

Child Maltreatment

<http://cmx.sagepub.com>

Is the Adoption and Safe Families Act Influencing Child Welfare Outcomes for Families With Substance Abuse Issues?

Anna Rockhill, Beth L. Green and Carrie Furrer

Child Maltreat 2007; 12; 7

DOI: 10.1177/1077559506296139

The online version of this article can be found at:
<http://cmx.sagepub.com/cgi/content/abstract/12/1/7>

Published by:



<http://www.sagepublications.com>

On behalf of:

[American Professional Society on the Abuse of Children](#)

Additional services and information for *Child Maltreatment* can be found at:

Email Alerts: <http://cmx.sagepub.com/cgi/alerts>

Subscriptions: <http://cmx.sagepub.com/subscriptions>

Reprints: <http://www.sagepub.com/journalsReprints.nav>

Permissions: <http://www.sagepub.com/journalsPermissions.nav>

Citations (this article cites 10 articles hosted on the SAGE Journals Online and HighWire Press platforms):
<http://cmx.sagepub.com/cgi/content/refs/12/1/7>

Is the Adoption and Safe Families Act Influencing Child Welfare Outcomes for Families With Substance Abuse Issues?

Anna Rockhill
Portland State University

Beth L. Green
Carrie Furrer
NPC Research, Inc.

The Adoption and Safe Families Act (ASFA) was designed to promote more timely permanent placements for children in the child welfare system. To date, however, available data have said little about whether ASFA is meeting its intended goals. This study looks at the impact of ASFA on parents struggling with substance abuse issues. The authors compared child welfare outcomes, pre- and post-ASFA, for children of more than 1,900 substance-abusing women with some treatment involvement. After the implementation of ASFA, children in this study spent less time in foster care, were placed in permanent settings more quickly, and were more likely to be adopted than remain in long-term foster care. The proportion of children who were reunified with their parent or parents stayed the same. These outcomes were apparent even controlling for case and family characteristics. Results are discussed in terms of the influence of ASFA on service delivery systems.

Keywords: *child welfare, permanency, substance abuse, ASFA*

In 1996, Congress passed the Adoption and Safe Families Act (ASFA; PL 105-89), designed to promote more timely permanent placements for children in the child welfare system. Viewed as landmark child

welfare legislation by supporters and critics alike, states were required to collect a variety of information about child welfare outcomes and foster care systems in order that the influence of this legislation could be carefully studied. With a few exceptions, however (U.S. General Accounting Office [GAO], 2002; Wulczyn, Hislop, & Chen, 2005), to date available data have been able to say surprisingly little about whether ASFA is meeting its intended goals or whether it is having some of the negative consequences that many feared. In particular, almost nothing is known about the impact of the ASFA legislation on a population thought to be particularly vulnerable to the shortened permanency timelines and other changes set forth, namely, parents struggling with substance abuse issues (U.S. Department of Health and Human Services [U.S. DHHS], 1999; Young, Gardner, & Dennis, 1998). Our study addresses this critical information gap by examining differences in child welfare outcomes for these parents before and after the implementation of ASFA in Oregon.

Authors' Note: Support for this research was supported by Grant 04115 from the Robert Wood Johnson Foundation's Substance Abuse Policy Research Project. We would also like to thank the Department of Human Services, Children, Adults and Families Division of the state of Oregon and the Oregon Department of Alcohol and Substance Abuse. We gratefully acknowledge the ongoing input from our team of data collectors, namely Marcela Lopez and Linda Newton Curtis, and statistical advice from Dr. Jason Newsom.

CHILD MALTREATMENT, Vol. 12, No. 1, February 2007 7-19
DOI: 10.1177/1077559506296139
© 2007 Sage Publications

THE ASFA

The ASFA was passed largely as a response to growing concerns about “foster care drift”; that is, children experiencing multiple, unstable foster care placements over extended periods, children virtually lost within the child welfare system. At the time that ASFA was passed, the average length of time in out-of-home care for children in the child welfare systems of 22 states was nearly 2 years, and 18% of these children had been in care for 5 years or longer (U.S. House of Representatives, 1998). There was a corresponding desire to decrease the amount of time it takes to establish a “permanent” placement for children. This was grounded in a belief that foster care is not good for children when they lack a sense of permanency and are therefore unable to forge the stable and enduring relationships with adults and other surrogate family members that are deemed crucial to success (Goldstein, Freud, & Solnit, 1973). Consequently, adoption was viewed as desirable, particularly for those children who had been in foster care for a long time and for whom reunification with birth parents was unlikely. Those supporting the legislation also argued that the pendulum had swung too far in the direction of family preservation at the expense of children’s safety and their need for a permanent home (Roberts, 2002). This is made clear in much of the testimony before Congress (Lowry, 2004) and by advocates such as Elizabeth Bartholet (1999), who voiced concern that children were being returned to “unsuitable” parents and that birth parents were being given too long to resolve the issues that brought the children into care in the first place.

The ASFA legislation addresses these issues through several mandates. First is the requirement that permanency hearings be held for children who are in out-of-home care for 12 months and that states file a petition to terminate parental rights for children in care for 15 of the most recent 22 months (although there are circumstances that serve as exceptions to the latter). Second, states are permitted to expedite permanency decisions or “fast-track” certain cases. For example, states may forgo offering services to parents who are deemed unlikely to achieve reunification based on having a previous termination of parental rights (TPR) or if there has been a child fatality. Another ASFA provision eliminates long-term foster care as an appropriate permanency option. Finally, there are financial incentives for states to increase the number of children who are adopted. Proponents characterized ASFA as symbolizing a shift away from “reunifying broken homes” and toward “putting the health and safety of children first.” They praised the

legislation as “aggressively [seeking] to move children through foster care to permanency in an expedited manner” (Lowry, 2004, p. 1022).

However, ASFA is not without its critics. Prior to passage of the legislation, concern was expressed regarding the potential that scarce child welfare resources would be diverted to pursuing adoption and that birth families would have an even harder time obtaining needed services (Moye & Rinker, 2002). This concern remains, and certainly the lack of appropriate services, especially in some areas of the country, is likely to pose a significant barrier to reunification for many families.

Families with substance abuse issues have been noted as facing particular challenges under ASFA given the lack of adequate treatment services, the shortage of publicly funded treatment slots, and the lack of ancillary services that women often need to succeed in treatment (U.S. DHHS, 1999). One survey of state child welfare agencies found that they were able to provide treatment for only a fraction of the parents requiring substance abuse treatment (Child Welfare League of America, 1997). Our own research identified numerous barriers to treatment for families with substance abuse problems; on average it took almost 3 months for women to access substance abuse services even after the implementation of ASFA (Green, Rockhill, & Furrer, *in press*; Rockhill, Green, & Newton-Curtis, *in press*). That these barriers continue to exist is supported in a few empirical studies. Worcel, Green, Burrus, and Finigan (2004) reported that among substance-abusing families who were involved with child welfare but not participating in a drug court intervention, only between 50% and 75% received needed treatment services. A study of parents of children in foster care in Oregon found that only 30% of parents who were requested (by the child welfare agency) to obtain residential substance abuse services actually completed treatment; moreover, 80% of those requested to obtain outpatient services attended fewer than half of their treatment sessions (Child Welfare Partnership, 1998). However, a recent study by Rockhill et al. (*in press*) found that following ASFA, parents involved with child welfare were able to access treatment services more quickly and were more likely to complete treatment, compared to families in whose cases occurred before the implementation of the ASFA legislation.

Although there is a significant body of research concerning differences between substance-abusing adults who enter treatment and those who do not (Beckman, 1994; Grella & Joshi, 1999; Reiger et al., 1990; Weisner & Schmidt, 1992), very few studies have looked at differences in child welfare outcomes

for families who engage in and/or complete treatment versus those who do not. A few studies have examined the importance of treatment completion, although results are somewhat mixed. Gregoire and Schultz (2001) for example, found that although parents who completed treatment were more likely to be reported by their caseworkers as "clean and sober," they were no more likely to have custody of their children or to retain legal parental rights. Rittner and Dozier (2000) similarly found no relationship between compliance with treatment and the likelihood of reentry into the child welfare system. On the other hand, two recent studies found that successful treatment completion was associated with increased likelihood of reunification (Green, Rockhill, & Furrer, in press-a, in press-b; Smith, 2003). However, neither study was able to examine differences between those who needed treatment and did not receive it versus those who were able to access treatment services. Clearly, there is a need for additional research to better understand the role of treatment in facilitating outcomes for these families.

Research has established that parents with substance abuse issues historically have had lower rates of reunification (Lewis, Giovanni, & Leak, 1997; U.S. DHHS, 1999; Walker, Zangrillo, & Smith, 1991), and ASFA, critics say, "made it less likely that parents in need of substance abuse treatment will be able to receive treatment before their children are placed in permanent homes" (Moye & Rinker, 2002, p. 378). Perhaps even more problematic, however, is the fact that recovery from addiction is not a straightforward process. The U.S. DHHS has noted that only about one third of those in substance abuse treatment achieve permanent abstinence in their first attempt at recovery, whereas another third have multiple periods of abstinence and relapse over a number of years before achieving sobriety. Another third appear to have chronic relapses and may never fully reach permanent abstinence (U.S. DHHS, 1999). Young and her colleagues (1998) have suggested that ASFA pits important "clocks" against each other—the developmental clock of the child and the recovery clock of the parent—and note that these clocks are unlikely to run in synchrony. "In sum, the obstacles to reunification facing parents who have substance abuse problems and whose children are in foster care can be overwhelming" (p. 18).

At the same time, however, at least one of the primary proponents of ASFA has argued forcefully that the legislation does not go far enough in directing states to act aggressively in cases where substance abuse interferes with a parent's ability to care for their children. Bartholet (1999) has suggested that a major

weakness of ASFA is the fact that substance abuse and the child neglect that often accompanies it was not included on the list of egregious circumstances under which states are allowed to pursue an expedited TPR (except in cases of positive neonatal substance use tests). She says, "Immediate TPR . . . seems appropriate when parents are so caught up in their drug or alcohol addiction that they are unable to function as parents and are unable or unwilling to engage in treatment" (p. 198).

At present, whether ASFA has accomplished the goals of its supporters or had the negative impact feared by its critics is unknown. Only a few studies have been completed on the topic and their findings are somewhat limited. A Chapin Hall study found evidence that ASFA provisions were associated with an increase in the time to reunification, a reduction in the time between admission into foster care and adoption, and an increase in the probability of adoption (Wulczyn et al., 2005). A 2002 report by the U.S. GAO also found an increase in adoptions post-ASFA. However, the GAO (2002) report also concluded that "changes in other foster care outcomes cannot be identified due to the lack of comparable pre and post-ASFA data" (p. 3). Finally, we could find no studies that examined the effect of ASFA specifically on families with substance abuse issues, regardless of treatment status.

The current study addresses this critical gap by examining child welfare outcomes for children of more than 1,900 substance-abusing women with some treatment involvement who had at least one child placed in out-of-home care during either the 3 years prior to (pre-ASFA) or after the implementation of ASFA in Oregon. Specifically, we address the following questions:

1. What are the differences pre- and post-ASFA in children's:
 - a. length of stay in foster care
 - b. time to permanent placement
 - c. likelihood of adoption and reunification
2. What demographic, treatment, or other case characteristics are associated with these child welfare outcomes for children of substance-abusing women with some treatment involvement, pre- and post-ASFA?

METHOD

Sample

Two cohorts (pre- and post-ASFA) of women were identified using state child welfare and alcohol and drug treatment system records in the state of Oregon. The sample consisted of all of the women who:¹ (a) had at least one child placed in substitute

care for the first time during either the pre-ASFA (October 1, 1996 through June 30, 1998) or post-ASFA (December 1, 1999 through October 30, 2001) sampling period;² (b) were the primary caregiver for the children included in the child welfare case; (c) were part of a family that was identified by the child welfare system as having an alcohol and/or drug problem as a presenting issue; and (d) had at least one contact (data record) within the state's alcohol and drug treatment system. Using the state's child welfare data system (and in the absence of court or other case records), it was possible to identify substance abuse as a presenting issue only at the *family level*; in other words, the data do not identify the specific family member for whom substance abuse is a problem. It is for that reason that we included the treatment involvement variable as it allows us to identify cases in which the mother clearly had a substance abuse issue based on her having participated in some level of publicly funded treatment.

As a result, this sample includes only women who accessed at least one treatment service during their child welfare case. The results are therefore not generalizable to women who may have had a drug or alcohol problem but who did not receive treatment. Furthermore, because the child welfare system only identified substance abuse at the family level, it would be inappropriate to use these data to examine the question of treatment access or compliance; that is, we cannot accurately answer the question of how many parents who needed treatment received it or whether results were different for these parents.

Finally, families were selected if any one child entered substitute care for the first time during the period; thus, some families had other children placed in substitute care prior to our sampling frame. The analyses reported below focus on the child welfare outcomes for the targeted child who entered substitute care for the first time during the study time frame. If multiple siblings entered care on the same date, one child was randomly selected as the target child.

All cases meeting these criteria during the study time frame were included in the analysis: 921 in the pre-ASFA period and 990 in the post-ASFA period. We then obtained all subsequent child welfare and substance abuse treatment data records during the study time frame for these families. The follow-up period for each family, therefore, varies depending on when the family entered the child welfare system during our sampling frame and ranges from 16 to 36 months. Child welfare outcomes are calculated for the first case that opened during our time frame (the vast majority of cases, 88%, had only a single case opening during this period).

Measures

Child Welfare Data

Demographic and case characteristics. Data from Oregon's child welfare administrative database were received electronically and included the following information about each case: parent race/ethnicity, parent and target child ages on the day the target child entered substitute care, number of children in substitute care during the time frame, previous substitute care placement for the family (yes vs. no), type of maltreatment (physical, mental, or sexual abuse, threat of harm, neglect), and family stressors. During the investigation phase, Protective Service caseworkers can select up to 5 family stressors from a checklist that includes the following: drug or alcohol issues, spousal fighting, mental health issues, single parenting, difficult pregnancy or new baby stress, law enforcement involvement, inadequate housing, head of household unemployed, recent relocation, heavy child care responsibility, social isolation, parental history of child abuse, parental developmental disability, and other. A cumulative family risk variable was calculated by summing the total number of unique family stressors ever recorded for each family, with a maximum number of 14 stressors (unduplicated for simultaneous reports on multiple children, but including all reports made during the study time frame).

Child welfare outcomes. For the purposes of this article, three primary child welfare outcome variables were calculated: (a) length of stay in substitute care, (b) time to permanent placement, and (c) type of permanent placement.

Length of stay was calculated as the total unduplicated number of days the child spent in substitute care during the first case opening. If the final case disposition date for the target child was later than the end of the study time frame, the disposition date was replaced with the date that the follow-up period ended (i.e., October 1, 1999, for the pre-ASFA sample and December 1, 2002, for the post-ASFA sample). Thus, the length of stay variable is truncated for those remaining in the child welfare system past the end of the study time frame.

Time to permanent placement was calculated as the number of days that passed between the start of the target child's first substitute care placement and the date of the final case disposition (note that this did not necessarily coincide with the close of the case).

Type of permanent placement was defined as the permanent placement type recorded at the time of the final case disposition by the caseworker (returned

home, adoption, and other;³ if no final disposition was reached, the case was coded as “still open”).

Substance Abuse Treatment Data

Data for alcohol and drug treatment were collected using the Oregon Client Process Management System (CPMS), a statewide system that monitors alcohol and/or drug treatment services. Alcohol and drug intake workers are required to fill out CPMS forms at the beginning and end of each alcohol and drug treatment episode. Treatment records that indicated assessment only or detoxification only were omitted; all other treatment episodes were considered eligible for analysis.

Previous alcohol and drug treatment. CPMS treatment records were used to determine whether women had accessed alcohol or drug treatment in the 3 years before the start of the child welfare case (yes or no).

Demographic and alcohol and drug treatment characteristics. Demographic characteristics (education, marital status, and employment status) and alcohol and drug treatment characteristics (type of treatment, drug of choice, and frequency of use) were reported in association with each treatment episode and thus could differ over time for a specific individual. We selected the alcohol and drug treatment episode that started most immediately after the beginning of the child's placement in substitute care and used the demographic and treatment characteristics that corresponded to that treatment episode. Alcohol and drug intake workers also recorded the treatment modality for each treatment episode. Treatment modality was collapsed into two categories: outpatient (including education and pharmacotherapy) and residential. If the woman was in concurrent treatment modalities, the more restrictive environment was chosen. For example, a woman who received both outpatient and residential services concurrently was coded as residential.

Characteristics of substance use. CPMS includes information about the substance type. At intake, women were asked to report their primary drug of choice: (a) opiates (heroin, other opiates and synthetics, non-prescription methadone), (b) alcohol, (c) amphetamine or methamphetamine, (d) cocaine (including crack cocaine), or (e) marijuana or hashish. They were also asked to report how often they used their drug of choice. Responses were collapsed into three categories: (a) once per week or less, (b) two times per week to daily, and (c) two or more times per day.

Sample Characteristics

We first examined the differences in demographic, child welfare, and substance use characteristics in the

pre- versus post-ASFA samples. As can be seen in Table 1, most of the demographic characteristics for the women in the pre- and post-ASFA samples were very similar. Almost 72% of the women in both samples were White, and the remainder were Native American (5.8%), Black (4.4%), Hispanic (2.9%), and other or unknown (14.8%); this reflects the general foster care population for Oregon (Oregon Department of Human Services, 2002). At the start of the target child's substitute care placement, parents were, on average, 29 years old, and target children averaged 4 years of age. About half of the women reported that they did not complete high school. Most of the women were unmarried (85.9%) and unemployed (81.4%).

In terms of child welfare case characteristics, there was a statistically significant difference in the number of stress factors; post-ASFA families averaged 7.0 unique stressors compared to pre-ASFA families, who averaged about 6.5. In both samples, families had an average of 2 children in substitute care during the study time frame, and about 1 in 5 families had children previously placed in substitute care. Three fourths of both the pre- and post-ASFA families had threat of harm allegations, and almost half had neglect allegations. A significantly larger proportion of families in the pre-ASFA sample had physical and sexual abuse allegations (27.8% and 11.4%, respectively) as compared to post-ASFA families (23.6% and 5.9%, respectively).

In terms of treatment variables, about 4 out of 5 women who entered substance abuse treatment after the start of their target child's substitute care episode participated in outpatient treatment. Amphetamine or methamphetamine was the drug most likely to be listed as the primary drug of choice in both groups, although a significantly larger proportion of post-ASFA women reported this as their drug of choice than pre-ASFA women (50.0% vs. 45.0%, respectively). Alcohol was the second most frequently reported drug of choice, reported by approximately one fourth of the women. Almost half of the women reported using their drug of choice more than once per day. Finally, a significantly larger proportion of women in the post-ASFA sample had accessed public substance abuse treatment in the 3 years prior to the start of their target child's first substitute care episode (27.3%), as compared to women in the pre-ASFA sample (18.5%). This may be at least in part because of improvements in the state's data system during 1995-1996.

Descriptive Statistics for Child Welfare Outcomes

Tables 2 and 3 present descriptive information about child welfare outcomes pre- and post-ASFA.

Table 1: Sample Characteristics and Control Variables

Characteristic	Pre-ASFA		Post-ASFA	
	%	n	%	n
Demographics				
Race/ethnicity				
White	71.9	662	71.8	711
African American	5.2	48	3.7	37
Hispanic	2.5	23	3.3	33
Native American	5.8	53	6.0	59
Asian	0.1	1	0.2	2
Other/unknown	14.5	134	14.9	148
Average parent age	29.2	921	28.7	990
Average child age	4.5	921	4.1	990
Education				
Less than high school diploma/GED	51.9	478*	47.1	466
Marital status				
Unmarried or separated	86.4	786	85.5	835
Employment status				
Unemployed	81.9	754	80.9	801
Family characteristics				
Average number of stress factors	6.5	921	7.0	990*
Children in substitute care during time frame				
Average number of children in substitute care	1.7	921	1.7	990
Child previously placed in substitute care (% yes)	20.0	184	21.3	211
Type of alleged child abuse				
Physical (% yes)	27.8	245*	23.6	705
Mental (% yes)	9.9	87	8.1	848
Sexual (% yes)	11.4	100*	5.9	54
Threat of harm (% yes)	75.8	668	74.5	688
Neglect (% yes)	45.1	397	47.1	435
Substance abuse and treatment characteristics				
Previous alcohol or drug treatment (% yes)	18.5	170	27.3	270*
Type of substance abuse treatment				
Outpatient	80.2	739	77.2	764
Residential	19.8	182	22.8	226
Primary drug of choice				
Opiates	6.4	59*	4.4	43
Amphetamine/methamphetamine	45.0	413	50.0	493*
Cocaine	7.5	69	5.4	53
Alcohol	27.5	252	23.7	234
Marijuana	13.6	125	16.5	163
Frequency of use				
1 or fewer times per week	20.7	184	23.6	228
2 times per week to daily	32.9	292	30.4	293
More than once a day	46.4	412	46.0	444

NOTE: ASFA = Adoption and Safe Families Act. Total sample $N = 1,911$.

*Indicates a significantly higher proportion of participants, $p < .05$.

Table 2 presents length of stay in foster care and time to permanent placement both pre- and post-ASFA. The length of stay in foster care was shorter for children post-ASFA, by slightly more than 1 month (37 days). Interestingly, however, time to permanent placement ($M = 327$ days) was approximately the same in both the pre- and post-ASFA time frames. Note, however, that for this descriptive analysis, data were omitted for cases that had not reached permanency (see below for further discussion). Table 3

shows the known permanency outcomes for children pre- and post-ASFA. The proportions of children who were reunified or who had "other" types of permanency outcomes were similar pre- and post-ASFA. However, there was a larger proportion of children who were being moved toward adoption (10.5%) post-ASFA, compared to pre-ASFA (5.9%), and fewer children remaining in foster care at the end of the study time frame during the post-ASFA period (34.3%), compared to before ASFA (39.8%).

Table 2: Length of Stay and Time to Permanent Placement Pre- and Post-ASFA

	n	M (Days)	SD	Range (Days)
Length of stay				
Pre-ASFA	921	458.3	300.6	0-1,095
Post-ASFA	990	421.3	287.4	0-1,090
Time to permanency				
Pre-ASFA	554	324.3	251.3	0-1,017
Post-ASFA	650	328.8	258.3	0-1,066

NOTE: ASFA = Adoption and Safe Families Act.

Table 3: Permanent Placement Outcomes Pre- and Post-ASFA

	<i>Freed for Adoption</i>		<i>Reunified</i>		<i>Other Case Disposition</i>		<i>Still in Care</i>	
	%	n	%	n	%	n	%	n
Pre-ASFA ^a	5.9	54	47.9	441	6.4	59	39.8	367
Post-ASFA ^b	10.5	104	50.6	501	4.5	45	34.3	340

Note: ASFA = Adoption and Safe Families Act.

a. $n = 921$.

b. $n = 990$.

Although these analyses show basic differences pre- and post-ASFA for both length of stay and types of permanent placements, they do not control for case, family, or other risk characteristics that may account for these differences. Furthermore, these analyses rely on truncated data that may underestimate time to permanency by omitting those who had not reached permanency but the end of the study period. Therefore, we conducted a series of analyses that allowed us to control for these variables and to examine the extent to which these other demographic and risk-related variables predict child welfare outcomes.

Length of Stay in Substitute Care

First, we tested the effects of pre- versus post-ASFA status on length of stay in foster care. Using hierarchical multiple regression, we first entered demographic characteristics, number of family risk factors, child welfare case characteristics, substance abuse treatment history and type, and frequency and type of drug use (Table 1 contains all of the covariates included in the regression models). In the second step, we added a dummy-coded variable representing pre- versus post-ASFA status. As can be seen in Table 4, the ASFA variable uniquely accounted for a small but statistically significant change in the variance accounted for (R^2 change = .004, $p < .01$), and the regression coefficient was significant ($B = -0.06$), indicating that length of stay

was significantly shorter for the post-ASFA group, even controlling for a host of family risk characteristics and other variables.

In addition, regression results indicate that several other variables were significant predictors of length of stay. Specifically, single mothers and women with lower levels of education, more risk factors, or more children currently in substitute care and those who were either opiate or cocaine users tended to have children who spent more time in foster care. The full model accounted for 9% of the variance in length of stay.

Survival Analysis Predicting Time to Permanency

Next, although there were no significant overall differences in the time to permanent placement among those cases that had reached permanency, we conducted a Cox proportional hazards regression analysis to predict the length of time before the occurrence of this placement for all cases. The Cox regression is more appropriate than the overall pre- versus post-comparison because it allows us to include cases with censored data, that is, cases that had not yet reached permanency by the end of the study. Omitting these cases (e.g., analyzing only cases that had reached permanency) substantially underestimates the time to permanency by excluding cases that take the longest. Cox regression models allow estimation of models in which the dependent variable is a point-in-time probability of an (as yet) unobserved event occurring. We

Table 4: Pre- and Post-ASFA Differences in the Length of Stay in Foster Care

Predictors	B	R ² Change	df
Step 1: Control variables		.09***	24, 1700
Marital status (unmarried/married) ^a	-0.05*		
Employment (unemployed/employed)	-0.02		
Education (no high school/high school grad or higher) ^a	-0.12***		
Race/ethnicity			
White vs. African American	-0.04		
White vs. Hispanic	0.06		
White vs. Native American	-0.03		
Parent age (teen parent yes/no)	-0.04		
Number of family stressors	0.13***		
Target child age	-0.02		
Previous placement history (no/yes) ^a	0.05*		
Number of children currently in foster care	0.15***		
Threat of harm (no/yes)	-0.004		
Physical abuse (no/yes)	0.03		
Mental abuse (no/yes)	-0.02		
Sexual abuse (no/yes)	0.01		
Neglect (no/yes)	-0.01		
Substance abuse treatment history (no/yes)	-0.01		
Treatment type (outpatient-residential)	-0.05		
Frequency of use	0.04		
Primary drug used			
Opiate (no/yes) ^a	0.20*		
Alcohol (no/yes)	0.26		
Methamphetamine (no/yes)	0.33		
Cocaine (no/yes) ^a	0.22*		
Marijuana (no/yes)	0.21		
Step 2		0.004**	1, 1699
Pre-Post ASFA	-0.06**		

NOTE: ASFA = Adoption and Safe Families Act. Reported are standardized coefficients from the final step of the model.

a. Indicates the group associated with longer length of stay in foster care.

* $p < .05$. ** $p < .01$. *** $p < .001$.

considered the occurrence of a permanent placement decision as the event of interest and all of the cases that had not yet come to permanency in our study time frame as censored. We then calculated the time to permanency for all cases by replacing missing permanency dates (i.e., the case was still pending at the end of the study time frame) with the date that the follow-up period ended (exactly as we had done for length of stay); however, in the Cox models, these cases were considered censored. The Cox regression was set up in two steps, as described for the previous regression analysis.

As shown in Table 5, the addition of the pre-post ASFA variable led to a significant chi-square change of 7.43, $p < .01$. The regression coefficient was significant ($b = -0.17$), suggesting that the post-ASFA time frame was associated with faster times to permanency than the pre-ASFA time frame. With all covariates held constant, post-ASFA cases were 1.19 times more likely to reach permanency than pre-ASFA cases. Figure 1 illustrates the cumulative occurrence of permanency (i.e.,

cumulative hazard rate) as a function of the number of days from the beginning of the target child's entry into foster care to the date that the child was placed in a placement designated by the child welfare agency as permanent. The cumulative hazard rate takes into consideration all of the covariates included in the model and the characteristics of the cases that had not yet reached permanency as of the end of the study time frame (i.e., censored cases).

There were also several covariates that significantly predicted time to permanency. Specifically, women who were identified as Hispanic, who had at least a high school diploma or GED, fewer family stressors, or fewer children in substitute care, who were not opiate users, or who used substances less often than daily had cases that reached permanency more quickly.

Probability of Adoption and Reunification

Finally, we conducted two logistic regressions predicting the likelihood of adoption and reunification.

Table 5: Pre- and Post-ASFA Differences in the Time to Permanency

Predictors	B	Odds Ratio	χ^2 Change	df
Step 1: Control variables			1310.01 ***	24
Marital status (unmarried/married)	0.16	10.18		
Employment (not employed/employed)	0.07	10.08		
Education (no high school/high school grad or higher) ^a	0.29***	10.33		
Race/ethnicity				
White vs. African American	0.23	10.26		
White vs. Hispanic ^a	-0.26 [†]	0.77		
White vs. Native American	0.09	10.09		
Parent age (teen parent yes/no)	0.20	10.23		
Number of family stressors	-0.09***	0.92		
Target child age	-0.01	0.99		
Previous placement history (no/yes)	-0.10	0.90		
Number of children currently in foster care	-0.15***	0.87		
Threat of harm (no/yes)	-0.09	0.92		
Physical abuse (no/yes)	-0.11	0.90		
Mental abuse (no/yes)	0.12	10.12		
Sexual abuse (no/yes)	-0.16	0.85		
Neglect (no/yes)	-0.05	0.95		
Substance abuse treatment history (no/yes)	0.08	10.08		
Treatment type (outpatient/residential)	0.06	10.07		
Frequency of use				
2 to 7 times per week vs0. less often	0.05	10.05		
Daily vs. less often ^a	-0.16*	0.85		
Primary drug used				
Opiate (no/yes) ^a	-0.23**	0.79		
Alcohol (no/yes)	0.12	10.13		
Methamphetamine (no/yes)	0.05	10.05		
Cocaine (no/yes)	-0.04	0.96		
Step 2			70.43**	1
Pre-Post ASFA ^a	-0.17**	0.84		

NOTE: ASFA = Adoption and Safe Families Act. Reported are coefficients from the final step of the model.

a. Indicates the group associated with faster time to permanency.

[†] $p < .06$. * $p < .05$. ** $p < .01$. *** $p < .001$.

The first model tested the probability that the target child was either (a) freed for adoption or (b) still in substitute care at the end of our time frame (a minimum of 15 months following placement into foster care). As shown in Table 6, results indicated that the likelihood of being freed for adoption, as opposed to remaining in substitute care, increased by a factor of 2.2 in the post-ASFA time frame compared to the pre-ASFA time frame. Furthermore, infants were significantly more likely to be adopted than older youth: 36% of the infants in the full sample were placed in adoptive homes compared to 24% of their older cohorts. The type of abuse allegation mattered, as well. About 11% of the children from families with neglect allegations were freed for adoption, as compared to 24% from families that had other types of abuse allegations (e.g., physical, sexual, threat of harm) and not neglect. Overall, the model accounted for 30% of the variation in permanency decisions (freed for adoption vs. remained in foster care).⁴

The second model shown in Table 6 contrasts the probability of reunification versus the likelihood of any other permanency decision. As can be seen, there is no significant difference in the likelihood of reunification between the two periods. Results were similar when the likelihood of reunification was contrasted with all other arrangements at the end of the time frame (including remaining in care). This suggests that, at least in this sample, there was no significant reduction in the likelihood that children would be reunified following the implementation of ASFA. Several family and case characteristics were related to the likelihood of reunification, however. Specifically, mothers who were married, more educated, and employed were more likely to be reunified with their child, older children were somewhat more likely to be reunified, and cases in which there were allegations of threat of harm or neglect were more likely to be reunified. In addition, families in which there was a previous history of child welfare system involvement were less likely to be reunified.

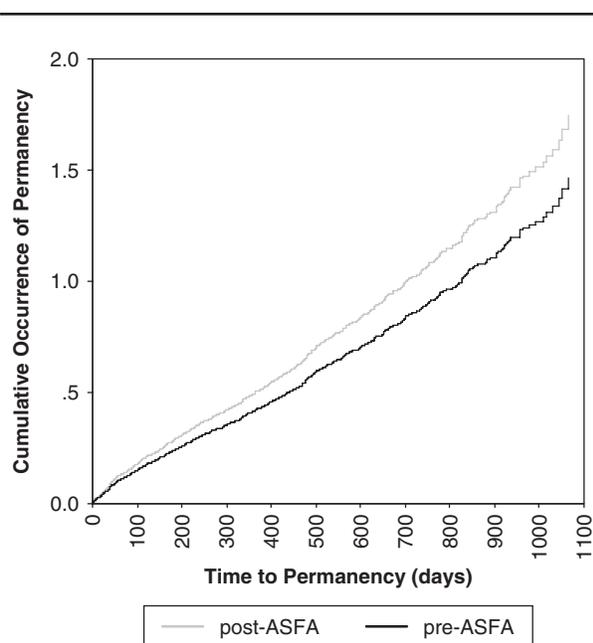


Figure 1: Cumulative Hazard Rate for Time to Permanency: Pre- Versus Post-ASFA Groups

NOTE: ASFA = Adoption and Safe Families Act. The y-axis is the cumulative hazard rate (not a probability) for the occurrence of permanency; the cumulative hazard rate is the compounding potential per day that a target child will reach permanency, given that the child had not reached permanency up to that point. The cumulative hazard rate takes into consideration all of the control variables entered in the model and the characteristics of the cases that had not yet reached permanency as of the end of the study time frame (i.e., censored cases). The rate of permanency is greater in the post-ASFA sample as compared to the pre-ASFA sample, and this divide becomes greater with each additional day that the case is open.

DISCUSSION

Supporters of ASFA aimed to reduce foster care drift and help ensure children would be placed in a permanent living situation in a timely way. To that end, children in our study spent less time in foster care, were placed in permanent settings more quickly, and were more likely to be adopted than remain in long-term foster care post-ASFA. The proportion of children who were reunified with their parent or parents stayed the same. These outcomes were apparent even controlling for a host of case and family characteristics.

These outcomes suggest that ASFA was able to accelerate (at least to a limited degree) the permanency process for children who might have otherwise remained in foster care, while at the same time, it did not unduly hinder the efforts of substance-abusing parents to have their children returned to them. However, it is notable that even after the implementation of ASFA, children spent an average of 421 days in

care (and note that because of the study time frame, this is likely an *underestimate*) and took just short of 11 months to be placed in a permanent living situation. Advocates of ASFA are likely to feel that these post-ASFA statistics are problematic and that children continue to spend too long in foster care. Bartholet (1999) has argued that states should be able to fast-track children of parents with addictions even when the other conditions outlined in the legislation are not present. On the other hand, critics were concerned that because of ASFA, parents who may have been able to be reunified with their children within a more lenient time frame would instead lose custody of their children. These data, however, show no evidence of the draconian decreases in reunifications that some feared, even among this population of mothers with substance abuse issues.

Overall, it seems fair to say that ASFA's impact, at least on these families, was modest, albeit largely in the direction favored by proponents of the legislation. Several reasons for this may be offered. First, and perhaps most importantly, Oregon is widely known for its progressive child welfare system; for example, it had ASFA-like regulations in place prior to passage of the federal legislation and had aggressively employed permanent planning for at least 10 years prior to the implementation of ASFA. Oregon was also (at least during the study time frame) considered "service rich" relative to some other states, especially in terms of publicly funded substance abuse treatment services. Furthermore, Oregon is one of a handful of states which has opted not to employ the fast-track provision of ASFA. Thus, families who in other states might face an immediate TPR are instead provided with services. This has two implications: First, time to permanency and length of stay might be longer post-ASFA in Oregon, compared to states that employ the fast-track provisions. Second, adoption rates might be increased to a greater extent in other states as more children are freed for adoption very early in the process.

Another explanation for the modest effects of ASFA in Oregon may be that considerable work was being done pre-ASFA to enhance collaboration among substance abuse treatment, child welfare, and the court systems—although improvements in the level of partnership may have been accelerated as a (largely unintended) consequence of the legislation (see Green & Rockhill, 2004; Green, Rockhill, & Burrus, 2002). For example, a large majority of treatment agencies reported that they had been working to improve the services offered to families involved with the child welfare system prior to the implementation of ASFA. Although a few reported making changes specifically in response to ASFA, most suggested that ASFA had

primarily acted to increase the sense of urgency to implement changes that were already in motion (Green & Rockhill, 2005). In addition, several local initiatives designed to expedite treatment services for women involved with child welfare, including court-located assessment teams and more intensive case management, were implemented prior to ASFA. Data supporting these kinds of gradual systems improvements were reported in Green, Rockhill, and Furrer (in press), in which we found modest shifts in how long it took women to access substance abuse treatment and their length of stay in treatment in a similar statewide sample pre- and post-ASFA. These kinds of system changes and service innovations have been called for to best meet the needs of substance-abusing families who are involved with the child welfare system (Green, Rockhill, & Furrer, in press; Howell, Kelly, Palmer, & Magnum, 2004; U.S. DHHS, 1999; Young & Gardner, 2002).

Finally, it is worth mentioning that efforts to improve the delivery and quality of services to these parents may have, paradoxically, mitigated the impact of ASFA on the timeliness of permanency outcomes by virtue of the judge's ability to grant exceptions to the TPR provisions in the legislation. Improvements in service delivery and quality may increase the number of parents who are making significant progress in treatment and who are therefore allowed to pursue reunification beyond the 12-month deadline. In the aggregate, this may offset the impact of the ASFA deadlines on those parents who have failed to make sufficient progress.

To a certain extent then, it appears that the modest size of these findings may be attributed at least in part to features of the child welfare system that are somewhat unique to Oregon. In states where child welfare systems were less aggressively moving toward timely permanency resolution prior to 1996 and that chose to implement provisions such as fast tracking, the impact of ASFA may be much greater, both in terms of moving children toward permanency more quickly and perhaps leading to greater increases in adoption and lower rates of reunification for parents with substance abuse issues.

That being said, this study also suggests one area in which efforts may enhance the interests of ASFA proponents and critics alike. Additional improvements in the ability of parents to access and engage in treatment in a timely way would be likely to positively influence reunification outcomes and decrease children's length of stay in foster care. Results from this study reported elsewhere include the finding that even after the implementation of ASFA, it took mothers almost 3 months from the day their child entered substitute

care to enter treatment, and only 56% were able to complete at least one treatment episode within their child welfare case (Green, Rockhill, & Burrus, in press). Other research has identified considerable barriers faced by parents attempting to access and remain in substance abuse treatment (Rockhill et al., in press; U.S. DHHS, 1999) despite the attempts at improving service delivery and quality described above. Poverty, for example, proved a major problem for the majority of parents in our qualitative study (Rockhill et al., in press). Other issues, such as lack of housing, also hindered parents' efforts to obtain treatment. Clearly, providing appropriate and accessible substance abuse treatment represents an ongoing challenge for both the child welfare and treatment system.

Study Limitations

As discussed above, the primary limitation of this study is a concern regarding our ability to generalize these findings to the experiences of other states or nationally. Oregon is not representative of the national foster care population in terms of minority populations, and child welfare clients in Oregon may present a somewhat different profile of substance abuse problems (specifically, predominantly methamphetamine use). More importantly, as described above, the state had legislation emphasizing timely permanency in place prior to ASFA and was engaged in a number of efforts to improve service coordination between treatment and child welfare systems. This raises the question of whether ASFA actually caused the changes reported in this study; given the nature of the design, it is possible that these changes could have occurred even without implementation of the legislation. However, qualitative data reported elsewhere (Green, Rockhill, & Burrus, in press; Green, Rockhill, & Furrer, in press; Rockhill et al., in press) do suggest that ASFA played at least some role in accelerating changes in both child welfare and treatment systems, although the extent of this influence cannot be definitely assessed.

In addition, our sample excluded women who needed treatment but for some reason failed to access the service. These women may be even more likely to have lower rates of reunification and perhaps faster permanency decisions, given their failure to comply with treatment orders. Moreover, our sample includes only children entering foster care for the first time and a single case opening for each child. Children facing multiple and subsequent entries into the child welfare system may have different time frames and permanency outcomes. A further limitation is the fact that our follow-up period is somewhat short and does not allow us to examine stability of permanent

Table 6: Pre- Versus Post-ASFA Differences in the Likelihood of Adoption and Reunification

Predictor	Adoption vs. Still in Care				Reunification vs. Other Permanency			
	B	Odds Ratio	χ^2 Change	df	b	Odds Ratio	χ^2 Change	df
Block 1: Control variables			144.15***	24			133.86	24
Marital status (unmarried/married)	0.06	1.06			0.61	1.8*		
Employment (unemployed/employed)	-0.35	0.71			0.50	1.6*		
Education (no high school/high school or more)	-0.02	0.98			0.59	1.8**		
Race/ethnicity								
White vs. African American	0.69	2.00			-0.14	0.87		
White vs. Hispanic	-0.77	0.46			-0.12	0.89		
White vs. Native American	0.44	1.56			0.02	1.0		
Parent age (teen parent/not)	0.51	1.67			0.14	1.2		
Family stressors	0.01	1.01			-0.07	0.93		
Child age (infant, toddler, elementary, high school)	-1.13**	0.32			0.24	1.3*		
Previous placement history (no/yes)	0.22	1.24			-0.63	0.53**		
Number of children currently in foster care	-0.19	0.83			0.04	1.0		
Threat of harm (no/yes)	-0.44	0.64			0.53	1.7**		
Physical abuse (no/yes)	0.36	1.44			-0.32	0.72		
Mental abuse (no/yes)	0.16	1.17			0.13	1.1		
Sexual abuse (no/yes)	-0.32	0.73			-0.59	0.55		
Neglect (no/yes)	-0.53*	0.59			0.51	1.7**		
Substance abuse treatment history (no/yes)	0.34	1.41			-0.17	0.84		
Treatment type (outpatient/residential)	-0.07	0.93			0.34	1.4		
Frequency of use	0.07	1.07			-0.10	0.09		
Primary drug used								
Opiates (no/yes)	0.77	2.15			-0.14	0.87		
Alcohol (no/yes)	1.04	2.84			0.34	1.4		
Methamphetamine (no/yes)	0.97	2.63			0.56	1.7		
Cocaine (no/yes)	1.51	4.51			-0.12	0.88		
Marijuana (no/yes)	0.85	2.34			0.48	1.6		
Block 2			12.77***	1			0.828	1
Pre-Post ASFA	0.80***	2.22			-0.15	0.86		

NOTE: ASFA = Adoption and Safe Families Act. Unstandardized coefficients are reported from final block of the analysis. Positive coefficients = increased likelihood of adoption (vs. still being in care).

* $p < .05$. ** $p < .01$. *** $p < .001$.

placements, time to actual adoption (as opposed to placement of a child with an adoptive resource), or recidivism into the child welfare system. Clearly, these are areas in need of further study.

Conclusion

Our results support the statement by Wulczyn and his colleagues (2005), who note, in regard to ASFA's impact on adoption trends, "It is most plausible that the passage of ASFA has enhanced the effect of state policies and practices" (p. 17). In fact, in this study, the impact of ASFA was modest even in regards to a group—mothers with substance abuse issues—that was expected to be particularly vulnerable to the new timelines. Oregon's practice of permanent planning and other features of the child welfare system may have mitigated ASFA's impact to a certain degree—and our study suggests that it will be important to attend to the broader policy context when interpreting outcomes

from other projects. However, these findings may also suggest the limits of systems reform in the cause of ASFA's primary objectives. It is likely that significant reductions in length of stay in foster care or time to permanency await more fundamental changes to both the broader service system and the communities within which families live.

NOTES

1. We elected to include only females in the sample because of the small (< 10%) number of males listed as the primary parent on the child welfare case record.

2. These dates reflect the implementation of ASFA in the state of Oregon and allowed the longest possible follow-up time frame for which data were available. Detailed child welfare administrative data were not reliably collected prior to 1996.

3. Other placement types included legal custody or guardianship, emancipation, incarceration, Oregon Youth

Authority custody, state hospital, runaway, married, relative placement, relative family foster care, and placed in other institution.

4. Nagelkerke R^2 reported.

REFERENCES

- Bartholet, E. (1999). *Nobody's children: Abuse and neglect, foster drift, and the adoption alternative*. Boston: Beacon.
- Beckman, L. J. (1994). Treatment needs of women with alcohol problems. *Alcohol Health & Research World*, 18(3), 206-211.
- Child Welfare League of America. (1997). *Alcohol and other drug survey of state child welfare agencies*. Washington, DC: Author.
- Child Welfare Partnership. (1998). *A study of families with children entering foster care in Oregon between mid-1992 and 1995, cohort III*. Portland, OR: Portland State University.
- Goldstein, J., Freud, A., & Solnit, A. (1973). *Beyond the best interests of the child*. New York: Free Press.
- Green, B. L., & Rockhill, A. (2004, April). *The impact of the Adoption and Safe Families Act on families with substance abuse issues: Results from a mixed-methods study*. Presented at the Annual Conference of the Child Welfare League of America, Washington, DC.
- Green, B. L., & Rockhill, A. (2005, April). *Hurry, hurry! Meeting the needs of substance-abusing parents involved with the child welfare system under the Adoption and Safe Families Act*. Presented at the 15th Annual Conference on Child Abuse and Neglect, Boston.
- Green, B. L., Rockhill, A., & Burrus, S. (2002, November). *Using a systems approach to understand & impact conflict and coordination between child welfare, substance abuse treatment, and judicial systems*. Washington, DC: American Evaluation Association.
- Green, B. L., Rockhill, A. M., & Burrus, S. (in press). Why all the fuss about collaboration? Clarifying the role of interagency collaboration for substance-abusing families involved with child welfare. *Child Welfare*.
- Green, B. L., Rockhill, A. M., & Furrer, C. (in press-a). Does substance abuse treatment make a difference for child welfare case outcomes? A statewide longitudinal analysis.
- Green, B. L., Rockhill, A. M., & Furrer, C. (in press-b). Understanding patterns of substance abuse treatment use by women involved with the child welfare system: Influences of family characteristics and social policy. *American Journal of Alcohol and Drug Abuse*.
- Gregoire, K. A., & Shultz, D. J. (2001). Substance-abusing child welfare parents: Treatment and child placement outcomes. *Child Welfare*, 80(4), 433-452.
- Grella, C., & Joshi, V. (1999). Gender differences in drug treatment careers among clients in the National Drug Abuse Treatment Outcome study. *American Journal of Drug and Alcohol Abuse*, 25(3), 385-406.
- Howell, J. C., Kelly, M. R., Palmer, J., & Magnum, R. L. (2004). Integrating child welfare, juvenile justice, and other agencies in a continuum of services. *Child Welfare*, 83(2), 143-156.
- Lewis, M. A., Giovanni, J. M., & Leak, B. (1997). Two-year placement outcomes of children removed at birth from drug-using and non drug-using mothers in Los Angeles. *Social Work Research*, 21(2), 81-90.
- Lowry, M. R. (2004). Putting teeth into ASFA: The need for statutory minimum standards. *Children and Youth Services Review*, 26, 1021-1031.
- Moye, J., & Rinker, R. (2002). It's a hard knock life: Does the Adoption and Safe Families Act of 1997 adequately address problems in the child welfare system? *Harvard Journal on Legislation*, 39, 375-294.
- Oregon Department of Human Services. (2002). *Foster care trends report*. Salem, OR: Author.
- Reiger, D. A., Farmer, M. E., Rae, D. S., Myers, J. K., Kramer, M., Robins, L. N., et al. (1990). Comorbidity of mental disorders with alcohol and other drug use: Results from the Epidemiological Catchment Area (ECA). *Journal of the American Medical Association*, 264, 2511-2518.
- Rittner, B., & Dozier, C. D. (2000). Effects of court-ordered substance abuse treatment in child protective services cases. *Social Work*, 45(2), 131-140.
- Roberts, D. (2002). *Shattered bonds: The color of child welfare*. New York: Basic Civitas Books.
- Rockhill, A. M., Green, B. L., & Newton-Curtis, L. (in press). Parents' efforts to access substance abuse treatment while involved with child welfare. *Child Welfare*.
- Smith, B. D. (2003). How parental drug use and drug treatment compliance related to family unification. *Child Welfare*, 82(3), 335-365.
- U.S. Department of Health and Human Services. (1999). *Blending perspectives and building common ground: A report to Congress on substance abuse and child protection*. Washington, DC: Author.
- U.S. General Accounting Office. (2002). *Foster care: Recent legislation helps states focus on finding permanent homes for children, but long-standing barriers remain* (GAO-02-585). Washington, DC: Author.
- U.S. House of Representatives, Committee on Ways and Means. (1998). *The green book*. Washington, DC: Author.
- Walker, C., Zangrillo, P., & Smith, J. M. (1991). *Parental drug abuse and african american children in foster care*. Washington, DC: National Black Child Development Institute.
- Weisner, C., & Schmidt, L. (1992). Gender disparities in treatment for alcohol problems. *Journal of the American Medical Association*, 268(14), 1872-1876.
- Worcel, S., Green, B., Burrus, S., & Finigan, M. (2004). *A retrospective evaluation of family treatment drug courts: Year two update*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.
- Wulczyn, F., Hislop, K., & Chen, L. (2005). *Adoption dynamic: An update on the impact of the Adoption and Safe Families Act*. Chicago: Chapin Hall.
- Young, N. K., & Gardner, S. G. (2002). *Navigating the pathways: Lessons and promising practices in linking alcohol and drug services with child welfare* (SMA-02-3639). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Young, N. K., Gardner, S. L., & Dennis, K. (1998). *Responding to alcohol and other drug problems in child welfare: Weaving together practice and policy*. Washington, DC: CWLA Press.

Anna Rockhill, senior research associate at the Child Welfare Partnership at Portland State University, has been conducting research and evaluation on child welfare-related topics for more than 12 years. Her experience includes research on substance abuse and child welfare, family decision meetings, the intersection of child maltreatment and domestic violence, and innovative models of foster care. She is currently co-principal investigator of the Title VI-E Waiver Evaluation. She received her master's degree from the University of Michigan (UM) and is currently a doctoral candidate at UM.

Carrie Furrer, research associate at NPC Research, has been working on behalf of children and their families for more than 10 years. Her experience includes research on adolescent motivation and health behaviors; program evaluation related to early childhood prevention and intervention, youth development, family support, drug and alcohol abuse prevention, child welfare, and family drug courts; and child and family counseling. She earned a PhD in systems science-applied developmental psychology from Portland State University.

Beth Green, vice president and senior research associate at NPC Research, has been involved in evaluating programs for children and families for more than 15 years. Her experience includes designing and implementing quantitative and qualitative evaluations of programs providing an array of services supporting child and family well-being. Most recently, she has served as the principal investigator for the Center for Substance Abuse Treatment's national evaluation of family treatment drug courts and for an evaluation of Oregon's statewide home visiting program.