There are two dependent variables in this study: reunification status and length of time to reunification. *Reunification status* was defined as whether the children return home with their parents after being placed in out of home care. This would follow that according to the Adoptions and Safe Families Act and the policy of the state of Michigan, reunification falls within the specified time frames of no more than eighteen months after the child is taken into care. This variable was binary in nature with the only response option being yes or no with regard to reunification.

The second variable was the question of the length of time it takes for the family to reunify. This variable is necessarily categorical due to how it is measured. It is measured in incremental terms based on the frequency of court hearings, and the SDM assessment requirements. The categories for length of time was: three months or less, up to six months, up to nine months, up to one year, longer than one year. Although the exact number of days a child is in care is available in some cases, using grouping allowed for standard results. Currently in child welfare outcomes are measured by the groups

listed above and the data gathered in the study were able to be applied to other child welfare outcomes.

Independent Variables

The first independent variable related to identifying which group the mother belongs to: mental illness only, substance abuse only, or both mental illness and substance abuse. Categorization was determined based on scores on the SDM assessment tool at the initial assessment. The initial assessment was completed regarding the family within the first thirty days of the case being opened and future assessments are completed every 90 days after (see appendix A for a copy of the assessment).

Mental illness and substance abuse for this study was measured based on a rating of less than 0 on the initial assessment. A score of 0 or above was rated as a strength. For this study, the variables were converted to binary scores with yes, mental illness or substance abuse is a deficit, or no, mental illness or substance abuse is not a deficit. If the score was less than 0 then the score was converted to a yes variable. If the score was rated 0 or above, then it was converted to no. Co-occurring was be defined as a parent that has a yes rating in both mental illness and substance abuse. Mental illness for this study was measured under the area of emotional stability behavior, with the definition of "some problems" or "chronic depression, severely low self-esteem, emotional problems." For this assessment and future assessments "some problems" is rated as -3 and "chronic problems" is rated as -5. The guide social workers used to complete the assessment for the family provided additional descriptors to distinguish between "some problems" and chronic problems." For a rating of "some problems" the mother's emotional stability

moderately impacts the family function, parents, employment or other aspects of daily living. For a rating of chronic or severe problems, the mother has chronic depression, apathy or severe loss of self-esteem or is hospitalized for emotional problems or is dependent on medication for behavior control. This rating was based on an interview with the family and observed behaviors by the social worker or other sources that have documented interactions with the mother. Substance abuse was rated at three different need levels, the first being "caretaker with substance problem/current treatment issue," the second and more severe "caretaker with a serious problem" and the third and most severe "problems resulting in chronic dysfunction." For a parent to be rated at the first level there needs to be disruptive behavior or discord in the family that is caused by the substance abuse. The second with a serious problem would include having problems such as a loss of a job, problems with law, and family dysfunction and that it causes a problem for the family. For chronic dysfunction, the mother would need to have a pattern of substance abuse problems that resulted in a chaotic or dysfunctional household.

Additionally, measured were the strengths and deficits that the family has, as measured by the SDM as potential predictors. These additional areas include: sexual abuse, parenting skills, domestic relations, social support, communication or interpersonal skills, housing, intellectual capacity, literacy, resource management, physical health, employment, and child characteristics, which may be designated as a strength or deficit. While in the assessment these areas are measured on a scale, for this study these were measured as binary strength or deficit. If the score was less than 0 then the score was converted to a yes variable. If the score was rated 0 or above, then it will be

converted to no. These areas were measured with the substance abuse and mental illness at intervals of ninety days, with the first assessment being completed within the first 30 days after removal as the initial assessment and then 120 days from removal for the next assessment, 210 days from removal adding 90 days until the point at which the child returns home or the timeframe has passed to determine if there is a change in the variables rating as a strength or a deficit. These areas were then compared between the substance abuse group, the mentally ill group, and the co-occurring group to determine if there are mediating variables.

Data Analysis Plan

The data were analyzed using IBM's Statistical Package for the Social Science (SPSS), version 21. The data were gathered directly from closed case files and entered into SPSS without any identifying information. For each case, the SDM data, the specific numerical rating was entered at the intervals of 30 days, and every 90 days thereafter until the case closes with either reunification or termination of parental rights.

Research Questions and Hypotheses

1. What is the relationship in reunification rates among mothers with mental illness, substance use and co-occurring mental illness and substance use in cases where children are removed due to neglect or abuse?

H_{01} — There is a no significant relationship in reunification rates for mothers with mental illness, in comparison to those with substance use, and mothers with co-occurring mental illness and substance use, in cases where children are removed due to neglect or abuse.

H_1 – There is a significant relationship in reunification rates between mothers with mental illness, in comparison to those with of substance use, and mothers with co-occurring mental illness and substance use.

To test this hypothesis, I used a two-way chi-squared analysis to determine if the three independent variables of mental illness, substance abuse, and co-occurring mental illness and substance abuse are independent of each other and if the dependent variable of reunification has a statistically significant difference in the frequency of reunification occurring. Through this statistical test, it was determined if the difference in rates were to happen based on a chance or coincidental occurrence or if the difference is related to the status of the mother with regards to the primary deficit.

2. What is the relationship in timelines for reunification for mothers with mental illness compared to mothers with substance use and mothers with co-occurring mental illness and substance use in cases where children are removed due to neglect or abuse and are reunified?

H_{02} – There is a no relationship in timelines in reunification rates with mothers with mental illness, in comparison to those with substance use and those with co-occurring mental illness and substance use.

H_2 –There is a significant relationship between mothers with mental illness, in comparison to those with substance use or mothers with co-occurring mental illness and substance use.

In this research question, I ran a chi-squared analysis with the binary independent variables of mental illness, substance abuse and co-occurring substance abuse and mental

illness and the categorical dependent variable of the timeline for reunification. The timeline has specific points which are reported. The specific points at which the assessment is completed within the first 30 days and then every 90 days after that point until the case closes or reunification efforts end. This was completed to determine if there is a difference in the time it takes for the parent to reunify.

3. What dynamic assessment factors from the Family Assessment of Needs and Strengths (FANS) predict reunification?

H_{03} – Dynamic assessment factors from the Family Assessment of Needs and Strengths (FANS) do not predict reunification.

H_3 – Dynamic assessment factors from the Family Assessment of Needs and Strengths (FANS) predict reunification

This hypothesis was only to be tested after determining if there is a relationship between reunification status and mother's primary deficit. If in Research Question 1, it was determined that there was a relationship then this researcher would determine if there is a relationship between the possible predictors and reunification status. To determine if there was a relationship between the possible predictors and the reunification status. The binary variable of reunification, which would be yes or no in answer was compared with each possible dynamic assessment factor including parenting skills, domestic relations, social support, communication or interpersonal skills, housing, literacy, resource management, physical health, employment, and child characteristics. The variables were given a numerical rating of -1 for a deficit and 1 for strength. These variables would be compared separately using individual chi-squared analysis. From this analysis, any

variable that is deemed to have a significant relationship would then be analyzed to determine if there is a relationship between mother's primary deficit and these possible mediating variables. After this a binary logistic regression would be run with the mother's group (mental illness, substance use, co-occurring mental illness and substance use) as a predictor and the potential predictor as a predictor and the reunification status would be the dependent variable. Each potential predictor would be run individually, and from that any potential predictor that after the analysis that the reunification status is no longer related to which group the mother belongs to; then the potential predictor would become a predictor of reunification. This was done to determine if there are predictive variables that are impacting reunification in a positive light or a negative light.

Threats to Validity

Internal Validity

In this study, the threats to internal validity, including the many variables within the assessment are being considered and addressed. One area where there was a possible concern to internal validity is that of attrition. Michigan assigned families to agencies as they can provide foster placement for the children there is some attrition when children must move and are unable to remain in the same agency. When the children move, the data regarding their reunification was no longer available. Furthermore, there may be a threat to internal validity based on maturation or the age of the parents or the children. This is not measured on the assessment tool and therefore could impact the data in an unknown way. In child welfare, there is a difference in the timelines allowed based on age and this may impact how long it takes for the parents to reunify. When children are

under three years of age, their parents are given six-months to a maximum of twelve months to reunify. When children are over three years of age, parents are given twelve months to a maximum of eighteen months to reunify. Additionally, as children age, reunification often can become harder because behaviors are more ingrained. Additionally, as this study is looking at correlational issues there is often a misconception to move from correlation to causation which needs to be remembered and addressed. Correlations may show a relationship and should not be mistaken for a causation.

External Validity

A concern of any study was to reduce the possible threats to validity of the data. In this study, the data is being gathered from a small non-profit agency within the state of Michigan. While the goal is that the data is representative of the whole of children placed in foster care, it is possible that this may not be a complete representation. Additionally, while this area covers multiple counties, these counties are more rural than others and the services available may be less than other areas. This may limit how this can be generalized because the sample is limited to one area.

Ethical Procedures

Permission to use the data was given by the board of the non-profit organization on February 5, 2014, and formal approval was given by the agency on August 5, 2017. Approval was granted by the university's Institutional Review Board on August 31, 2017 (approval number 08-31-17-0243315). The data were stored on a password protected computer as a SPSS file without any case identifying information. The only information to be stored was numerical data, which did not include any personally identifying

information. As I worked for the agency for a specific period, cases were pulled from prior to my employment or were cases that I had no direct interaction with.

Summary

The purpose of this study was to determine if there is a relationship in reunification between mothers that have mental illness as the primary deficit, mothers who have substance abuse as their primary deficit and mothers with co-occurring substance abuse and mental illness and the primary deficits. This was accomplished by studying archival data from an agency in Michigan as related to the SDM assessments completed.

I hypothesized that there was a relationship between reunification rates and the mother's primary deficit. Additionally, I hypothesized that there was a relationship between the length of time to reunification and the mother's primary deficit. I additionally hypothesized that there were variables that are predictors of reunification. I tested my hypothesis through a chi-square with the independent variables of substance abuse, mental illness, and co-occurring substance abuse and mental illness and the dependent variable of reunification. I tested my second hypothesis with a chi-squared with the independent variables of mental illness, substance abuse, and co-occurring substance abuse and mental illness and the categorical dependent variable of length of time to reunify. I would have tested the third hypothesis after determining if there was a relationship between reunification status and possible mediating variables using a chi-squared and if there is a relationship further testing would be completed using a binary logistic regression.

Chapter 4: Results

Introduction

My purpose in this study was to assess reunification rates of mothers who had their children removed from them due to child abuse or neglect based on falling into three categories, those with mental illness, those with substance abuse and those with co-occurring mental illness and substance abuse.

The research questions for this study were as follows:

1. What is the relationship in reunification rates among mothers with mental illness, substance use and co-occurring mental illness and substance use in cases where children are removed due to neglect or abuse?
2. What is the relationship in timelines for reunification for mothers with mental illness comparison to mothers with substance use and mothers with co-occurring mental illness and substance use in cases where children are removed due to neglect or abuse and are reunified?
3. What dynamic assessment factors from the Family Assessment of Needs and Strengths (FANS) predict reunification?

Chapter 4 consists of the following: reviewing the data collection, the study demographics, and the data analysis related to the above listed research questions and a chapter summary.

Data Collection

I collected data case files that ranged from 2004 through 2014. Cases were included if the mother was identified as a member of one of the three groups: having

mental illness, substance abuse or mental illness and substance abuse. The that I data gathered included all available case files at the agency that provided the cases. This would be representative of cases in child welfare in the counties which they serve. I gathered data from 89 cases, of which two were excluded as they did not fall into one of three categories.

Study Demographics

I gathered cases from several counties in southeast Michigan. All cases were children removed from their mothers for abuse or neglect. Only four cases belonged to the substance only category, 38 that belonged to the mental illness only, and 45 that belonged to the co-occurring disorders category.

Data Analysis

The data analysis plan in Chapter 3 was to analyze the data using IBM's Statistical Package for the Social Science (SPSS), version 21. The plan was to gather the data directly from closed case files and enter the data into SPSS without any identifying information. For each case, the SDM data, the specific numerical rating was entered at the intervals of 30 days, and every 90 days thereafter until the case closed with either reunification or termination of parental rights.

In the study, I analyzed the data using IBM's Statistical Package for the Social Science (SPSS), version 24, because this was the current version available at the time of data analysis. The data were gathered from the case files and entered into SPSS and excel without any identifying information. The ratings were entered at the intervals of 30 days, and every 90 days thereafter, until the case closed, parental rights were terminated, or the

family leaves the agency. Originally, the plan was to exclude the cases in which the family left the agency; however, it seemed that it would be beneficial to include the data.

Results

This study only included females, who had children removed from their care due to abuse or neglect. In this study there were eighty-nine cases, two cases were excluded as they did not meet the criteria for group inclusion. Of these cases reunification occurred fourteen times, nine reunified with their mother and five reunified with their father. Of the cases, 52 cases (59.8%) closed with adoption. Of these cases 2 (2.3%) closed in legal guardianship and 19 (21.8%) were closed with a status of left the agency or went to relatives. Of the 87 cases, 4 (4.6%) did not have a negative rating in emotional stability and 38 (43.7%) did not have a negative rating on substance abuse, 45 cases (51.7%) had negative ratings in both substance abuse and emotional stability.

1. What is the relationship in reunification rates among mothers with mental illness, substance use and co-occurring mental illness and substance use in cases where children are removed due to neglect or abuse?

A two-way chi squared was run between the mother's status and reunification status. the chi-squared value was 0.889, p=0.641 and the likelihood ratio was 1.282 with 2 degrees of freedom. This value was not statically significant as the critical value was 0.02. Please see Table 1 for a distribution.

Table 1

Reunification Status

		Co-occurring	Mental health	Substance abuse	Total
No reunification with mother	Count	41	33	4	78
	% within reunification mother	52.6%	42.3%	5.1%	100.0%
	% of total	47.1%	37.9%	4.6%	89.7%
Reunification with mother	Count	4	5	0	9
	% within reunification mother	44.4%	55.6%	0.0%	100.0%
	% of total	4.6%	5.7%	0.0%	10.3%
Total	Count	45	38	4	87
	% within reunification mother	51.7%	43.7%	4.6%	100.0%
	% of total	51.7%	43.7%	4.6%	100.0%

2. What is the relationship in timelines for reunification for mothers with mental illness comparison to mothers with substance use and mothers with co-occurring mental illness and substance use in cases where children are removed due to neglect or abuse and are reunified?

In the substance only category there were no reunifications. This group was not included in the analysis.

In the mental illness category there were five reunifications, the range for quarters (measured every 90 days, after the initial assessment was completed at 30 days) to

reunification was a span of nine quarters. The minimum was four quarters and the maximum was thirteen. Three of the five reunification happened in four quarters and one happened in five. There was one outlier with thirteen quarters. A chi-squared analysis was run with the category of mental illness, the chi-squared value was 4.550, p=0.208 and a likelihood ratio of 5.603 with 3 degrees of freedom. This value was not statically significant as the critical value was 7.815.

In the co-occurring mental illness and substance use the minimum number of quarters to reunification was three and the maximum was five. There was a total of four cases in this category. The Chi-Squared value for mental illness is 7, p=.136 with a likelihood ratio of 8.376 and 4 degrees of freedom. This was not statistically significant as the critical value is 9.488. The chi-squared value for substance use the chi-squared value was 10.111, p=0.257 with a likelihood ratio of 11.287 and 8 degrees of freedom.

3. What dynamic assessment factors from the Family Assessment of Needs and Strengths (FANS) predict reunification?

This question was to be tested after determining if there is a relationship between reunification status and the mother's primary deficit. As there was no significant relationship between reunification status and the mother's primary deficit, this analysis was not run and this question was not answered.

Summary

In this study, the sample size was less than that to be significant. The needed sample size was 242 cases using an alpha of .05, power of .80 and an effect size of .30. The sample size was 87 cases. The groups were not equal in size and one group was

significantly smaller than the others. There was no significance found in any of the data, due to the size of the sample. Chapter 5 will provide interpretation of the findings as they relate to the literature review found in Chapter 2. In addition, implications for social change will be discussed as it relates to the future of child welfare. Chapter 5 will also discuss recommendations for future research and how ensure there is significance in future studies.

Chapter 5: Results

Introduction

Research in child welfare has largely focused on the need for termination of parental rights for parents that have mental illness concerns. Studies that assess reunification typically focus on parents with substance abuse concerns while leaving out parents with mental illness. Research related to mothers with mental illness is heavily focused on denying services due to the mental illness and quickly moving towards adoption (Ackerson, 2003; Martin et al., 2002). I conducted this study to compare mothers who have substance abuse with those that have mental illness as well as those with co-occurring substance abuse and mental illness. I conducted this study to determine what the difference in reunification might be between the three groups and learn where the greatest need for services is. In this study, a small percentage of reunification existed and none was in the substance only group, which had only four cases. The percentage of reunifications was significantly smaller than the national average. In this study, reunification occurred close 16% of the time, whereas the national average was 51% (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau,, 2012). This study had a small sample size and there were not statistically significant answers, but questions were raised.

Interpretation of the Findings

The findings of this study brought attention to an area that needs further research. Previous research estimated that child welfare cases that involved only substance abuse

were 8% of the cases (Niccols et al., 2012). In this study. the number was 4.7% of the cases were only substance abuse related. However, studies also estimate substance abuse to be involved in 50% to 80% of cases, while not specifying if this is only substance abuse or substance abuse and other issues, including mental illness (Anthony et al., 2010; Niccols et al. (2012). In this study, 51.7% of the cases had substance abuse and mental illness as identified concerns, which seems to echo what is observed in research. Although the previous research did not provide estimations on how many cases involved mental illness only, 43.7 % of cases were mental illness only. This would suggest that mental illness is more entrenched in the child welfare system than assumed.

Question 1

Although the sample size was small, and the results did not meet the level of significance, in the substance only group, which had four cases, there were no reunifications. There were five reunifications with the mothers of 38 cases in the mental illness only category. With the co-occurring disorders category, there were four reunifications of 45 cases. It would appear that mothers with mental illness were reunifying more often than those with substance abuse. Although this is a preliminary view because the sample size was smaller than expected and did not return a significant value, it brings cause for further investigation.

Question 2

Within the two categories that had reunifications, the timelines to reunification were similar. The mental illness only had an outlier in which reunification happened after 13 quarters. This is not typical in reunification as the federal law gives no more than eight

quarters for a maximum. The additional reunifications happened within four or five quarters. The time to reunify is similar between mothers with mental illness only and those with co-occurring substance abuse and mental illness.

Question 3

This question was not answered as there was not a statistically significant difference in reunification rates between mothers with substance abuse, mental illness and those with co-occurring mental illness and substance abuse.

Limitations of the Study

Within this study, there were several concerns related to internal and external validity. One of these concerns was that the study used data from only one agency. While that agency covered multiple counties in one state, it did not cover the entire state and did not include cases from urban areas. The nationwide data reports that 51% of children exiting foster care left due to reunification in the 2012 fiscal year (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau,, 2012). However, in this study reunification with the mother occurred 10.3% of the time and reunification with the father occurred 5.7% of the time. This number was far less than the expected number of reunifications which raises more questions. Are the low number of reunifications due to the rural nature of the areas covered by the agency had more barriers to reunification? There is a lack of consistent public transportation in less urban areas so accessing resources and services would be more difficult. Most of the effective substance abuse programs required attendance several days a week, which may be difficult to achieve in

rural areas (Moore et al., 2012). For those mothers this may have limited their ability to reunify and could explain the lack of reunification for those with substance abuse only.

Additionally, a limitation in this study is that once a child left the agency, even to be placed in another agency's foster home, the agency no longer had access to the reunification status of the child. This would imply that children with problematic behaviors would need to be placed with another agency, even while starting with this agency. This study, did track how many children left the agency to another agency placement in order to have a complete understanding. In this study 13 children (14.9 %) left the agency to unknown places and 6 children (6.9 %) were placed with a relative.

However, the biggest limitation in this study was the sample size. The agency had only 89 cases available, of which 2 had to be excluded as they did not meet the criteria for any of the three groups. This would be an area where access to state-wide cases would result in a larger sample size, as well as the ability to pull a sample from all the cases in order to have equal groups. This could also provide a clearer picture of areas where the numbers may not line up with the state or national data. Overall, the limitations were managed as well as possible. The study did not have statistical significance due to the sample size but did raise questions that additional studies would need to address.

Recommendations

Future research in this area is needed to assess a larger sample size, perhaps gathering the data on a state level or regional level with multiple states. Also, it would be helpful to compare geographical regions in future research as some areas may reunify less often than others, for example urban versus rural.

As people begin to assess the other variables as they relate to reunification of children with their families, it is likely that reunification will be more frequent, and children will have better outcomes. While this study had a small number of reunifications, which occurred in the mental illness or co-occurring substance abuse and mental illness groups, it is noted that this number is far smaller than the typical reunification and therefore could include more reunifications in the substance abuse only group, should a larger sample size be taken. Assessing what families need to have better outcomes in reunification can assist in developing programs that speak to those needs specifically and help families overcome barriers. In the child welfare system where over 400,000 children exist at any time; every action needs to be taken to safely return children to their parents.

With this study having reunifications coming from mothers with mental illness or mothers with co-occurring substance abuse and mental illness, it may be time to reassess the language that allows for mother's not to be given a chance to reunify due to their mental illness and provide them with the support they need to function with their mental illness and parent their children. There may also be a need to expand services in rural areas, such as providing transportation or in-home services to help families succeed. At minimum this is an area where more research needs to happen, to see the specifics of who is reunifying with mental illness, are they diagnosed with mental illness or simply presenting as emotionally unstable.

Conclusion

There are still over 400,000 children in foster care in the United States at any given time and about half are reunified with their parents (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau,, 2012). Additionally, only about a quarter of the children in foster care exit to adoption (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau,, 2012). That leaves over 100,000 kids that need permanency, that are sitting in a broken system without having a permanent family or their own family. It is time to look at all the variables to see what can be done to improve outcomes for families and children.

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Appendix A: Family Assessment of Needs and Strengths

FAMILY ASSESSMENT OF NEEDS AND STRENGTHS
Michigan Department of Human Services

Household Name:	
Primary Caretaker:	
Secondary Caretaker	
DHS FC Worker Name:	
DHS FC Worker Load #:	
POS Agency Name:	
POS Agency Worker:	

Check One:

☐ **Initial Service Plan**
☐ **Updated Service Plan**

Date Completed: _____
CHILDREN INFORMATION:
Child's Name: **Child' Case Number:**

Rate the caretaker(s) on all items, except for Item S14. Select the score that applies to each caretaker under each category. For items where the foster care worker is unable to obtain information at the ISP, Record US for Unable to Score. If a parent refuses contact at the 1st USP, "US" may be used with prior supervisory approval.

		Primary Caretaker	Secondary Caretaker	Most Serious
S1.	**Emotional Stability Behavior**			
	a. Exceptional coping skills ..... +2			
	b. Appropriate responses 0			
	c. Some problems ..... -3			
	d. Chronic depression, severely low esteem, emotional problems ..... -5			
	e. Unable to score ..... US			
S2.	**Parenting Skills**			
	a. Strong skills ..... +2			
	b. Adequate skills 0			
	c. Improvement needed ..... -3			
	d. Destructive/abusive parenting ..... -5			
	e. Unable to score ..... US			
S3.	**Substance Abuse**			
	a. No evidence of problem 0			
	b. Caretaker w/substance problem/current treatment issues ..... -3			
	c. Caretaker with serious problem ..... -4			
	d. Problems resulting in chronic dysfunction ..... -5			
	e. Unable to score ..... US			
S4.	**Sexual Abuse**			
	a. No evidence of problem 0			
	b. Caretaker has failed to protect child(ren) from sexual abuse ..... -4			
	c. Caretaker has abused child(ren) sexually ..... -5			
	d. Unable to score ..... US			
S5.	**Domestic Relations**			

a. Supportive Relationship ..... +2
b. Single caretaker not involved in domestic relationship 0
c. Domestic discord, lack of cooperation ..... -2
d. Serious domestic discord/domestic violence ..... -4
e. Unable to score ..... US

S6. Social Support System
a. Strong support system ..... +2
b. Adequate support system 0
c. Limited support system ..... -2
d. No support or destructive relationships ..... -4
e. Unable to score ..... US

S7. Communication/Interpersonal Skills
a. Appropriate skills 0
b. Limited or ineffective skills ..... -2
c. Isolating/hostile/destructive ..... -4
d. Unable to score ..... US

S8. Housing
a. Adequate housing 0
b. Some housing problems, but correctable ..... -2
c. No housing, eviction notice ..... -4
d. Unable to score ..... US

S9. Intellectual Capacity
a. Average or above functional intelligence 0
b. Some impairment, difficulty in decision making skills ..... -2
c. Severe limitation ..... -4
d. Unable to score ..... US

S10. Literacy
a. Literate 0
b. Marginally literate ..... -2
c. Illiterate ..... -3
d. Unable to score ..... US

S11. Resource Availability/Management
a. Strong money management skills ..... +1
b. Sufficient income to meet needs 0
c. Income mismanagement ..... -2
d. Financial crisis ..... -3
e. Unable to score ..... US

S12. Employment

a. Employed ..... +1
b. No need 0
c. Unemployed but looking ..... -1
d. Unemployed, not interested ..... -2
e. Unable to score ..... US

S13. Physical Health Issues

a. No problem 0
b. Health problem or physical limitation that affects family ..... -1
c. Serious health problems or physical limitation ..... -2
d. Unable to score ..... US

S14. Child Characteristics Child(ren)

a. Age appropriate, no problems 0
b. Minor physical, emotional, intelligence problems ..... -1
c. One child has severe/chronic problems that result in substantial dysfunction ..... -2
d. Children have severe/chronic problems that result in substantial dysfunction ..... -3
e. Unable to score ..... US

Based on this assessment, identify below the priority needs and strengths of the household below (indicate S code only). Address the priority items in the Treatment Plan and Service Agreement and any needs scored under Substance Abuse:

Household Name: _____

PRIMARY NEEDS

S1	Emotional Stability Behavior	S8	Housing	1. _____
S2	Parenting Skills	S9	Intellectual Capacity	
S3	Substance Abuse	S10	Literacy	2. _____
S4	Sexual Abuse	S11	Resource Availability / Mgmt	
S5	Domestic Relations	S12	Employment	3. _____
S6	Social Support System	S13	Physical Health issues	
S7	Comm. / Interpersonal Skills	S14	Child Characteristics	

PRIMARY STRENGTHS

S1	Emotional Stability Behavior	S8	Housing	1. _____
S2	Parenting Skills	S9	Intellectual Capacity	
S3	Substance Abuse	S10	Literacy	2. _____
S4	Sexual Abuse	S11	Resource Availability / Mgmt	
S5	Domestic Relations	S12	Employment	3. _____
S6	Social Support System	S13	Physical Health issues	
S7	Comm. / Interpersonal Skills	S14	Child Characteristics	

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AUTHORITY: P.A. 280 OF 1939
RESPONSE: Voluntary.
PENALTY: None

MICHIGAN FOSTER CARE STRUCTURED DECISION MAKING
FAMILY ASSESSMENT & REASSESSMENT OF NEEDS AND STRENGTHS

DEFINITIONS

S1. EMOTIONAL STABILITY

A. Exceptional Coping Skills - Caretaker displays the ability to deal with adversity, crises, and long-term problems in a positive manner. Has a positive, hopeful attitude.

B. Appropriate responses - Caretaker displays appropriate emotional responses. No apparent dysfunction.

C. Some problems - Based on available evidence, caretaker's emotional stability appears problematic in that it interferes to a moderate degree with family functioning, parenting, or employment or other aspects of daily living. Indicators of "some" problems with emotional stability include:

- staff has repeatedly observed or been given reliable reports of indicators of low self-esteem, apathy, withdrawal from social contact, flat affect, somatic complaints, changes in sleeping or eating patterns, difficulty in concentrating or making decisions, low frustration tolerance or hostile behavior;
- frequent conflicts with coworkers or friends;
- few meaningful interpersonal relationships;
- speech is sometimes illogical or irrelevant;
- frequent loss of work days due to unsubstantiated somatic complaints;
- caretaker has been recommended for, or involved in, outpatient therapy within past two years;
- diagnosis of a mild to moderate disorder; or
- difficulty in coping with crisis situations such as loss of a job, divorce, or separation or an unwanted pregnancy.

D. Chronic or severe problems - Caretaker displays chronic depression, apathy, and/or severe loss of self-esteem. Caretaker is hospitalized for emotional problems and/or is dependent upon medication for behavior control.

- observed, reported, or diagnosed chronic depression, paranoia, excessive mood swings;
- inability to keep a job or friends;
- suicide ideation or attempts;
- recurrent violence;
- stays in bed all day, completely neglects personal hygiene;
- grossly impaired communication (e.g., incoherent);
- obsessive/compulsive rituals;
- reports hearing voices or seeing things;
- diagnosed with severe disorder;
- repeated referrals for mental health/psychological examinations;
- recommended or actual hospitalization for emotional problems within past two years;
- severe impulsive behavior; or
- incapacitated by crisis situations.

S2. PARENTING SKILLS

A. Strong Skills - Caretaker displays knowledge and understanding of parenting skills and is utilizing these skills with child(ren) on a daily basis. Parent shows an ability to identify positive traits in their children (recognize abilities, intelligence, social skills, etc.), encourages cooperation and a positive identification within the family.

B. Adequate skills - Caretaker displays adequate parenting patterns which are age-appropriate for the child in the areas of expectations, discipline, communication, protection, and nurturing. Caretaker has the basic knowledge and skills to parent.

C. Improvement needed - Improvement of basic parenting skills needed by caretaker. Caretaker has some unrealistic expectations, gaps in parenting skills, demonstrates poor knowledge of age-appropriate disciplinary methods, is ambivalent about parenting, and/or lacks knowledge of child development which interferes with effective parenting. Includes:

- frequent parent/child conflict over discipline;
- children sometimes left unsupervised;
- parents sometimes inattentive to child's emotional needs or are rejecting;
- any single preponderance of evidence referral for inappropriate discipline, violent behavior towards child(ren), lack of supervision, or "failure to thrive" (includes current);
- parent lacks knowledge/needs assistance in dealing with special needs child(ren); or
- occasional parent/child role reversal.

D. Destructive/abusive parenting - Caretaker displays destructive/abusive parenting patterns. Based on available evidence, it appears that caretaker(s) uses extreme punishment, or that their actions are tantamount to emotional abuse/neglect or that caretaker has abdicated responsibility for supervision, protection, discipline and/or nurturance. Indicators include:

- two or more preponderance of evidence referrals for inappropriate discipline, violent behavior towards child(ren), lack of supervision, or "failure to thrive" (prior and current);
- caretaker makes it clear that child(ren) are not wanted in home;
- discipline routinely involves use of an instrument (belt, board) or unusual deprivation (lock in cellar or closet);
- routine badgering and belittling of child(ren);
- caretaker discipline and control completely ineffective or caretaker makes no effort;
- caretaker unable to prevent abuse by others;
- caretaker contributes to child's delinquent involvement;
- prior termination of parental rights for sibling(s);
- persistent parent-child role reversal;
- caretaker refuses/unwilling to acknowledge that child has been sexually abused.

S3. SUBSTANCE ABUSE

A. No evidence of problems - No evidence of a substance abuse problem with caretaker. Based on available evidence, it does not appear that the use of substances interferes with the caretaker's or the family's functioning. Use does not affect caretaker's employment, criminal involvement, marital or family relationships, or his/her ability to provide supervision, care, and nurturance for children.

B. Caretaker with problem **or** current treatment issues - Caretaker displays substance abuse problem resulting in disruptive behavior or causing discord in family. Based on available

evidence, it appears that caretaker's substance abuse creates problems for the caretaker or the family. Consider as "problems" the following:

- the caretaker has been arrested once in the past two years for alcohol or drug-related offenses or has refused breathalyzer (PBT) testing;
- caretaker has experienced work-related problems in the past year as a result of substance use;
- staff have observed or received reliable reports that children have, on more than one occasion, been left unsupervised, inadequately supervised or let longer than planned by the caretaker because of substance abuse (i.e., caretaker physically absent due to use or passed out or seeking drugs);
- staff have observed or received reliable reports that caretaker's substance abuse results in conflict in family over use (e.g., arguments between spouses or between children and caretaker over use);
- staff have observed withdrawal symptoms: twitching and tweaking (uneasiness), restlessness, runny nose, flu-like complaints, overly tired, multiple bathroom breaks in a short period of time, mood swings;
- house is in disarray, Activities of Daily Living not tended to;
- caretaker admits that he/she is experiencing some problems due to substance abuse;
- caretaker is currently in out-patient treatment (including AA/NA);
- caretaker has received treatment for substance abuse and has been in recovery for less than one year.

OR, caretaker is currently receiving treatment or is attending a support program for substance abuse.

C. Caretaker with serious problem - Caretaker has serious substance abuse problem resulting in such things as loss of job, problems with the law, family dysfunction. Based on available evidence, it appears that caretaker's substance abuse creates serious problems for the caretaker or the family. Consider the following criteria as indicators of a serious problem:

- child born positive for drug exposure or Fetal Alcohol Disorder;
- caretaker has ever been fired for substance abuse (and has not sought or benefited from treatment);
- home raided;
- caretaker has been arrested two or more times for alcohol or drug-related offenses within the last year;
- staff have observed indicators of intoxication such as slurred speech, glassy eyes, unsteady gait, order of alcohol, drug paraphernalia;
- unusual strong order in home similar to cat urine, nail polish remover, ammonia or ether; large amounts of products such as cold medicines, antifreeze, drain cleaners, lantern fuel, duct tape, coffee filters, batteries or clear glass beakers and containers;
- reliable reports of, or staff have observed, violence toward family members by caretaker while under the influence;
- reliable reports of daily intoxication;
- caretaker has been diagnosed as substance dependent and has received treatment within past two years and is still using;
- child or spouse reports observation of caretaker using drugs, or children have knowledge of whereabouts of drugs in household;
- history of positive and/or missed urine screens and PBTs.

D. Problems resulting in chronic dysfunction - Caretaker has chronic substance abuse problems resulting in a chaotic and dysfunctional household/lifestyle. There has been a pattern of serious, long-term problems related to substance abuse. Other examples may include but are not limited to:

- multiple job losses;
- multiple arrests that are related to the caretaker's substance abuse;
- caretaker has had a serious problem with substance abuse, has been in treatment multiple times, and has had multiple relapses;
- caretaker has a serious medical problem(s) resulting from substance abuse: Hepatitis B, C or D, HIV, cirrhosis, esophageal problems, irritable bowel, acute pancreatitis, repeated Sexually Transmitted Diseases; toxic psychosis; extreme weight loss;
- there has been regular pre-natal exposure of children to substances - this includes exposure in more than one pregnancy, children diagnosed Fetal Alcohol Spectrum Disorder, or children medically determined substance dependent at birth.

S4. SEXUAL ABUSE

A. No evidence of problem - Caretaker is not known to be a perpetrator of child sexual abuse.

B. Failed to protect - Caretaker has failed to protect a child from sexual abuse.

C. Evidence of sexual abuse - Caretaker is known to be a perpetrator of child sexual abuse.

S5. DOMESTIC RELATIONS

A. Supportive relationship - Supportive relationship exists between caretakers and/or adult partners. Caretakers share decision making and responsibilities.

B. Single caretaker not involved in domestic relationship - Single caretaker.

C. Domestic discord, lack of cooperation - Current marital or domestic discord. Lack of cooperation between partners, open disagreement on how to handle child problems/discipline. Frequent and/or multiple partners.

D. Serious domestic discord/domestic violence - Serious marital discord or domestic violence. Repeated history of leaving and returning to abusive spouse or partners. Involvement of law enforcement in domestic violence problems, restraining orders, criminal complaints.

S6. SOCIAL SUPPORT SYSTEM

A. Strong support system - Caretaker has a strong, constructive support system. Active extended family (may be blood relations or close friends) who provide material resources, child care, supervision, role modeling for parent and children, and/or parenting and emotional support.

B. Adequate support system - Caretaker uses extended family, friends, community resources to provide a support system for guidance, access to child care, and available transportation, etc.

C. Limited support system - Caretaker has limited support system, is isolated, or reluctant to use available support or support system is negative.

D. No support or destructive relationships - Caretaker has no support system and/or caretaker has destructive relationships with extended family and community resources.

S7. COMMUNICATION/INTERPERSONAL SKILLS

A. Appropriate skills - Caretaker appears to be able to clearly communicate needs of self and children and to maintain both social and familial relationships.

B. Limited or ineffective skills - Caretaker appears to have limited or ineffective interpersonal skills within the family and community which limit ability to make friends, keep a job, communicate needs of self or children to schools or agencies.

C. Isolated/hostile/destructive - Caretaker isolates self/children from outside influences or contact, and/or have interpersonal skills that are hostile/destructive towards family members or others. Available evidence indicates very chaotic, disrespectful communication or behavior patterns or extreme isolation; very diffuse or extremely rigid personal boundaries; extreme emotional separateness or attachment.

S8. HOUSING

A. Adequate housing - Family has adequate housing of sufficient size to meet their basic needs.

B. Some housing problems, but correctable - Family has housing, but it does not meet the health/safety needs of the children due to such things as inadequate plumbing, heating, wiring, housekeeping, or size.

C. No housing, eviction notice - Family has eviction notice, house has been condemned, is uninhabitable, or family has no housing.

S9. INTELLECTUAL CAPACITY

A. Average or above functional intelligence - Caretaker appears to have average or above average functional intelligence.

B. Some impairment, difficulty in decision making skills - Caretaker has limited intellectual and/or cognitive functioning which impairs ability to make sound decisions or to integrate new skills being taught, or to think abstractly. Available evidence indicates that caretaker's intellectual ability impairs their ability to function independently and to care for child(ren). Indicators include:

- deficiencies, even after instruction, in everyday living skills such as taking a bus, shopping for food or clothing, or using money;
- difficulties in performing, even after instruction, such basic child care tasks as preparing formula, changing diapers, taking temperatures, administering medication, preparing meals, or dressing children appropriately for weather conditions;
- grossly inappropriate social behavior for chronological age;
- previous school placement in a special education or developmental disabilities program;
- caretakers' IQ indicates that he/she is mentally impaired (score of 50-55 to approximately 70).

S10. LITERACY

A. Literate - Caretaker has functional literacy skills, is able to read and write adequately to obtain employment, and assist children with school work.

B. Marginally literate - Caretaker has marginally functional literacy skills that limit employment possibilities and ability to assist children.

C. Illiterate - Caretaker is functionally illiterate and/or totally dependent upon verbal communication.

D. Severe limitation - Caretaker is limited intellectually and/or cognitively to the point of being marginally able or unable to make decisions and care for self, or to think abstractly. It appears that the caretaker has severely limited intellectual ability and that it seriously limits or prohibits ability to function independently and to care for child(ren). Indicators of a major problem include:

- caretaker's IQ indicates that he/she is moderately, severely, or profoundly mentally impaired (score below 50-55);
- caretaker's employment is in a sheltered workshop or is unable to work;
- outside assistance is provided or has been recommended for caretaker's daily living;
- previously placed in, or recommended for, residential treatment facility, or specialized group home because of limited intellectual ability;
- inability to recognize and respond appropriately to situations requiring prompt medical attention (e.g., diarrhea, fever, vomiting) or emergency medical care (e.g., potential broken bones, serious burns) for family members;
- restricted ability to make judgments to protect the child(ren) from abuse, neglect, or injury.

S11. RESOURCE AVAILABILITY/MANAGEMENT

A. Strong money management skills - Family has limited means and resources but family's minimum needs are consistently met.

B. Sufficient income - Family has sufficient income to meet basic needs and manages it adequately.

C. Income mismanagement - Family has sufficient income, but does not manage it to provide food, shelter, utilities, clothing, or other basic or medical needs, etc.

D. Financial crisis - Family is in serious financial crisis and/or has little or no income to meet basic family needs.

S12. EMPLOYMENT

A. Employed - One or both caretakers are gainfully employed.

B. No need - One or both caretakers are gainfully employed, or are out of labor force, e.g., full-time student, disabled person, or homemaker.

C. Unemployed, but looking - One or both caretakers need employment or are under-employed and engaged in realistic job seeking or job preparation activities.

D. Unemployed, but not interested - One or both caretakers need employment, have no recent connection with the labor market, are not engaged in any job preparation activities nor seeking employment.

S13. PHYSICAL HEALTH ISSUES

A. No problem - Caretaker does not have health problems that negatively affect family functioning.

B. Health problem, physical limitation that negatively affects family - Caretaker has a health problem or physical limitation that negatively affects family functioning. This includes pregnancy of the caretaker.

C. Serious health problem, physical limitation - Caretaker has a serious/chronic health problem or physical limitation that affects ability to provide for and/or protect children.

S14. CHILD CHARACTERISTICS

A. Age appropriate - Child(ren) appears to be age-appropriate, with no abnormal or unusual characteristics.

B. Minor problems - Child(ren) has minor physical, emotional, or intellectual difficulties. Minor child is pregnant.

C. Significant problems - One child has significant physical, emotional, or intellectual problems resulting in substantial dysfunction in school, home, or community which puts strain on family finances and/or relationships.

D. Severe problems - More than one child has significant physical, emotional, or intellectual problems resulting in substantial dysfunction in school, home, or community which puts strain on family finances and/or relationships.