Termination of Parental Rights: A Descriptive Review*

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Many years ago in England a day for honoring mothers was observed and was called "Mothering Sunday." Other nations and peoples also have long observed similar days. In the United States, Mother's Day received national recognition on May 8, 1914, when President Woodrow Wilson proclaimed Mother's Day as an annual observance after a campaign led by Mrs. Anna Jarvis.[1] The fantasy, and it is a fantasy, that natural parents are always the best parents is one in which it is difficult to lose faith.

The Pennsylvania Dutch have a saying "We grow too soon old und too late schmart." Over the years in our experience with children with the failure-to-thrive syndrome, multiple trauma or the "battered child syndrome," we have had many problems presented to us and made many attempts to solve them. Because it is well known that dealing with such problems is not purely a medical one but one requiring multi-disciplinary collaboration,[2,3,4] and because what one is able to do or wishes to do may or may not be in accord with the law and the court,[5,6] we have collected a few cases, some old, some new, which we hope will demonstrate the problems. These may then serve as a focus for some discussion concerning the need for change, both in our attitudes and in our laws in regard to these matters.

Many children who have been identified as neglected or abused children remain with their families while professionals attempt to resolve or alleviate the families' underlying problems. Many such children, however, are living in situations which pose a threat to their well-being sufficient to require their immediate separation from the family. The management of these cases creates many anomalies. First, there is usually some plan to reunite the family; while concurrently, there may be court action to break up the family by obtaining custody of the child. Second, there is usually some effort to protect the relationships among the family members; while concurrently there may be an effort to re-establish the child in a foster home. And third, there is usually a focus on treating and stabilizing the individuals involved; while concurrently, there may be considerable indecision about the long-term placement of the children.

A strong argument has been made for permanent foster placement of

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neglected and abused children in order to provide these children with stability and continuity.[7,8] There can be no question of the impropriety of such a management plan in cases where the relationship between natural parent and child poses no threat, where visitation with natural parents may be appropriate, or where the permanent severing of the parent-child relationship is not legally feasible. Other cases, however, suggest the propriety of terminating the parental rights of the natural parents in order to provide the child with the needed stability and continuity.

We have been involved in the management of cases of abused and neglected children for a number of years and have attempted, both successfully and unsuccessfully, to approach these cases in various ways. Often we have focused upon termination of parental rights and will discuss several such cases below. We do not advocate termination of parental rights in all cases; we do not advocate termination of parental rights as an end in itself. We have, however, found it to be an effective and appropriate goal in many cases in which the reunion of parent and child is not feasible.

There have been, for many years, provisions in the American legal system for terminating parental rights.[9,10] Originally, the exclusive ground for termination of parental rights was the parents' abandonment, defined as evidence of a settled purpose to permanently sever the parent-child relationship. More recently, additional grounds for termination of parental rights have been enacted by some legislatures. Today parental rights may be terminated not only for abandonment but also for evidence of the parent's failure or refusal to perform parental duties to a child for a requisite period, usually six months to one year, and for evidence of the parent's continued incapacity, abuse or neglect which causes the child to be without the necessary parental care, control and support necessary for the child's mental and physical well-being, including evidence that such a situation either cannot or will not be remedied. In most states, laws governing termination of parental rights are incorporated either in the child-abuse-reporting legislation or in the adoption legislation. In all states strict proof is required to effect the termination of parental rights, the Courts being reluctant to sever legally and irrevocably the relationship between parent and child. Issues in cases of child custody must obviously be distinguished from issues in cases of termination of parental rights in that custody cases merely determine who shall have the right and responsibility for the care of a child from time to time, such decisions always being open to review; while termination of parental rights cases finally and permanently decide whether parents shall forever terminate any further legal rights and responsibilities in a child and *vice-versa*.

An examination of four case histories will, we believe, provide an interesting and useful introduction. All four cases involve termination of parental rights; all four cases involve infants; all four cases are replete with professional intervention; all four cases involve children with serious physical or emotional problems; in all four cases parental rights were successfully terminated. Lest you think the professionals involved in these cases became bored by repetition, we shall present these cases focusing upon their very salient differences.

The first case, Sarah, demonstrates an initial diligent effort to preserve a

parent-child relationship. That effort, after more than five years, failed and resulted in the parent-child relationship being terminated voluntarily.

Sarah

Sarah, age 2 years 2 months, was brought to the Psychiatric Clinic by her mother, who thrust her angrily at the social worker, saying that Sarah was "a little witch who hated everyone." Mother requested that Sarah be hospitalized immediately and put into a foster home, as she refused to care for her any more. This somewhat dramatic incident was the outcome of approximately a two-year struggle to help this mother and her child. Prior to this incident Sarah had been hospitalized twice, once at three months and again at five months, with chief complaints of vomiting and diarrhea. At both admissions she fell far below the third percentile in height and weight, and no organic reason could be found for her growth failure. During the hospitalizations Sarah's mother refused to have any contact with any hospital personnel and requested that she be phoned when Sarah's "bad behavior" had been corrected, for only then would she take her home.

Sarah's mother, in her mid-20's, was a small, petite woman, always fashionably dressed, with highly teased hair and heavy make-up. She alluded to a very chaotic and deprived background; she had an alcoholic, abusive father and was abandoned at age 10 by her mother. After leaving high school in the tenth grade she lived with a series of men, each of whom abandoned her. She eventually at age 20 became involved with a man who was married to another woman and lived in a common-law relationship with him. Her first child, Betsy, was born approximately a year later. The mother was pleased with the birth of this child, as she felt that the child cemented her somewhat tenuous relationship with the child's father. The father repeatedly warned his wife not to get pregnant again, as he felt that he could not support two families. Shortly, however, she became pregnant with Sarah, and from that point the relationship between mother and father gradually deteriorated. The mother hoped that the second child would be a boy and was tremendously disappointed to have a second girl.

From the beginning, Sarah was an unwanted and emotionally neglected child. The mother refused to accept the fact that Sarah was a girl and immediately nicknamed her "Joe" and dressed her as an infant only in boys' clothing. She was an irritable baby, crying frequently and having problems with feeding. When Sarah was two months old, her mother was abandoned by her husband, and shortly thereafter Sarah was admitted for her first hospitalization. It was not until another sib was born, one who also began having similar symptoms of failure to thrive, that this mother became involved with hospital personnel. Even then her "involvement" was characterized by demanding, hostile requests; she was verbally abusive, threatened to sue, would phone fifteen times a day requesting help and then hang up when efforts were made to contact her. In a period of six months she changed her unlisted phone number five times. In spite of this, contact was maintained with this mother, and she eventually requested that Sarah be placed. She accepted support of public health nursing, homemaker sources, and weekly visits by a "student" child welfare worker.

At the time of placement Sarah weighed 17 pounds, measured 41 cms in height, and was retarded in all areas of development. She had never talked and withdrew from contacts with her mother and her two sisters. After placement she daily consumed large amounts of food. After twenty-two months in the foster home she had made remarkable gains. During this period weight gain put her in the 50th percentile for weight and also the 10th percentile for height. She became completely toilet trained, gained good speech and slowly and tentatively began to give affection. On the Stanford-Binet she scored an age level of 3 years 9 months at a chronological age of 4 years 1 month, putting her in the low average range of intelligence.

After Sarah had been in the foster home only a few months, her mother began to make repeated attempts to have her return home, but the court always upheld the continuation of foster home care. The foster parents with whom Sarah was placed were a young couple in their mid 20's with two younger children, ages 3 and 9 months. From the beginning this couple expressed a wish to adopt Sarah but were not able to do so because of the mother's repeated attempts to get Sarah returned to her home, and her requests for monthly visits. After Sarah had been placed in the foster home for approximately three and one-half years, her mother became pregnant for the fourth time and this time achieved her much-wanted boy. It was only after the birth of this child that Sarah's mother was able to think seriously about placing her for adoption. She made one last attempt to petition the court for Sarah's return, and when this was refused, she immediately signed relinquishment papers. Shortly after that time Sarah's mother moved from the city and all contact was lost with her.

After five years in the foster, now adoptive home, Sarah is within the 50th percentile for height and weight. She is described as having good peer relationships, but can still only tentatively give and accept affection. She is now in the second grade and has many learning and behavioral problems.

In terms of termination of parental rights this case raises many questions.

1. Was the tremendous effort made to involve Sarah's mother in therapy worth the ultimate result, her willingness to place the child in foster care?
2. Was the cost of the eventual deficits in Sarah's emotional and probably intellectual growth worth the protection of a mother's right to her children?
3. Should we professionals have been more aggressive advocates for this little girl?

In retrospect we now feel older and smarter. Today we would be more aggressive in removing this child from her natural environment after two hospitalizations for failure to thrive. We are more pessimistic about our ability to rehabilitate such parents. We are more certain that such a child's development will be deviant if intervention is not a prolonged type such as long-term foster placement or termination of parental rights and adoption. We do not shy away from kidney transplant or divorce of husband and wife. Why should we be timid about advocacy of family transplant or divorce of child and parent?

Sarah's case, in essence, represents progress commensurate with the parent's ability to cope. As long as there seemed to be any parental potential, the professionals involved bided time for the sake of the parent.

Sarah was offered a permanent home only when her mother voluntarily relinquished her parental rights, permitting Sarah's foster parents to adopt her. But at the same time Sarah's need for the stability of a permanent environment was not met during her formative years. One might speculate that the long wait for Sarah's adoption may well have been worthwhile in that an adversary proceeding was avoided by her mother's voluntary relinquishment. But a careful look at the case of Mary Walker will indicate the fallacy of such reasoning. Mary's adoption was also delayed for several years but was finally effected against the vigorous opposition of her parents.

Mary

Mary was hospitalized at the age of three months for failure to thrive and bilateral parietal skull fractures; all other medical studies were within normal limits.

Initial history obtained from the parents was cause for much concern. Both came from backgrounds of severe deprivation and actual physical abuse. Parents married young and impulsively after a seventeen-day courtship. For the first two years of this marriage they lived with paternal grandparents, and during this time their first child, Charles, was born. Grandparents were viewed as intrusive and manipulative, and the couple eventually moved to their own apartment shortly after the mother learned of her pregnancy with Mary. The pregnancy was described as difficult: mother had nausea, was tired and depressed. Mary was born prematurely and from the beginning was seen as a sensitive, difficult infant. She vomited frequently and was difficult to hold and cuddle. At six weeks mother told her local pediatrician that Mary "hated her" and she herself was fearful that she was "going crazy" under the strain of the care of Mary. The pediatrician suggested psychiatric care, which the family refused.

Again, as with the case of Sarah, we initially felt that this might be a treatable situation. Both parents, although exhibiting adolescent behavior, expressed an eagerness for help and a desire to change. Mary was returned to her family, arrangements were made for a nurse specialist to make frequent home visits, and the parents agreed to be seen in psychotherapy on a weekly basis. After six months of frequently canceled appointments it became apparent to the respective therapists that Mary was becoming increasingly at risk within her own home. Mother obviously cared more for her son and was unusually cruel to Mary and continued to make unrealistic demands upon her. Foster placement was suggested at the end of three months, but the parents refused. At the end of six months mother phoned several times in a day saying that she was fearful that she was going to kill Mary and that she had bruised Mary's face. The next day, with the help of the nurse specialist, both children were placed with maternal grandparents. Shortly thereafter both parents moved to another state. We attempted to follow the parents, but were unsuccessful. Maternal grandmother was contacted and stated that both children were doing well and gaining weight slowly.

The next contact with this family resulted when a pediatrician who saw Mary with multiple bruises wrote to the original attending physician for records. We then learned that Mary had returned to her own parents and,

after a short period, was removed following a court hearing in another state because of suspected abuse. Mary was placed in foster homes but eventually was taken from that state and returned to paternal grandparents. There she was cared for by her father's sister and her husband, Mr. and Mrs. Carpenter, and their three children. Soon the Carpenters moved to their own home and took Mary with them. Within a year they asked the state about the possibility of adopting Mary, and three years after Mary went to live with the Carpenters the first hearing on adoption was held.

As part of the preparation for the hearing, a complete developmental evaluation of Mary was done, and at the age of 4½ she was found to be a little girl whose height and weight were still below the third percentile but had steadily increased since she had been placed with the Carpenters. Stanford-Binet and other functionings were within normal range. Mary also was seen for psychiatric evaluation at age 6. She might have separated a bit too easily from her parents, but she seemed to relate to her adoptive parents and siblings in rather ordinary fashion. Her human figure drawing was of a lady of which she said "I think I'll make it my mother," referring to her adopted mother by name.

Under the Adoption Act of 1970, the petitioners averred that (1) there was a settled purpose of relinquishing parental claim by the natural parents. Or that they refused or failed to perform their duties for more than six months; and (2) that by repeated and continued abuse and neglect of the child the natural parents' rights to the child may be legally terminated. The court did terminate the rights of the natural parents and the adoption and custody of Mary were awarded to Mr. and Mrs. Carpenter.

On followup it was learned that two years subsequent to the adoption of Mary, Mr. and Mrs. Carpenter separated. The adoptive mother took the girls with her to another state and the older son stayed with his father. As regards Mary, the adoptive father reported that he had heard that she had had some problems in school and had done some stealing from peers and teachers.

In retrospect we again feel we should have been more aggressive advocates for Mary's welfare. Physicians should have pushed child welfare for legal protection of the child, but we cannot change history. Neither our court or our welfare system was as sophisticated then as they are now. And we are not as enthusiastic about our therapy for parents. It is worth noting that although we evaluated the adoptive parents, we did not predict their marital breakup.

The need to have uniform laws in all states and continuity in welfare and legal systems seems to be a lesson to be learned here.

The case of Danny demonstrates tremendous progress in serving the best interests of the child. Danny had what might be called the good fortune to have been so seriously neglected and abused that the professionals were more responsive to his urgent needs. In addition, Danny had the good fortune to be placed with foster parents who were aggressive in assuring Danny an environment and future which would best serve his interests.

Danny

Danny was the fourth of five children. Even before his birth, Danny's

family was known to the local child protective agency, and a social worker had visited the home several times over a period of some four years. Shortly after Danny's birth, his father deserted the family, and Danny's mother became increasingly overwhelmed by her family responsibilities.

At the age of 18 months, Danny was taken to the emergency room of a local general hospital after ingesting liquid lye. Because of the seriousness of his internal injuries, he was transferred to a children's hospital. There, physicians, psychiatrists, psychologists, social workers, and nurses made comprehensive evaluations of this child's condition both at the time of admission and subsequently. Danny was initially diagnosed as failure to thrive and was found to be withdrawn and to have significantly below average intelligence. But later evaluation showed that he developed rapidly in the hospital's warm, protective environment.

His mother told the hospital social worker that Danny was a "bad" child, and that he had opened and drunk the bottle of lye himself. A report of suspected abuse was filed at the local child welfare agency. Although the case worker who was sent to investigate the home encouraged Danny's mother to visit the child, during the following four months of hospitalization she never visited her son.

When Danny was ready to be discharged from the hospital, his mother refused to take him home, saying that she already had more than she could manage at home. The agency petitioned and received custody of Danny from the juvenile court and soon after placed him with foster parents. Danny adjusted well to his new home. After two years there his injuries, a gastrostomy and esophageal burns, had healed. He reached normal height and weight and his intelligence test scores jumped from 72, recorded upon admission to the hospital, to 130.

In the meantime, Danny's mother had another child, was unemployed and living in substandard housing, and again began to drink heavily. She was arrested and jailed for criminal neglect of her other children. The police took the four children to the child welfare agency shelter. The mother was soon released from jail, criminal charges against her were dropped, and the juvenile court awarded the agency custody of the children, who were each immediately placed in different foster homes. To date these children have lived in various temporary homes, and there has been no judicial inquiry as to their well-being. Danny's foster parents requested that the agency initiate proceedings on their behalf for their adoption, but the agency refused because Danny's mother would not voluntarily relinquish her parental rights and the agency and their counsel believed there was not sufficient grounds for involuntary relinquishments. The foster parents then petitioned the court for involuntary termination of the mother and father's parental rights and for adoption.

In preparation for the hearing, lawyers representing the agency, Danny's mother, and the foster parents conferred extensively; and counsel and the judge consulted with agency and hospital personnel to better understand the abilities, motivation and legal status of all concerned. By the time the case was brought to court, the agency did not entirely oppose the petition to terminate parental rights. Neither the child's mother nor her lawyer appeared at the hearing. The court terminated the parental rights of Danny's mother

for failure to perform her parental duties and terminated the parental rights of her father on the grounds of abandonment. The court also granted the foster parents' petition for adoption.

We view Danny's case as an extremely successful one. That success cannot be attributed to any single component involved. Instead we credit the interdisciplinary approach to Danny's case as the basis of its success. Neither the agency, the hospital, physicians, psychiatrists, psychologists, social workers, nurses, foster parents, lawyers or judges alone could have provided for Danny; but together they were able to establish that from medical, emotional and legal standpoints Danny's best interests would be served by severing his ties to his parents and permitting his adoption by his foster parents.

Families who have problems of child abuse and neglect tend to be quite mobile. They move from home to home, hospital to hospital, agency to agency, case worker to case worker. As a result, one of the impediments faced by professionals who have intervened in such cases is that of continuity. First, it may be difficult to obtain information on events which have preceded the current involvement with the family. Second, it may be difficult to follow future events with the family, in terms of both evaluation and treatment. And finally, it may be impossible to maintain legal jurisdiction over the family as they move from county to county or state to state.

Billy

A newborn male infant, Billy, was referred to Children's Hospital as an emergency for the repair of tracheoesophageal fistula, a surgical problem that would have been fatal 25 years ago. This baby underwent an excellent surgical repair even though his post-operative course was stormy, and he had to feed by continuous alimentation and gastrostomy for some weeks. After three months he was a well child physically, the many "nurse mothers" he had on the infant ward having done an excellent job. Even while on the infant ward he grew and became curious and was able to take a piece of paper and attempt to swallow it. This piece of paper became stuck in the narrow esophagus and had to be removed by endoscopy. It was for this reason that we wanted to be certain that this child would have excellent care upon return home.

This infant's life, however, was further complicated in that he was the fourth child born to a 22-year-old mother. His three sisters, ages 4, 2 and 1, had never had any immunizations, and the one-year-old child weighed only 15 lbs. The mother told various stories about the whereabouts of her husband and was accompanied to the hospital by another man. It was learned that this family lived in a four-room shack that had no plumbing or heating. Contacts were made with the Child Welfare Services in the county from which the baby had been referred, only to find that the family had moved to another state. We then had the problem of trying to find who would assume responsibility for this child; whether it would be the home county, the county from which the child had been referred, or the county in another state where the family was then living.

The mother seldom visited and little information could be obtained from her. All efforts and hopes of involving the parents and preparing them for dealing with this infant following discharge from the hospital were of no avail.

Letters to the Child Welfare Service in the other state and conversations with the local Child Welfare Agency did not clear up the question of responsibility. The Child Welfare Service in the other state would pursue this matter only if the district attorney in that city had been willing to pursue it in a legal fashion and make them responsible. He was, however, unwilling to do this.

The hospital social worker then decided to seek consultation from the local juvenile court. This was a tremendous help, for the judge then wrote to the juvenile court in the neighboring state and told him of our concern about this baby. Correspondence with the Department of Public Welfare in the other state told us that the family had been contacted but refused to have the baby temporarily placed in foster care while they could be helped to maintain some sense of family stability. The hospital again contacted the local juvenile court judge, who subsequently appointed a Neighborhood Legal Services attorney as guardian *ad litem* for this child.

Finally, when Billy was six months old and still in the hospital, a juvenile court hearing was held by the local judge and Billy was declared deprived and neglected. In the meantime, the Child Welfare Services in the other state was able to find a foster home; the foster parents were brought in and learned how to care for Billy, and he was eventually discharged to their care.

In the ensuing two and a half years, this little boy lived in this excellent foster home. The family became very attached to Billy, and after a court hearing in the other state, the Department of Public Welfare was awarded guardianship of this child, parental rights were terminated and the foster family petitioned to adopt this little boy. He has since been formally and legally adopted; he has continued to thrive and is an active, loving preschooler.

We have learned that Billy's natural parents have moved twenty-two times since we saw them and never took any advantage of their once-existing rights to the child, although they had originally threatened to do so.

In this case we believe all went as well as one could expect. The hospital intervened early and appropriately. Child Welfare Services was able to communicate and coordinate care, not only between two counties in Pennsylvania, but between two states.

Our juvenile court was able to communicate and coordinate legal matters between Pennsylvania and West Virginia, and accepted petitions for guardianship of the child by Child Welfare Services, termination of parental rights and adoption by a foster family.

The reporting and management of child abuse and neglect cases and termination of parental rights are legislated on a state-by-state basis. All states have enacted such legislation in one form or another, and while the provisions of most have great similarity, there is little uniformity from state to state and virtually no reciprocity. Even within a state coordination may be limited. For example, some states have and some do not have a central registry of reported cases which enable a family's case history to be reviewed

even when the family presents itself to different professionals, different agencies or different hospitals. To date the functioning of central registry systems is quite limited in all states and almost nonexistent between different states. To complicate matters further, within a single jurisdiction the management of a single case may be quite fragmented. In Pennsylvania, for instance, the Oprhan's Court has exclusive jurisdiction over adoption and termination of parental rights; the Juvenile Division has exclusive jurisdiction over deprived and neglected children; and the Domestic Relations Division has jurisdiction over most custody cases between parents of the child and often between parents and third parties. Moreover, there may be concurrent involvement with any of these courts and the criminal court in such cases if criminal charges are also pending against one of the parties. Clearly there exists an urgent need to synthesize procedures for abuse, neglect and termination cases, not only among the various jurisdictions but even within a single jurisdiction.

We have, out of our experience, seen a need to focus on several points. There needs to be a change in attitude about the sanctity of the rights of a parent. Termination of parental rights must be considered at times in the best interests of a child.

There is a need for uniform laws in all fifty states regarding abuse, neglect, custody and adoption procedures.

There is a need for uniformity of operations of child protective units of child welfare agencies to enable a reasonable exchange of information, perhaps with court or legislative guidelines attached. In the case of Mary, parents moved from state to state and there was no ability to follow and assure that she was adequately parented. Only chance enabled intervention to be accomplished.

Most of all, there is a need for continued effort to increase communication between agencies and hospitals, and professionals in the law, behavioral science and medicine. Until this is accomplished we believe the care of children is in jeopardy.

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