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We Shouldn't Have to Work So Hard to Terminate Parental Rights

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"WE SHOULDN'T HAVE TO WORK SO HARD TO TERMINATE PARENTAL RIGHTS": REMARKS ON MENTAL HEALTH AND CHILD WELFARE DECISION MAKING FROM THE *DANIEL THURSZ UNEASY ALIGNMENTS: THE MENTAL HEALTH TURN IN THE AMERICAN LEGAL SYSTEM* SYMPOSIUM

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Abstract

This paper provides a synopsis of Linda-Jeanne Mack's remarks from the Daniel Thursz Uneasy Alignments: The Mental Health Turn in the American Legal System *Symposium in March of 2022. A theoretical framework of Ambiguous Loss and the 7 Core Issues of Permanency explains the unique challenges that caregivers and children experience when separated through the child welfare system. The author discusses how mandated therapeutic services are then used to guide decision making in reunifying families or terminating parental rights. A case study from the author's former practice illustrates the use of mental health services to determine a family's ability to reunify.*

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When I was asked to speak at the *Daniel Thursz Uneasy Alignments: The Mental Health Turn in the American Legal System* Symposium, I knew that I wanted to talk about my experience as a social worker and researcher working in child welfare. I also knew I wanted to share pieces of my own personal story that have brought me to my work. I started my remarks by sharing my own positionality. This experience led to my theory about how mental health is used to guide decision making about families involved in the child welfare system, specifically about reunification after out-of-home placement has occurred, and terminations of parental rights. This includes decision making based on the mental health status of both the child and their caregivers. I posit that such decisions are guided by traditional knowledge about mental health and do not acknowledge the unique experiences of families who are separated by the child welfare system. After describing how I use two theoretical frameworks to view my practice and research, I conclude with a case example illustrating the use of mental health challenges as a justification for not reunifying a family. This Article is a commentary on my remarks.

After I graduated from college, I began volunteering at a residential shelter for women in recovery from substance abuse. All the women were mothers reunifying with their children after separation through the child welfare system. I led a playgroup with the children each week for over a year and found that I liked spending time with their mothers just as much. This is when I knew I wanted to be a social worker. I immediately started a Master of Social Work program, took my first job as a case manager for youth in therapeutic foster care, and over a decade later, I am a PhD student studying child welfare and family well-being. My journey as a practicing social worker included several years working as a director of a child welfare program by day, and as a clinician at a community mental health center by night. Through my professional work, I also learned more about the impact of separation on all members of the family, and thus, learned more about myself and where I came from. For instance, it had never occurred to me how growing up in multigenerational housing for my early years of life with cousins adopted by my grandmother shaped how I came to my work or that my own grandparents' history with adoption shaped the way our family communicated. As I continue to learn each day, my family and my childhood are always at the forefront of my motivation to answer the questions that inspire my research and practice.

After discussing my positionality, I described the two theoretical frameworks that guide my work to attempt to understand the mental health and well-being needs of families who experience separation. The first, Boss's ambiguous loss framework, describes the impact of family separation on the child and parent.[1] For both members of the dyad, the other person is physically

1. PAULINE BOSS, AMBIGUOUS LOSS: LEARNING TO LIVE WITH UNRESOLVED GRIEF (2000).

absent, but psychologically present. The boundaries of connection become blurry, and it is hard for one to know their role in the relationship. When a child is in foster care, their caregiver is still alive, and they likely still maintain contact with one another at a weekly visit or over the phone, but are unable to live together. Scholars like Mitchell[2] apply the concept of ambiguous loss to interpret what caregivers and social workers might consider challenging mental health related behaviors from a child placed out of their home. The ambiguous loss framework theorizes these behaviors may actually stem from an inability to express in words the grief associated with non-death loss.

The second theory I use is the Seven Core Issues of Permanency,[3] which is an adaptation of the original Seven Core Issues of Adoption[4] to include other forms of family separation. The Seven Core Issues are loss, rejection, shame and guilt, grief, identity, intimacy, and mastery and control.[5] These issues describe the unique experiences of both the separated child and their caregivers; for example, the shame and guilt a mother feels after losing custody of her child or the grief a child feels when they miss their mother. I argue that looking at mental and behavioral health for child welfare-involved families through these lenses can change the decision making thought process in child welfare cases.

Though mental health is not listed as a reason for removal in publicly available administrative data, the limited data that is available includes categories that likely could encompass mental health. According to the most recent Adoption and Foster Care Analysis Reporting System, neglect (63%), parental drug abuse (36%), and caretaker inability to cope (14%) were the top three removal reasons for children and youth.[6] Further, according to the National Conference on State Legislators, up to eighty percent of children in out-of-home placement experience mental health issues, compared to the general population of children who experience rates of mental health challenges at approximately eighteen to twenty-two percent.[7] Despite the prevalence of mental health challenges associated with child welfare-involved families, little scholarship focuses on how mental health status is used as a decision-making tool in whether to separate or reunify a family.

2. Monique B. Mitchell, *"No One Acknowledged My Loss and Hurt": Non-Death Loss, Grief, and Trauma in Foster Care*, 35 CHILD & ADOLESCENT SOC. WORK J. 1 (2018).

3. SHARON ROSZIA & ALLISON DAVIS MAXON, SEVEN CORE ISSUES IN ADOPTION AND PERMANENCY: A COMPREHENSIVE GUIDE TO PROMOTING UNDERSTANDING AND HEALING IN ADOPTION, FOSTER CARE, KINSHIP FAMILIES AND THIRD PARTY REPRODUCTION (2019).

4. Deborah N. Silverstein & Sharon Kaplan, *Lifelong Issues in Adoption*, AM. ADOPTION CONG. (1982), https://www.americanadoptioncongress.org/grief_silverstein_article.php.

5. *Id.*

6. U.S. DEP'T OF HEALTH & HUM. SERVS., AFCARS REPORT (2021).

7. *Mental Health and Foster Care*, NAT'L CONF. OF STATE LEGISLATURES (Nov. 1, 2019), https://www.ncsl.org/human-services/mental-health-and-foster-care.

In my work, reunification plans and service plans for parents mandated by the child welfare agency generally include some type of therapeutic intervention for both children and caregivers. This requirement for mental health treatment is often in place whether there appears to be an immediate need for it or not. As these plans are legally mandated, completing treatment is not negotiable, if caregivers hope to maintain custody of their children or have their children returned to their care. When thinking about the use of mandated mental health treatment in child welfare cases, I often recall a specific family that I worked with whose possibility of reunifying depended entirely on mental health service use.

The family consisted of a father and his three daughters.[8] We will call the father Mike, and the daughters Jessica (11), Bridget (7), and Ilana (5). Each daughter was placed in a separate foster home. My role was to write a report on each child, including their medical, mental health, educational, and family histories, for the child welfare agency. These reports form the basis for recommendations for permanency—which refers to reunifying a child, or making a plan for adoption, guardianship, or some other type of living arrangement before the child ages out of the system—and includes well-being domains.

The two eldest girls had been in foster care for six years, and the youngest, Ilana, for her entire life. Bridget was in a residential treatment center, Ilana was in a pre-adoptive placement, and Jessica in a standard foster home. After reviewing the maltreatment investigation records, I learned that the girls had been removed after child protective services received a report that their mother and father had smoked marijuana outside of the hotel room where the mother and children were receiving shelter services. The kids had gone to bed, and the couple was sitting outside relaxing with friends, legally engaging in smoking marijuana, an activity that many parents in the area engage in, as marijuana has been legal in that state for several years. The family's case was opened for services. At a mandated home visit, child welfare services dictation noted that the mother's shelter space was "dirty" and she was "struggling with her mental health." At this point, the child welfare agency decided to petition the court to remove the children and provide a service plan for reunification. The children's mother ultimately decided not to engage with the child welfare agency, but their father wanted the girls. He told the social workers he could take them to a shelter or all of them could move in with one of his siblings. Unfortunately, the child welfare agency and the courts declined this request and the kids remained in out-of-home placement.

When I met the family, the system had a goal of adoption for all three girls, but Mike was fighting it. He was completing service plan tasks consistently to

8. For confidentiality, names and identifying details about the individuals are changed.

attempt to reunify with his children. I was told that despite his adherence to the service plan, the child welfare agency did not believe he could care for them. Much to the child welfare agency's frustration, the judge involved would not terminate his parental rights to facilitate his daughters' being adopted because he was meeting all required tasks, except for going to individual therapy. Mike, a staunch Christian and first-generation immigrant, did not believe in therapy. He felt strongly that he should not be forced to engage in something that was against his cultural and religious beliefs. However, he did support his daughters receiving therapeutic services and tried to include himself in meeting with their providers.

When I reviewed the state's records and met child welfare staff, I heard about three girls with behavior problems and significant mental health diagnoses and a father who was unable to care for his kids. When I met with each member of the family, I saw something quite different. I met Ilana first. Ilana's pre-adoptive mother, Ms. A., had cared for Ilana since she was placed in foster care at birth. Ms. A. told me at the first meeting that, despite what the child welfare agency wanted, she did not feel comfortable finalizing an adoption for Ilana. She believed that Ilana's father could care for his children, if only he did not struggle with poverty. He was very active in Ilana's life. They would speak on the phone frequently and visited often. His relatives could support him if he regained custody of his girls and his brothers would often join family visits. When I was visiting their home, Ilana showed me the gifts she received from her father and told me how she hoped to go home with him someday.

Next, I met Bridget, a seven-year-old girl with a diagnosis of Reactive Attachment Disorder ("RAD") and a long list of "behaviors" in her file. Children with RAD struggle to attach and build healthy relationships with caregivers and may be described as aggressive or disobedient. This diagnosis is one I commonly see for children in foster care. In fact, most kids I have seen over the years who had any kind of behavior problem were diagnosed with RAD by someone at some point in their young lives. When I met Bridget, she was quiet and polite. She had a love of music and spending time outdoors with the residential staff. I asked a staff member about the RAD diagnosis: "Oh yeah, she's always had it," she said. She added, "you know, so many kids in foster care do." I pressed about symptoms and she said, "[Bridget is] just really quiet; sometimes she is sad when she comes home from visits with her family." I was told about a good kid who rarely acted out, did well in school, and had lots of close relationships in her life. I also interviewed her school guidance counselor who was shocked to learn that Bridget had a RAD diagnosis and reported Bridget rarely sought assistance during the school day and never struggled with behavior.

Then came Jessica. The child welfare social worker told me how difficult Jessica was. In fact, I was told that she was "so bad, we can't in good faith send her home to her father anyways." Jessica lived in the same foster home for the

entire six years she had been separated from her family. Jessica spoke a different language than her foster parents. She was receiving in-home family services daily for her "bad behaviors," but unfortunately, her therapist also did not speak the same language as the foster family, so in-home sessions happened without her caregiver. I spoke to her therapist and asked about the need for services, especially if they were not used as intended. She shared that "sometimes Jessica doesn't listen; she spends a lot of time in her room and she doesn't like to do her homework." Her therapist also said that Jessica had a diagnosis of Oppositional Defiant Disorder ("ODD") but was unable to explain why. Her teacher described Jessica very differently than her social worker and foster mother did. He said she was quiet, reserved, and hardly got in trouble, but spent a lot of time alone. When I met Jessica, she told me about how desperately she wanted to be home with her family and that she often stayed in her room on the phone with her father or her younger sisters. She missed them and longed for the time they would all be together.

I also met Mike and his brothers at a family visit. I watched the two of them interact with the three girls. There was so much love in the room, and it was undeniable the bond they all had as a family unit, despite so many years of living apart. I ultimately recommended to go against the child welfare agency's goal of terminating Mike's parental rights for his three daughters. As I was finishing up my reports, thankfully, Mike got a new reunification social worker who shared similar identities with Mike. She was a strong advocate for him, and we worked together to create my recommendations based on what she thought he might need to reunify with his daughters. This included support with housing and setting up Mike's daughters with after school programs and medical providers. The social worker believed that as long as he had his daughters back, that would be all that Mike really needed to succeed. After I submit my assessments, I am no longer in contact with the family or the social worker on the cases I work on. Unfortunately, this means that I will never know if Mike was able to reunify with his daughters. I truly hope he did.

In Mike's case, the child welfare agency worked incredibly hard to find reasons to terminate a father's rights and legalize his daughters' adoptions instead of reuniting them together as a family. This case highlights the experience of a family, where the system used both the parent and the children's mental health as reasons, without merit, to accomplish permanent legal separation. Though I do not sit in every child welfare office or courtroom across the United States, this justification seems more common than not. In fact, I regularly hear stories just like this one from my colleagues still working in or working with the child welfare system in various capacities. I also know from both experience and regularly reading the news, that across the country, especially since the COVID-19 pandemic, waitlists to receive mental health care are incredibly long and there are people who are in real need of treatment. Not only should families not be

forced to receive mental health care when they do not need it, but also, our very small population of community mental health workers do not need to be overburdened by families mandated to be in therapy by the child welfare system. Mandated mental health care cannot be a catchall when our resources are already so stretched. No one in the family that I described benefited from their use of mental health care, and yet, it guided decision making about their ability to reunite as a family. I conclude by reflecting on a statement that a colleague once said, that illuminates the experience of Mike and his daughters: "We should not have to work so hard to justify terminating a parent's rights."