Intentions and Results

A Look Back at the Adoption and Safe Families Act
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Funding for this paper series was provided by the Annie E. Casey Foundation.

We thank them for their support but acknowledge that the information and conclusions presented herein are those of the authors alone and do not necessarily reflect the opinions of the Foundation, the Center for the Study of Social Policy, and the Urban Institute.
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CONCLUSION
Building Upon the Child Welfare Reform Efforts of the Adoption and Safe Families Act (ASFA)
President Clinton signed the Adoption and Safe Families Act (ASFA) of 1997, Public Law 105-89 105th Cong., 1st sess. on November 19, 1997. The Act was the most significant piece of legislation dealing with child welfare in almost twenty years. It was passed in response to growing concerns that child welfare systems across the country were not providing for the safety, permanency, and well-being of affected children in an adequate and timely fashion. The ambitious new law aimed to reaffirm the focus on child safety in case decision making and to ensure that children did not languish and grow up in foster care but instead were connected with permanent families.

Twelve years after the law was enacted, the Center for the Study of Social Policy (CSSP) in partnership with the Urban Institute has led an effort to reflect on what has been learned about the intended and unintended consequences of ASFA and the degree to which its goals have been realized. Together we have co-sponsored a series of papers on the effects of the ASFA law and its implementation written from the distinctive perspectives of researchers, policymakers, advocates, and parents and youth with first-hand experience of the child welfare system. The papers in this series examine the consequences of ASFA for children and families and for the child welfare systems that intervene in their lives.

The work of analyzing legislation as far-ranging as ASFA inevitably will be partial. For every topic that we singled out for closer scrutiny, many more possibilities had to be passed over. If deciding on topics proved more challenging than anticipated, the process also produced more papers than originally planned because of the varied subjects and viewpoints deemed essential to any assessment of ASFA.

The series begins with a framework paper, co-authored by Olivia Golden and Jennifer Macomber. The framework provides an overview that summarizes the key features of the ASFA legislation, the major debates and controversies surrounding its interpretation and implementation, and the available data on its results. Five perspective papers follow, which capture the personal experiences and reflection of their authors: Parents—Lynne Miller, Jeanette Vega, Jackie Crisp, Lawrence Pratt, Deborah McCabe, Paulette Nelson, Bertha Marquez, Youshell Williams and Tracey Carter; Youth—Manny Sanchez, Natasha Santos, Pauline Gordon, Tamara,* Akeema,* Natalie Kozakiewicz, Jessica Wiggs, Wunika Hicks, Eric Green and Erica Harrigan. Each of these authors tells a unique and compelling story and provides a different perspective, such as the experience of a parent struggling to be reunified with her children while conquering substance abuse and of a teenager who spent most of her formative years in foster care. Reviews of the efficacy of the law and its subsequent policies frequently overlook the perspectives of the

* Name has been changed.
constituencies most directly affected. These parent and youth accounts poignantly demonstrate the complex impact of a federal law that influences decision making with respect to family composition and definition. Authors of the other perspective papers include one of the original drafters of the ASFA legislation (Cassie Statuto Bevan); a judge who has extensive experience in implementing and enforcing the law (Ernestine S. Gray); and the New York City Child Welfare Commissioner charged with carrying out the law’s dictates (John B. Mattingly).

The next section of the series includes seven policy briefs by respected researchers and policy analysts. The briefs review crucial questions such as the impact of ASFA on special populations: parents with mental health (Barbara Friesen, Joanne Nicholson, Katharine Kaplan and Phyllis Solomon) and substance abuse (Sid Gardner and Nancy Young); families involved with the criminal justice system (Martha Raimon, Arlene Lee, and Philip Genty); those caught up in the immigration system (Yali Lincroft and Bill Bettencourt); and older youth (Jennifer Macomber). Other papers address the priority issues of adoption (Richard Barth) and preserving family connections (MaryLee Allen and Beth Davis-Pratt). The authors of these seven briefs draw heavily upon existing research in framing and supporting their analyses and recommendations.

This series is not intended to deliver a uniform message or arrive at a master list of findings. In fact, the authors often disagree with one another or draw different conclusions about both successes and continuing challenges within the child welfare system twelve years after the passage of ASFA. This lively give-and-take is to be expected when considering issues as important, sensitive, and difficult to analyze and regulate as state intervention into families’ lives.

While many individual papers conclude with recommendations that reflect the author’s perspective, the last part of the series presents recommendations that incorporate common themes that emerged from the entire project. While drawing on the insights of all authors, the summary represents the recommendations of the Center for the Study of Social Policy alone.

Legislating social policy that defines when the state has the power and the responsibility to intervene in family life for the sake of child safety is inherently difficult. There will perhaps always be a divide between those who believe the state is overstepping its authority and those who believe the state is not vigilant enough in executing its protective role. We need to know more about the short- and long-term impact of our decisions to fully assess whether our child welfare law and policy achieve the best outcomes for those most in need, while recognizing the often competing interests of individuals and groups affected by the law. We hope this series will promote and illuminate discussion and help to frame the next generation of policy reforms.

Susan Notkin        Kristen Weber        Olivia Golden        Jennifer Macomber
Parents with a Mental Illness and Implementation of the Adoption and Safe Families Act

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Introduction

This paper examines how implementation of the Adoption and Safe Families Act (ASFA) may affect families in which a parent has a mental illness. We present evidence that such parents may suffer discrimination when the psychiatric diagnosis alone leads to an assumption of risk in lieu of a more complete assessment of a parent’s behavior or parental competence. We argue that decisions about child placement, custody, or termination of parental rights should never be based solely on a diagnostic label or on assumptions about the possible ramifications of a parent’s mental illness. Instead, parents with mental illnesses and their families deserve a thorough assessment that takes into account all dimensions of parent and family functioning and needs, and thus can better inform service planning and/or legal proceedings. Further, if it is determined that a parent’s mental illness, compounded by inadequate services and supports, does compromise his or her functioning as a caregiver, then those resources should be provided and accessible as a part of “reasonable efforts.” The goals of child safety and child well-being should always remain paramount, but we must also bear in mind that separating children from their parents and transferring responsibility for their lives to multiple caregivers in the foster care system can often be traumatic and not in their best interests. We offer recommendations for professional training and for innovations in policy, practice, and research that will improve the implementation of ASFA and reduce the likelihood of negative impact on children and families coping with parental mental illness.
A key challenge in thinking about the impact of parental mental illness on children and parents is how to negotiate the tension between the rights of parents and the best interests of children. In examining this basic tension, Allen and Bissel (2004) note that parents’ rights are rooted in the due process clause of the Fourteenth Amendment; this clause provides protection against governmental interference with fundamental rights, the oldest of which is the interest of parents in the “care, custody, and control of their children” (p. 57). The concept of “the best interests of the child” has its own strong foundation in Supreme Court decisions that have held for the state’s prerogative to restrict or override parental rights when there is “compelling government interest” to do so (p. 57). Striking the proper balance between these competing interests is an ongoing concern of our government systems and our society alike.

**Parents with Mental Illnesses and the Child Welfare System**

When the children of parents with a mental illness are placed in foster care, families face many barriers to reunification. Even before ASFA was enacted, parents who had mental illnesses found themselves at high risk of losing permanent custody of their children, because of their own needs and circumstances, a lack of appropriate services, the ill-informed responses of others, such as child welfare personnel, and adverse state laws or state agency policies and practices (Hollingsworth 2004).

Several studies document a long history of states’ placing of legal restrictions on the rights of persons with mental illness. For example, Hemmens, Miller, Burton, & Milner (2002) found that the number of states restricting the parenting rights of persons with a mental illness rose from twenty-three in 1989 to twenty-seven a decade later. A recent study of state statutes (Scott 2008) revealed that five states and the territory of Puerto Rico listed a parental mental illness among possible “aggravated circumstances,” (i.e., as potential grounds for not making reasonable efforts to reunify a family [see Table 1]). The basis for deciding that reasonable efforts are not warranted varies among the five states. Arizona and California cite parents’ inability to care for a child or to benefit from services; Alaska and Kentucky apply the same standard but require a finding that remediation is unlikely within a twelve month timeframe. North Dakota focuses on parents’ lack of effort to obtain treatment. In some cases, these statutes list mental illness alongside crimes such as murder, manslaughter, and felony assault—remarkable evidence of the social prejudice and stigma associated with having a mental illness. In addition, thirty-six states currently list a parental mental illness as a possible factor when termination of parental rights is being considered (Lightfoot & LaLiberte 2006).

**Parental Mental Illness and Child Maltreatment**

The body of research evidence pertaining to the relationships between parental mental illness, child maltreatment, and parental competence is complex, and findings depend on the nature of the research questions asked. Addressing the frequency of mental illness among parents who abuse their children, Gelles (1996) found that only about ten percent could be diagnosed either as suffering from a mental illness or as affected by psychopathology. The percentage of parents with mental illness in the U.S. who neglect or abuse their children is unknown. Three population-based studies (Bland & Orn 1986; Egami, Ford, Greenfield, & Crum 1996; Walsh, MacMillan, & Jamieson 2002) have established an association between parental mental illness and increased risk of child maltreatment. This correlation, however, is neither inevitable nor universal; Walsh et al. (2002) point out that the majority of respondents in their sample who reported that one or both parents had a mental illness did not report a history of being involved in abuse or neglect.

**Impact of Parental Mental Illness on Children**

Whether involved in the child welfare system or not, children of parents with mental illnesses are more likely to face developmental and behavioral problems than children of parents without such challenges (Beardslee, Keller, Seifer, Podarfsky, Staley, Lavori, & Shera 1996; Oyserman, Mowbray, Meares, & Firminger 2000; Riley, Coiro, et al. 2008). Programs that have succeeded in improving the health and functioning of children, as well as in aiding parents with mental health disorders, include those designed for families with a parent who suffers from depression (Riley, Valdez, et al. 2008) and those assisting families with more diverse challenges, including depression, who are enrolled in Early Head Start programs (Chazan-Cohen, et al. 2007; Love, et al. 2005).

Besides parental mental illness, risk factors for possible child maltreatment include environmental and social drawbacks such as unaffordable housing.
<table>
<thead>
<tr>
<th>State</th>
<th>Statute</th>
<th>Mental Illness as grounds for not providing reasonable efforts</th>
<th>Protective Language for people with a mental illness</th>
<th>Excerpt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>12-15-65(m)</td>
<td>NO</td>
<td>NO</td>
<td>A mental illness or mental deficiency of such nature and duration that, according to the statement of a psychologist or physician, the parent or guardian will be incapable of caring for the child without placing the child at substantial risk of physical or mental injury even if the department were to provide family support services to the parent or guardian for 12 months.</td>
</tr>
<tr>
<td>Alaska</td>
<td>47.10.086(c)(5)</td>
<td>YES</td>
<td>NO</td>
<td>A mental illness or mental deficiency of such magnitude that it renders the parent or guardian incapable of benefitting from the reunification services.</td>
</tr>
<tr>
<td>Arizona</td>
<td>8-846(B)(1)(b)</td>
<td>YES</td>
<td>NO</td>
<td>A mental illness or mental deficiency of such magnitude that it renders the parent or guardian incapable of benefitting from the reunification services.</td>
</tr>
<tr>
<td>Arkansas</td>
<td>9-27-303(46)(c)</td>
<td>NO</td>
<td>NO</td>
<td>A mental disability that is described in Chapter 2 (commencing with Section 7820) of Part 4 of Division 12 of the Family Code and that renders him or her incapable of utilizing those services.</td>
</tr>
<tr>
<td>California</td>
<td>W.and I.361.5</td>
<td>YES</td>
<td>NO</td>
<td>A mental disability that is described in Chapter 2 (commencing with Section 7820) of Part 4 of Division 12 of the Family Code and that renders him or her incapable of utilizing those services.</td>
</tr>
<tr>
<td>Colorado</td>
<td>19-1-115</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Connecticut</td>
<td>17a-111b</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Delaware</td>
<td>Tit. 13 1103</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>DC</td>
<td>4-1301.09a</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Florida</td>
<td>5.39.806</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>15-11-58</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Hawaii</td>
<td>587-71</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Idaho</td>
<td>16.2005</td>
<td>NO</td>
<td>YES</td>
<td>If the parent has a disability, as defined in this chapter, the parent shall have the right to provide evidence to the court regarding the manner in which the use of adaptive equipment or supportive services will enable the parent to carry out the responsibilities of parenting the child.</td>
</tr>
<tr>
<td>Illinois</td>
<td>705 ILCS 405/2-13.1</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Indiana</td>
<td>31-34-21-5.6</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td>232.102.12</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Kansas</td>
<td>38-2255</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Kentucky</td>
<td>610.127</td>
<td>YES</td>
<td>NO</td>
<td>Mental Illness as defined in KRS 202A.011 or mental retardation as defined in KRS 202B.010 or other developmental disability as defined in KRS 387.510 that places the child at substantial risk of physical or emotional injury even if the most appropriate and available services were provided to the parent for twelve (12) months.</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Ch. Code Art. 672.1</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Maine</td>
<td>22 §4055.</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Maryland</td>
<td>§ 3-812</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>I.119.29C</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Michigan</td>
<td>712A.19b</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>260.011</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Mississippi</td>
<td>43-21-603</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Missouri</td>
<td>211.183</td>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>
### Table 1: State Statutes Addressing Mental Illness as Grounds for Not Providing Reasonable Efforts

<table>
<thead>
<tr>
<th>State</th>
<th>Statute</th>
<th>Mental Illness as grounds for not providing reasonable efforts</th>
<th>Protective Language for people with a mental illness</th>
<th>Excerpt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montana</td>
<td>41-3-423</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Nebraska</td>
<td>43-283.01</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Nevada</td>
<td>432B.393</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>169-C:24-a</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>New Jersey</td>
<td>30:4C-11.2</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>New Mexico</td>
<td>32A-4-22</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>New York</td>
<td>FCA 1039-b</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>North Carolina</td>
<td>§ 7B-507</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>North Dakota</td>
<td>27-20-32.2, 27-20-02</td>
<td>YES</td>
<td>NO</td>
<td>Fails to make substantial, meaningful efforts to secure treatment for the parent’s addiction, mental illness, behavior disorder, or any combination of those conditions for a period equal to the lesser of: (1) One year; or (2) One half of the child’s lifetime, measured in days, as of the date of the petition alleging aggravated circumstances is filed.</td>
</tr>
<tr>
<td>Ohio</td>
<td>2151.419</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Oklahoma</td>
<td>10-7003-4.6.</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Oregon</td>
<td>419B.340</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>42 Pa.C.S.A. § 6351, § 6302</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Rhode Island</td>
<td>40-11-12.2</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>South Carolina</td>
<td>20-7-763</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>South Dakota</td>
<td>26-8A-21.1</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Texas</td>
<td>262.2015</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Tennessee</td>
<td>37-1-166.</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Utah</td>
<td>78A-6-302</td>
<td>NO</td>
<td>YES</td>
<td>In the absence of one of the factors described in Subsection (1), a court may not remove a child from the parent’s or guardian’s custody on the basis of (b) mental illness or poverty of the parent or guardian; or (c) disability of the parent or guardian, as defined in Section 57-21-2.</td>
</tr>
<tr>
<td>Vermont</td>
<td>22-18-1.1 Ann. Stat. Tit. 33, 5515</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Virginia</td>
<td>Ann. Code 16.1-281</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Washington</td>
<td>Rev. Code 13.34.132</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>West Virginia</td>
<td>49-1-1</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Ann. Stat. 48.355</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Wyoming</td>
<td>Ann. Stat. 14-2-309a,b</td>
<td>NO</td>
<td>NO</td>
<td><strong>NO</strong></td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>8-23B-4-447s</td>
<td>YES</td>
<td>NO</td>
<td>A mental disability or defect of such magnitude that it prevents him or her from benefiting from reunification services and he or she will not be able to care properly for the minor.</td>
</tr>
</tbody>
</table>

**Note:** The table continues with states and their respective statutes. The full content is not displayed here due to its length and complexity. For a complete view, please refer to the source document.
inaccessible or inadequate health care, prevalent community violence, social isolation of families, parents’ physical illness, and parental involvement in substance abuse or criminal activity (Brown, Cohen, Johnson, & Salzinger 1998; Hay & Jones 1994; Leventhal 1996). Hollingsworth (2004) found that one or more of these environmental factors, when combined with the presence of mental illness, correlated very significantly with the loss of child custody among affected women. Examining the effects of social-context factors on the positive-parenting practices of African American women, Oyserman et al. (2002) found that the relative degree of social and financial stress and the women’s current mental health status strongly predicted the character of parenting attitudes, the extent of parental involvement, and the type of parenting style. It is within this complex framework of interacting forces that we should seek to understand the historical ramifications of ASFA.

Impact of ASFA Provisions

Reasonable Efforts

Federal law requires state social service agencies to demonstrate that reasonable efforts are made to “provide assistance and services to prevent the unnecessary removal of a child from his or her home” and to “make it possible for a child who has been placed in out-of-home care to be reunited with his or her family” (Child Welfare Information Gateway, http://www.childwelfare.gov/systemwide/laws_policies/statutes/reunify.cfm retrieved on July 25, 2008). Satisfying the reasonable efforts requirement would seem to entail that services should be available and accessible to families confronting parental mental illness, and that the timeframe of service delivery should be sufficient to allow parents to participate meaningfully and benefit fully. Those overseeing the process should carefully gauge the necessary timeframes for treatment, prognosis, and predictions of future parenting capacity in light of the characteristics of mental illnesses in general, while also taking into account the nuances and distinctive patterns of a given parent’s illness. In order to do this job right, child welfare practitioners and mental health specialists must be well trained, strongly supported, and prepared to work together.

- Effective interventions may not be available

Families in need often have trouble finding appropriate services, meaning empirically tested interventions that successfully address the specific challenges of parents living with mental illnesses and the special circumstances confronting their children (Hinden, Biebel, Nicholson, Henry, & Katz-Leavy 2006). A recent study of programs across the U.S. that include services to parents with a mental illness and their respective families revealed that of fifty-three such programs, only twenty had been specifically designed to meet the needs of these parents. In most cases, the type of funding source—its particular mission and set of priorities—dictated or shaped the program’s distinctive target group, eligibility requirements, and intended outcomes. The programs’ theoretical orientations, geographical settings, and relative comprehensiveness of outreach also varied widely. Despite these differences, however, the programs shared an essential set of family-centered and strengths-based services, such as flexible family case management, parent support, education and parent skills training. Unfortunately, very few of the programs reviewed had undergone formal evaluations from which it is possible to generalize about their effectiveness (Hinden et al. 2006; Nicholson, Hinden, Biebel, Henry & Katz-Leavy 2007).

- What works?

Hollingsworth (2004) concludes that parents with a mental illness benefit from being connected with respite services and support groups, receiving information and practical guidance on aspects of parenting, and getting help in locating and accessing community services. Based on their study of parenting among African American women with mental illness, Oyserman et al. (2002) assert that providing access to financial resources, social support, and quality mental health services can play a vital role in enabling positive parenting.

In a similar vein, the Nurse-Family Partnership model (Olds, et al; 2002) is being implemented and tested in Louisiana and targets the needs of young mothers with depression and their children (Boris, Larrieu, Zeanah, Nagle, Steier & McNeill 2006). In this approach, nurses and mental health counselors take corrective aim at the impact of depression and partner violence on the mother, the infant, and the mother-infant relationship. Another promising model, Family Options (Cowling 2004; Nicholson, Biebel, Williams & Albert 2008), blends principles and strategies of psychiatric rehabilitation with a family team concept. Preliminary data on this family-centered model indicate that mothers are making gains in receiving useful...
services and improving their life skills, parenting practices, and showing improvements in well-being and functioning. (Nicholson et al. 2008).

Services may be available but may not be fitting or easily accessible

Parents with mental illnesses and providers alike describe extensive barriers to the accessing of effective mental health services (Blanch, Nicholson & Purcell 1994; Nicholson 1996). Parents’ participation may be impeded or constrained by services that are too far away, are offered at inconvenient times, or are simply ill-suited to their particular needs. Extended family members may undermine parents’ efforts to seek care by not providing emotional support (Nicholson, Geller, Fisher & Dion 1993) or by neglecting to help out with transportation or child care (Nicholson 1996; Nicholson, Sweeney & Geller 1998a). Traditional adult mental health services tend not to focus on parenting or parental needs as such; in fact, a recent survey of state mental health program directors found that only twelve states routinely asked clients about their status as parents, and four of these states had written policies or practice guidelines covering the provision of services to this segment of the client population (Nicholson, Biebel, Williams, & Katz-Leavy 2004). Furthermore, existing services are often not family-centered, and services for adults and children are sometimes offered in separate locations, creating logistical problems for families. Mental health and child welfare services may not be well coordinated, while adult and child mental health services may be fragmented in terms of design and delivery (Blanch, et al. 1994).

When “reasonable efforts” are not required

ASFA spells out situations in which states are exempted from making “reasonable efforts” to provide assistance and services to parents or families (Child Welfare Information Gateway, http://www.childwelfare.gov/systemwide/laws_policies/statutes/reunify.cfm). A core example of such an exemption would be a case in which the courts determine that a parent has committed a heinous crime such as murder, torture, or chronic abuse. States may adopt additional grounds for bypassing the “reasonable efforts” standard. As noted, five states and Puerto Rico specify that reasonable efforts to support reunification are not required when evidence is presented that cites a parental mental illness as the reason that it is unlikely that the parent will be able to care for a child within a reasonable timeframe. (Scott 2008).

Central to the concept of “reasonable efforts” is an emphasis on assisting families to preserve or repair parent-child relationships in order to maintain the integrity of the family unit. Ironically, certain routine practices in child welfare and mental health, often instituted with little or no empirical evidence of their efficacy, may work against family preservation or reunification for parents with mental illness (Nicholson, Geller, & Fisher 1996); indeed some of these procedures may exacerbate parents’ mental illnesses and lead to increased maladjustment in children (Nicholson, Sweeney, & Geller 1998a). For example, removing children from their parents’ care may sometimes trigger symptoms of trauma in parents as well as in children. Another example stems from the common practice of setting a period of time during which parents may not have contact with their children who have been placed in foster care. Often justified as a means of allowing the child “time to settle into the foster home” or of giving a parent “time to work on his or her own issues,” this practice may aggravate emotional and behavioral dysfunction among both children and parents. Foster parents and kinship care providers may not be sufficiently attuned to the nature of birth parents’ mental illnesses (Nicholson 1996). They may refuse to allow birth parents access to their children, resulting in lost opportunities to guide and support those parents in ways that could promote family reunification.

Parents’ feelings and behaviors, growing out of past experiences, affect their willingness and ability to form productive relationships with professional and natural support providers (Nicholson, et al. 1998b). Many parents report finding it difficult to trust mental health and child welfare providers (Nicholson et al. 1998a) and extended family members, most obviously in cases where one of those family members had abused them as children (Nicholson, et al. 1998b). Parents who themselves had negative experiences in foster care may understandably become very upset at the prospect of placing their children in foster care.

The rationale of “time to work on your own issues” often comes into play with parents who must be hospitalized, yet a lack of information as to their children’s whereabouts and well-being may contribute to parents’ worries and, in the worst case, to their decompensation (Nicholson, et al. 1998a). Some psychiatric hospitals go so far as to
Concern for a child's safety may appropriately trigger his or her prompt removal from parental care. Effective service planning, however, hinges on an ongoing assessment that closely tracks each parent's expression of mental illness, each child's unique needs, and the shifting contours of family life over time. Evaluations based on information obtained at only one point in time may not accurately capture the parent's capabilities or the child's needs. Illnesses may wax and wane, with periods when the parent is functioning well and other times when he or she requires greater attention and help. Or, a parent with a mental illness may function well in one area and face challenges in another; for example, he or she may be able to provide care for children, but have difficulty balancing care-giving with the demands of work. Thus an instance of perceived child neglect may stem from an inability to sustain employment, or perhaps a consequent loss of housing, and yet be attributed to a more basic incapacity to parent.

Parents with mental illnesses report a common feeling of being under intense scrutiny because of the routine assumption that they are unfit to parent, sometimes from the moment of a child's birth (Nicholson, et al. 1998a). This scrutiny can sometimes serve as motivation to perform well, but can also undermine a parent's self-confidence. Parents who mask their difficulties for fear they will be judged as inadequate may be perceived as "withholding information" or as having a "lack of insight." Children of parents with a mental illness may welcome an opportunity to talk with someone about their situation, but they may also be confused or anxious about betraying their parents or being separated from them.

The Place of Assessment in Termination of Parental Rights

The concepts of "reasonable time" and "foreseeable future" are particularly important in assessing parental competence in termination of parental rights proceedings. Factors that complicate the task of determining how a mental illness will affect the capacity to parent or of predicting future "competence" include the lack of a clear and widely accepted definition, the unsuitability of traditional psychological instruments, the uncertain impact of situational influences such as poverty or family structure, and the scarcity of normative data from which to measure parenting abilities (Ackerson 2003; Budd & Holdsworth 1996; Budd, Poindexter, Felix, & Naik-Polan 2001; Grisso 2002; Ostler 2008). Decisions of great consequence to parents and children are often made with little basis in careful, scientific assessment, and with considerable discretionary authority granted to the state. In Montana, for example, if two outside mental health professionals testify that a person will be automatically file child abuse reports whenever parents are admitted for treatment. Some hospitals also have policies that either prohibit or work to discourage parent-child contact (Nicholson, Geller, et al. 1993; Biebel, Nicholson, Williams & Hinden 2004; Biebel, Nicholson, Geller, & Fisher 2006). From the other direction, children whose parents are hospitalized may not be given information regarding their parents' condition, location, or timeline for release and return. The courts may hold parents responsible for any negative impact of the routine child welfare and mental health practices described above on the parent-child relationship. The courts then blame parents for having an "insecure relationship" with their children, and their children may be removed from their care and/or custody.

The matter of visitation also presents complicated challenges for parents with mental illnesses. Those who are allowed weekly visitation in accordance with child protection service plans, as long as they "show up" and behave "appropriately," are judged to be committed to their children by caseworkers and by the court. If either parents or children express anger or pain, however, they may be deemed dysfunctional or labeled as "difficult." Parents will sometimes opt out of these visits altogether if they become too distressed by the repeated separations from their children or feel too burdened by the fear of ultimately losing custody (Nicholson, et al. 1998a).

Certain common characteristics of mental illnesses (e.g., conditions that are perceived as chronic or cyclical, or in which relapse is common) may lead the court to determine that reasonable efforts are not required (Nicholson, et al. 2004). Although new treatment and rehabilitation strategies for mental illnesses have never been better, the course of an illness—emergence of symptoms, diagnosis, treatment, and recovery—is rarely linear, while prognosis and outcomes may vary depending on gender, race, and ethnicity (DHHS, 1999). Therefore, affected parents required individualized approaches that take into account their unique circumstances throughout the family's period of contact with the child welfare system.

Initial and Ongoing Evaluation

Concern for a child's safety may appropriately trigger his or her prompt removal from parental care. Effective service planning, however, hinges on an ongoing assessment that closely tracks each parent's expression of mental illness, each child's unique needs, and the shifting contours of family life over time. Evaluations based on information obtained at only one point in time may not accurately capture the parent's capabilities or the child's needs. Illnesses may wax and wane, with periods when the parent is functioning well and other times when he or she requires greater attention and help. Or, a parent with a mental illness may function well in one area and face challenges in another; for example, he or she may be able to provide care for children, but have difficulty balancing care-giving with the demands of work. Thus an instance of perceived child neglect may stem from an inability to sustain employment, or perhaps a consequent loss of housing, and yet be attributed to a more basic incapacity to parent.

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unable to assume a parenting role because of mental illness, the child welfare system is relieved of any requirement to provide services to the parent (Lightfoot & LaLiberte 2006).

To address this critical issue, Jacobsen, Miller, and Kirkwood (1997) recommend the model of a multidisciplinary assessment team that promotes collaboration between mental health and child welfare personnel and that shapes interventions according to an assessment of parents’ particular strengths and deficits. Other constructive guidelines aimed at more comprehensive assessments of parenting competency call for direct observation of parenting and for information-gathering that relies on multiple sources, perspectives, and points in time (Ostler 2008). Budd (2005) identifies three core features that should distinguish parental assessment: a focus on parenting rather than diagnosis, a functional approach that emphasizes behaviors and skills in everyday performance, and the application of a minimal parenting standard (Risley-Curtiss, Stromwell, Hunt, and Teska 2004) contend that some assessments of parental fitness focus on optimal capacity rather than the more appropriate standard of sufficient parenting capacity.

The American Psychological Association has issued guidelines for evaluations in child protection cases that emphasize objectivity, specialized forensic expertise, informed consent, and nondiscriminatory practice (American Psychological Association Committee on Professional Practice and Standards 1998). Yet current practice appears to be at odds with many of these guidelines (Budd 2005; McWey, Henderson, & Tice 2006; Risley-Curtiss, et al. 2004). For example, mental health professionals conducting assessments to be used in court proceedings will sometimes meet with parents only once or twice for a period of one or two hours (Budd 2005; McWey, et al. 2006). In addition, some never observe parents interacting with their children (McWey, et al. 2006; Risley-Curtiss, et al. 2004). Yet the reports of these professionals often have great influence in family court decisions.

**When Reasonable Efforts Require Reasonable Accommodations**

Many state statutes put forward the concept of “mental disability” as possible grounds for the termination of parental rights (Bazelon Center 2008. http://www.bazelon.org/newsroom /2007/UNJUST011107.html retrieved on October 3, 2008). Embedded in the Americans with Disabilities Act (ADA) is a requirement that public agencies pursue strategies for ensuring effective participation of individuals with disabilities in the operations of publicly funded services. Unfortunately, there has been little success in invoking ADA mandates on behalf of parents with psychiatric disabilities in termination of parental rights proceedings (Bazelon Center 2008). However, the ADA requirement of “reasonable accommodations” to ensure client participation in services would seem to apply to publicly funded legal services for parents with mental disabilities, as well as to more traditional family preservation services.

The Clubhouse Family Legal Support Project (CFLSP) is a good example of an effort to integrate mental health and legal services, and to tailor legal services to the needs of parents with mental illnesses (Nemens & Nicholson 2006). CFLSP provides low-income parents with legal advice and referrals, pro bono representation, and linkage to community supports, training and education. The project also gives attorneys representing parents with mental illnesses coaching and information on matters such as custody and visitation, child welfare proceedings, housing and other family-related concerns in the legal system. CFLSP has provided training on parenting and mental illness to attorneys, judges, and mental health clinicians since 1999.

**ASFA Timeframe**

Commendably, ASFA’s timeframes were designed to prevent children from languishing in the foster care system (see Framework Paper), but they can present further trials for parents with mental illness. ASFA establishes that if reasonable efforts are not required, then an initial hearing regarding termination of parental rights must be held within thirty days of the permanency planning hearing (Baker, et al. 2001). This timetable in essence expedites the process of terminating parental rights. Even when reasonable efforts to reunify are required, a hearing must be held within twelve months to finalize the permanency plan. Some parents with mental illness find it difficult to meet reunification goals within this timeframe. Although filing of the mandatory termination petition does not take place until the child has been in the foster care system for 15 of the prior 22 months, the decision to terminate parental rights often comes at the twelve-month hearing, if it is determined that sufficient progress has not been made. McWey, et al. (2006) describe cases in which, even with the court’s recognition of ongoing progress, parents with mental illnesses had their rights terminated because they were unable to meet reunification goals within the requisite timeframe. In
addition, expediting the process towards termination of parental rights may not in itself contribute to accomplishing ASFA goals; many children must wait in care for adoption for up to two years after their parents’ rights have been terminated (Lowry 2004).

**Workforce Challenges**

Because mental health professionals do not routinely ask about parenting status, adults served in the mental health system may not be identified as parents (Nicholson et al. 1993; Nicholson, et al. 2004). Mental health professionals serving the general adult population often report that they do not have the skills or knowledge to work with clients in their specific role as parents. These providers are also concerned about confidentiality issues and possible complications for the treatment relationship if child abuse or neglect is identified and reported (Maybery & Reupert 2006). Servais and Saunders (2007) suggest changes in professional training to increase the quality of services and reduce the stigma involved in pertinent cases.

Child welfare professionals are not necessarily equipped or required to identify and address the mental health needs of their adult clients. At the organizational level, management must support the thoughtful review of all policies and procedures that impinge on the capacity of the workforce to meet the needs of families with parental mental illness. Some training opportunities currently exist (see, e.g., <http://www.ce4alliance.com/courses/100123>; guidelines for attorneys, judges, and child welfare agencies proposed by the Youth Law Center in 2000). Expanded training would help workers explore assumptions and potential biases regarding these families and to develop the skills essential to working with them as effectively as possible.

**Summary**

Our review of the interaction of ASFA implementation with the capacities, needs, and challenges of families with a parent affected by a mental illness has identified four major areas of concern that call for immediate action:

1. **Eliminate discrimination against parents with mental illnesses** based on stigma, fear, or lack of information that sometimes leads to renouncing “reasonable efforts” toward family reunification. This will require policy changes, as well as better education and support of personnel in all systems that work with these families.

2. **Significantly increase the availability of appropriate, effective services for parents with mental illness and their children** to ensure safety, improve parenting, and promote family integrity. The top levels of government must lead the way to new possibilities of collaboration and integration. Better communication and joint planning are necessary among federal, state, and local child welfare and mental health agencies and within the mental health field, moving from age-based programming to family-centered systems. Responsibility for improving the response to these vulnerable families is not limited to child welfare and mental health agencies, however. A fresh approach to designing systems and services should build on the strengths of families by meeting their needs for safe housing, employment and financial support, medical and mental health care, child care, and other vital resources.

3. **Substantially bolster professional training, and develop policy and practice guidelines to enhance practice bearing on parents with mental illness and their children.** Practice improvements should strive to anticipate and prevent instances requiring child welfare intervention, as well as to perfect the response to families once they encounter protective services.

4. **Accelerate research addressing families in which a parent has a mental illness** to (a) provide essential descriptive information about the families, their characteristics, experiences, and needs; (b) develop and test promising interventions, and (c) increase our knowledge base with respect to the short-term and long-term outcomes of these approaches. Key players among federal agencies should offer substantial support for this research and promote interdisciplinary and interagency collaboration in pursuit of these goals. Such agencies would include the Substance Abuse and Mental Health Services Administration, the National Institutes of Health, the Administration on Children, Youth, and Families, and the National Institute on Disability and Rehabilitation Research, among others.
Policy Recommendations

Policy Recommendation 1
Ensure that a mental health diagnosis is not the sole grounds for limiting the rights of parents in child welfare proceedings. The State of Utah has added statutory language that prevents the court from taking custody strictly on the basis of mental illness, poverty, or the disability of the parent or guardian (see Table 1). Focusing on parents’ diagnoses or labels misses the real question of parental functioning and can lead to underestimating or misjudging parental capacity to meet children’s needs.

Policy Recommendation 2
When parents with mental illnesses demonstrate substantial progress toward meeting reunification goals, grant an accommodation (if necessary) of an extended timeline beyond the twelve-month timeframe for permanency hearings established by ASFA and/or the timeframe required for initiating termination of parental rights.

Policy Recommendation 3
Strengthen provisions for services and supports to parents with disabilities that may be associated with mental illness. Idaho’s statutes contain affirmative language that allows a parent with a disability to demonstrate his or her ability and competency to parent with the enabling presence of supports or assistive technologies.

Policy Recommendation 4
By means of a multidisciplinary process, develop and disseminate guidelines for comprehensive evaluations of parental competence that can be used to forge appropriate service plans for families. Such guidelines should be widely shared with professional organizations, accrediting bodies, and state licensing boards.

Policy Recommendation 5
Require that the advocacy and legal representation needs of parents with mental illness be served by individuals knowledgeable about the nature of mental illnesses and trained in the search for appropriate services and supports to meet the goals of reunification plans.

Policy Recommendation 6
Allocate federal and state funds to specialized programs for parents with mental illnesses and their families. Require that program efforts include all relevant agencies responsible for serving adults, children, and families and address the range of mental health, social service, and legal needs.

Policy Recommendation 7
Provide incentives for federal and state agencies to address the composite needs of all family members (both children and adults) in a comprehensive and coordinated way.

Policy Recommendation 8
Require state agencies whose mandates and activities touch the lives of families living with parental mental illness (e.g., mental health, child welfare, public health, education, juvenile justice) to develop interagency protocols aimed at facilitating integrated care for parents and children.

Recommendations for Improving Practice

Practice Recommendation 1
Improve training for child welfare, law enforcement, legal, medical, psychiatric, and judicial personnel who make crucial decisions regarding the best interests of children when parents have a mental illnesses.

Practice Recommendation 2
Increase child welfare service options and enhance the ability to individualize supports for parents with mental illnesses and their families.

Practice Recommendation 3
Require state mental health authorities: (a) to determine the parenting and family status of all individuals receiving public sector services; (b) to achieve a blending of resources from adult and child mental health funding streams to support families; and (c) to train workers to provide appropriate and efficacious services for families living with parental mental illnesses.

Practice Recommendation 4
Promote, when appropriate, continuing contact between parents with mental illnesses and their children even after parental rights have been terminated. This practice may contribute to a sense of permanency and continuity, especially for older children.
Research Recommendations

Research Recommendation 1

Promote research to study the impact of current policies and routine practices on children and parents when families living with parental mental illness become involved with child welfare.

Research Recommendation 2

Continue research addressing the effects on children of separation from parents, and of living in foster care or adoptive homes, with a focus on challenges faced by children and parents when a parental mental illness is involved. Seek solid comparative data on outcomes for children placed in foster care vis-à-vis those for children who remain at home with appropriate supervision and support for parents.

Research Recommendation 3

Continue to build the evidence and knowledge base that will support ever more effective interventions for families living with parental mental illness.

Footnotes

1 In this paper, the phrase “parents with a mental illness” includes any parent who has received a diagnosis of mental illness from a mental health professional, or who is perceived and treated as having a mental health problem by others who either influence or wield power over the family’s relationship to the child welfare system (e.g., child welfare caseworkers, law enforcement personnel, judges, and attorneys). Use of the term “mental illness” does not include persons with a primary diagnosis of substance use disorder or developmental disability, but may encompass parents with co-occurring substance use or medical conditions. Some parents with mental illnesses in the child welfare system may be characterized as having severe disorders. The Substance Abuse and Mental Health Services Administration defines severity as follows: “A diagnosable mental disorder found in persons ages 18 years and older that is so long lasting and severe that it seriously interferes with a person’s ability to take part in major life activities.” (Substance Abuse and Mental Health Services Administration 2008, retrieved on October 7, 2008 from http://www.oas.samhsa.gov/MentalHealthHP2010/ terminology.htm). Those who come within this definition are likely to need considerable support and individualized services. Another important term is “disability” (discussed below), defined as an impairment that substantially limits one or more major life activities (Disability Info.gov, 2008, retrieved October 6, 2008 from http://www.disabilityinfo.gov/digov-public/public/DisplayPage.do?parentFolderId=219). Parents with mental illnesses may or may not be deemed to have a disability, depending on the individual expression of their condition (symptoms, coping skills, course of illness), the unique needs of their children, and the resources and supports that can be brought to bear on their specific situations.

References


Conclusion

Building Upon the Child Welfare Reform Efforts of the Adoption and Safe Families Act (ASFA)

Over the past twelve years, mandates for children’s safety and permanency under the federal Adoption and Safe Families Act (ASFA) have dramatically altered how most child welfare systems operate. The Center for the Study of Social Policy and the Urban Institute commissioned a series of papers, “Intentions and Results: A Look Back at the Adoption and Safe Families Act,” to examine ASFA’s impact on children, families, and child welfare system performance. Overall, most of the authors conclude that ASFA has accomplished much; however, these papers also identify areas where child welfare jurisdictions fall short and fail to ensure that every child grows up in a safe and supportive family. Specifically, while many children who enter foster care eventually are reunified with their families, adopted by another family, or otherwise linked to an alternative permanent living arrangement, certain populations of children have not uniformly achieved these outcomes. Many jurisdictions struggle to adequately and appropriately work with families who face complex issues related to substance abuse, mental health, incarceration, or undocumented immigration status.

This paper summarizes the key conclusions of papers in the series and provides a next-stage agenda for child welfare reform work in this crucial area.

Learning based on a decade of ASFA Implementation

ASFA created a profound shift in the legal framework and operations of child welfare systems of all states and counties. Specific contributions of ASFA identified by the authors in this series include:

- Clarity that foster care is a short-term solution to familial problems when a child’s safety is threatened rather than a long-term solution to a child’s ultimate well-being;

- Requirements that courts and child welfare systems follow clear deadlines and review processes to determine whether a child should return home or find permanency through another option;

- Unprecedented legal recognition that placement with a relative is an acceptable permanency option for a child and that public systems should help relatives to care for their kin; and

- A significant increase in the number of children leaving the foster care system through guardianship and adoptions.
Important areas of unfinished business raised by the papers are discussed below:

1. ASFA has increased exits from the foster care system through adoption and guardianship, yet many youth exit foster care through emancipation and many without connections to a family.

   Papers in this series highlight the importance of ASFA’s focus on moving children to permanent families more quickly. Based on the understanding that a “child’s sense of time” requires cases to be resolved as fast as possible and that children should not languish in foster care, ASFA created timelines to promote quicker decision-making regarding reunifying a child with his/her family or finding another permanent home. Since ASFA’s inception, there has been a significant increase in adoption and guardianship for children in the foster care system. However, the permanency results for older youth have not been as positive. Older youth remain in foster care for long periods of time, and as they age their chances of achieving permanency through adoption or guardianship diminish. It is troubling that the number of youth who have “emancipated” (i.e., have left foster care when they reach majority age, either 18 or 21) has increased since ASFA was passed. Some authors point out that the greater emphasis on termination of parental rights (TPR) without a permanent family identified beforehand may lead to a larger number of youth being rendered legal orphans and that a portion of these youth never find another permanent family, emancipating from the system with no legal family connections.

2. ASFA acknowledged the need to support birth families to prevent removal if possible and to reunify quickly and safely with their children, but did not fully address what must happen to make this a reality for many children.

   ASFA requires “reasonable efforts” to prevent removal of children and support family reunification but adequate investments in community-based services and supports for struggling families are missing. Several papers, including the testimonials of parents, describe confusion over what services should be made available to families and what constellation and quality of services constitute “reasonable efforts.” Many families with varying needs are referred to a similar set of services (anger management, parenting classes, and psychological evaluation) without adaptation for their unique needs or assessment of the impact of these services on behavioral change. Further, as many authors discussed, there is a dearth of immediate, meaningful services for families in need of housing support, substance abuse, and mental health treatment, and other services to stabilize families, especially those living in poverty. The ASFA timeline prevents some families from being reunified. Several authors suggest that the ASFA timelines requiring a decision to be made regarding TPR if a child has been in foster care 15 of the last 22 months do not adequately account for the needs and situations of many families. The ASFA timeframes are particularly problematic for families with complex mental health and substance abuse issues, for incarcerated parents, and for immigrant families. The decisions to terminate parental rights are difficult ones, which require child welfare systems and the courts to understand the nuances and intricacies of the rights, desires, and needs of the parents and children in individual families. As authors and parents point out in this series, this decision making is complicated by the relative lack of effective and accessible
services for families with complex needs. This lack of service provision can qualify as a “compelling reason” for the state not to move toward TPR in accord with strict ASFA timeframes. Interestingly, the authors presented differing views about the use of “compelling reasons”: one opinion is that states are broadly using this exception for not moving quickly enough to TPR and permanency, while others suggest that “compelling reasons” are not being used enough to accommodate the individual needs, circumstances, and desires of families.

3 ASFA recognized, but did not sufficiently support, relative placement options.

In addition to adoption and reunification, ASFA included placement with relatives, legal guardians, or another planned permanent-living arrangements as appropriate permanency options for children who cannot be reunified with their parents. While the intention was to create a means of uniformly ensuring safety of children, some provisions of ASFA created challenges for a child to be placed with a fit and willing relative. Specifically, ASFA regulations require that relative foster homes be licensed in the same way as foster homes for children in non-relative placements, with only limited case-specific exceptions. Recent federal legislation, the 2008 Fostering Connections to Success and Increasing Adoptions Act (FCSIAA), makes this requirement a bit less restrictive by allowing states to waive non-safety-related licensing standards for relative homes on a case-by-case basis.

ASFA provides financial incentives for states to place children with adoptive families, but no similar incentive for supporting children in exiting foster care for permanent legal guardianship (including relative/kinship guardianship). In addition to the incentive to states, adoption subsidy programs through many states provide significant support to caregivers to adopt rather than become permanent legal guardians. Authors note that these provisions have disproportionally affected children of color whose relatives are willing to become legal guardians, but not adoptive parents, to their kin and who may need sufficient subsidy and support to adequately care for these children. Again, in 2008 the FSCIAA changed this provision by supporting states in providing financial subsidies to kinship legal guardianship placement as long as certain conditions have been met.

4 ASFA revealed a need for improved collaboration, supports, and services from other public systems such as mental health, housing, income support, and criminal justice systems.

Many families who require child welfare intervention are already involved with or need the help of other human services systems. However, ASFA primarily addresses the operations of the child welfare system and does not provide specific guidance or mandates to ensure that services and supports of other public systems are provided in a timely and accessible manner to children and families. As a result, there has not been sufficient attention at either the federal or state levels to strategies that ensure cross-system collaboration.

Services to families with multiple issues and needs (e.g. substance abuse, mental health, domestic violence, incarceration) are often insufficient and infrequently coordinated. Some authors suggest that ASFA’s requirement of timelier decision making resulted in the development of special programs for some parents in some localities, such as family drug courts or substance abuse programs for mothers involved with child welfare systems. However, the availability of these programs and other services is not widespread, and access to programs informed by research is particularly lacking across the nation.
Data systems for families who are involved with multiple public institutions are disconnected so that leaders and workers in the field do not routinely know the full extent of the need for services and service coordination. ASFA provided much focus on the data needs of child welfare systems, but the next step will require that states and localities have the ability to track families across social service systems. Specifically, authors note the need to collect data on families involved with the child welfare system and criminal justice, mental health, and substance abuse systems. Further, cross-system collaboration is necessary to design solutions to ensure the coordination and delivery of multiple services and supports that many families need.

Infrastructure improvements continue to be needed in the child welfare systems in order to better support children and families.

The child welfare workforce requires strengthening. The work of child welfare is challenging and requires highly skilled, trained, and supervised case workers who are adequately paid and supported. Currently, child welfare systems struggle to hire enough workers, train them sufficiently, and retain them. Authors also point to the inadequate number of available bilingual workers; the lack of training and understanding among workers about mental illness and substance abuse issues; the inconsistent training on the ASFA “compelling reasons” exceptions; and the need for greater worker competency in addressing the needs of culturally, ethnically, and racially diverse families.

Practice and policy don’t adequately focus on the well-being of children in the child welfare system. While ASFA highlights the mission of the child welfare system to promote the safety, permanence, and well-being for the children under its care, much greater attention, in both the law and its implementation, has focused on the two goals of child protection and permanence. Once children are removed from unsafe or high-risk situations, the law and the resources that accompanied the law do not provide a clear framework of expectations regarding the system’s obligations related to the developmental and emotional needs of children. Specifically, workers are often ill-equipped to address the trauma of abuse or neglect, the impact of removal and multiple placements, the issues of attachment and separation anxiety, and other needs of children involved in the child welfare system. Additionally, although child well-being is the responsibility of multiple systems, including education, juvenile justice, mental health, etc., children involved in foster care frequently experience inadequate services coordination and delivery due to a lack of role clarification, conflicting case plans, and inadequate teaming and practice by interdisciplinary/interagency professionals.

Building on the Unfinished Work of ASFA

The goals of ASFA are as valuable and relevant today as they were when ASFA was passed in 1997. The new Fostering Connections to Success Act (FSCIAA) continues to support the goals of safety, permanency, and well-being of children by providing much-needed support for relatives interested in caring for children; requiring coordination of health care and education for children in foster care; supporting sibling placement; and funding tribes to administer child welfare systems that serve their members. Further, the field is recognizing the need to ensure that older youth for whom a permanent legal family cannot be found have strong connections with caring adults. In the past, older youth who failed to achieve permanency with their families have not seen strong concerted efforts to find them other families. The Fostering Connections Act doubles...
adoption incentives for older child adoptions and adoptions of children with special needs. Youth who have been in foster care also can access some additional supports through Chafee legislation for assistance with education, employment, and medical insurance.

Laudably, most child welfare reform efforts focus on ensuring that all children are safe, healthy, and connected to families and that families are able to adequately and safely care for their children. The Center for the Study of Social Policy has written and continues to write much about how public systems and communities can achieve these goals for all children and families and for specific groups who may experience overrepresentation or disparate treatment. Each paper in this series contains specific and detailed recommendations to improve outcomes for children and families and improve child welfare practice. Rather than present a summary of these recommendations or reiterate recommendations previously made by CSSP in other documents, this paper sets forth a more limited set of policy, research, and practice changes identified by the authors as essential to a comprehensive agenda for action. In moving forward, this agenda should include:

- **Providing a national focus and support for community-based prevention and early intervention services to families.** Child welfare systems are currently funded and operate to support families who have come to their attention due to child abuse and neglect. However, each of the authors emphasized how critical it is to collaborate with communities to provide adequate supports for families before they reach the circumstances that contribute to child maltreatment. We know that the greatest number of children who enter the foster care system is infants—often having very young parents—and thus, specific attention and interventions should support these families. Additionally, the vast majority of families involved in child protection live in poverty or are among the working poor. A range of supports must be available and coordinated to help struggling families to remain intact, including safe and stable housing, health care, economic stability, child care, and quality mental health and substance abuse treatment. Child welfare systems alone cannot achieve the goals of safety, permanency, and well-being without attending to these pressing needs of families and collaborating with other systems that have the resources and expertise to provide these supports.

- **Increasing efforts and supports to keep families together, or if separated, to reunify them quickly.** Although obvious, it is important to affirm that families should be provided with appropriate and timely services to help them resolve issues that led to their involvement with the child protection system. As many of the families involved with the child welfare system are low income, significant investment in services to support these families must occur, and systems must have the flexibility to tailor these services to support the unique needs of individual families.

  Stronger guidance to the states should be provided in order to ensure that “reasonable efforts” to prevent removal or support family reunification are uniformly and fairly made available to families. For example, the federal government has already issued guidelines for measuring the quality and timeliness of substance abuse treatment, which could be used to assess “reasonable efforts.” Further, “aggravated circumstances” that allow child welfare agencies to bypass providing reasonable efforts should be more thoroughly examined to eliminate uneven and unfair application.
Finally, to be successful, families must understand the interventions and planning by the State and accompanying court proceedings. Based on the testimonial of parents and youth, it is apparent that many did not understand their case plan or court proceedings. In addition to access to strong legal advocates with adequate resources and specialized training, families could benefit from programs such as the Family Navigators or Peer Advocates that help guide them through their experience with the child protection system.

Developing and supporting specialized treatment, especially for families challenged by substance abuse, mental illness, or incarceration. Many parents and youth involved in child welfare systems are struggling with significant, often debilitating, substance abuse and/or mental health problems. Other families are often separated due to parental incarceration. First, better data must be collected on families involved in multiple systems so that a fuller understanding of the number and needs of families is attained. Second, successful reunification of families and treatment of parents in the child welfare system rests on the field's knowledge and effective delivery of programs designed to meet the unique needs of families. While a body of knowledge about such programs accrues, greater investment in promising programs is required so that a broader array of effective and culturally appropriate programs is available to parents and children. Finally, child welfare jurisdictions must be supported in forming meaningful collaborations with substance abuse, mental health, and criminal justice agencies to ensure that these programs are readily accessible to families involved in the child welfare system; case workers and courts understand and can support the program's treatment modalities; and outcome data can be collected, analyzed, and shared so that programs can be evaluated for effectiveness.

Reassessing the ASFA timelines so that parents are provided adequate opportunity and support to change and reunify their families and that children do not languish in foster care. Several authors made recommendations on allowing for exceptions to the ASFA timelines due to the needs of parents. Examples include providing exceptions in complicated immigration cases, in cases where a parent with a mental illness is making substantial progress, and in cases where an incarcerated parent has a strong relationship with the child. Currently, systems struggle with wanting to use a standard to determine at what point parental rights should be terminated, but having the flexibility to account for the unique circumstances of families. The current construct of ASFA does not provide sufficient flexibility so that child welfare workers and judges can apply a more nuanced approach to accommodate the unique situation of a family while keeping the short- and long-term needs of a child paramount.

Analyzing current child welfare legislation and practices for fairness towards the unique needs of immigrant families and children. The issues faced by immigrant families involved in the child welfare system have increased and changed since the implementation of ASFA. Continued analysis is needed to determine how the child welfare system can provide appropriate services and supports to immigrant families, coordinate responses with the interventions of immigration agencies and deportation decisions and timelines, and work with families where parents may be undocumented residents and their children are legal citizens.
Committing to widely available and effective post-permanency supports for children and youth in both adoptive and legal guardianship placements. Post-adoption services remain underfunded and poorly designed despite the fact that twice as many children receive federally supported adoption subsidies than receive federally supported foster care. Children in foster care, some of whom will later be adopted or enter into permanent legal guardianships, have high rates of behavior problems that often continue after adoption. As systems focus on finding permanent homes for older youth who have been in foster care for long periods of time, post-permanency supports will be even more critical to supporting the long-term stability of the placements and addressing the needs of youth who were once in care. Currently states bear the sole burden for funding post-permanency supports. Federal funding is needed to ensure that post-permanency supports are widely available and accessible to families.

These individual reform efforts will be insufficient without an accompanied focus on improving the infrastructure of the child welfare system. A highly qualified and productive workforce is critical to effective work with families. Child welfare agencies must be able to hire quality workers and supervisors, train them adequately and regularly, and pay them sufficiently well.

Ultimately, reform efforts should result in improved outcomes for children, youth, and their families. As is evident from the testimonials offered in this series, youth and parents are often-ignored experts on which policies, practices, and supports are helpful and those which are not. Their voices and insights must be routinely solicited and incorporated into any agenda for reform.

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Footnotes

1 States are required under ASFA to file for TPR if a child has been in out-of-home placement 15 out of the most recent 22 months with limited exceptions. Courts are also required to conduct a permanency hearing after 12 months of out-of-home placement to determine a permanent plan for the child, whether it is return home, filing of termination of parental rights and adoption, legal guardianship, or other appropriate plan. See Golden and Macomber, The Adoption and Safe Families Act Framework Paper, for a more detailed examination of state variation in adapting these ASFA provisions.

2 Specifically, children must have been cared for by this relative provider for six consecutive months and must be eligible for federal foster care payments in the home of the relative.
