



ADOPTION AND SAFE FAMILIES ACT OF 1997 SIGNED INTO LAW

On November 13, 1997, the President signed the Adoption and Safe Families Act of 1997 (P.L. 105-89) into law. The law represents a compromise between the Adoption Promotion Act (H.R. 867) which passed the House in April 1997, and a Senate substitute that was a modified version of the Promotion of Adoption, Safety, and Support for Abused and Neglected Children (PASS) Act (S.1195), which passed the Senate on November 8. Following is a summary of the major provisions of the bill.

Title I. Reasonable Efforts and Child Safety Provisions

- (§ 101) *Reasonable Efforts*. Clarifies that reasonable efforts are not required in certain "aggravated circumstances" such as murder of a sibling, felony assault, abandonment, torture, chronic abuse, and sexual abuse. In these cases, a permanency hearing is required within 30 days.
- (§ 107) *Documentation of Efforts for Adoption*. For every child whose permanency plan is adoption or placement in another permanent home, states are required to document the steps taken to find an adoptive family or permanent home including child-specific recruitment efforts.
- (§ 103) *Termination of Parental Rights*. Requires states to file a petition for termination of parental rights (TPR) if a child has been in foster care for 15 of the most recent 22 months, unless the child is in the care of a relative, a state agency documents a compelling reason that a petition would not be in the best interests of the child, or the state has not provided services it deems necessary for safe reunification.

- (§ 106) *Criminal Record Checks*. States are required to provide procedures for criminal records checks for any prospective foster or adoptive parents, before they can be finally approved for placement of a child eligible for federal subsidies.
- (§ 104) *Notice of Reviews and Hearings*. Requires that the foster parents and any preadoptive parent or relative caring for a child must be given notice of, and an opportunity to be heard in, any review or hearing involving the child.

Title II. Incentive for Providing Permanent Families for Children

- (§ 201) *Adoption Incentive Payments*. The bill provides adoption incentive payments to states of \$4,000 per child or \$6,000 per child with special needs for each adoption that exceeds the previous year's level.
- *Technical Assistance to Promote Adoption*. HHS is authorized to provide technical assistance to states and localities to promote adoption of foster children. \$10

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million is authorized for each of fiscal years 1998-2000, with at least half of these funds reserved for providing technical assistance to the courts. However, HHS was not appropriated any money for FY98 as the appropriations bill was done prior to this bill.

- (§ 202) *Interjurisdictional Adoption*. Requires states to develop plans for the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children. Further, it disallows any IV-E funding if a state denies or delays the placement of a child for adoption when an approved family is available outside of the jurisdiction, or if a state fails to grant a hearing to an individual alleging such a violation.

Title III: Additional Improvements & Reforms

- (§ 301) *Child Welfare Demonstrations*. The bill removes the limit on the number of child welfare waiver demonstrations, but allows HHS to authorize no more than 10 projects each year.
- (§ 302) *Permanency Hearings*. Establishes a permanency planning hearing within 12 months of a child's placement, rather than within 18 months as in current law.
- (§ 303) *Kinship Care*. Requires the Secretary of HHS to prepare and submit a report, by June 1, 1999, on the extent of the placement of children in foster care with relatives.
- (§ 305) *Reauthorization of Family Preservation Program*. Continues the Program, now called the Promoting Safe and Stable Families Program, through FY 2001, with funding at \$275, \$295, and \$305 million for FYs 1999, 2000, and 2001 respectively. The use of the program funds are expanded to include time-limited reunification services and adoption promotion and support services.
- (§ 307) *Eligibility for Adoption Assistance in Cases of Dissolved Adoptions*. Children who become available for adoption because of the dissolution of their adoption or the death of their adoptive parents continue to be eligible for assistance under Title IV-E in a subsequent adoption if they were previously eligible.
- (§ 306) *Health Care Coverage for Adopted Children with Special Needs*. As a condition of receiving Title IV-E funds, a state must provide health insurance coverage for any child with special needs for whom there is an adoption assistance agreement and who the state has determined cannot be placed with adoptive parents without medical assistance because of the child's special needs for medical, mental health, or rehabilitative care. Such

coverage may be provided through the Medicaid option or through a state health insurance program, but if the latter, the medical benefits, including mental health, must be of the same kind and type provided under Medicaid. Should sufficient funds not be available in the state health insurance program, the child may be deemed a recipient of IV-E adoption assistance and be eligible for Medicaid.

- (§ 308) *Quality Standards for Out-Of-Home Care*. States are required to provide, no later than January 1, 1999, that the state will develop and implement standards to ensure that children in foster care placements in public or private agencies receive quality services that protect the health and safety of children.

Title V. Effective Dates

- *General Effective Date*.
The effective date is November 19, 1997. States are expected to comply with the provisions of the law as of that date, with the exceptions noted below.
Exceptions to the Effective Date: Determination of Required State Legislation. A limited period of delay is permitted when the Secretary of the Department of Health and Human Services determines that a state must enact legislation to comply with certain state plan requirements. A "delayed effective date" will apply only to those requirements that the Secretary has determined require state legislation. The "delayed effective date" is defined in Section 501(b) as the beginning of the calendar quarter following the close of the state's first regular legislative session.

SAVE THE DATE!



HHS APPROVES CHILD WELFARE WAIVERS FOR MICHIGAN AND NEW YORK

On December 19, HHS Secretary Donna E. Shalala announced approval of child welfare waiver demonstration projects for Michigan and New York.

Under Michigan's waiver, the Michigan Intensive Family Preservation Initiative will support a range of services intended to strengthen and assist families. Participating counties will receive a fixed amount of child welfare funds and have authority to use the funds in ways that best meet the specific needs of individual families. Counties can design their child protection and child welfare systems in ways that will better ensure the safety of children and improve the efficiency and effectiveness of child welfare services. Services may include child care, home visiting, family planning, home management, parent education, respite care, transportation, job training, educational activities, and other forms of assistance. Counties that achieve savings will be able to reinvest in additional services.

Similarly, New York's waiver will allow participating counties to receive a fixed amount of federal funds under Title IV-E of the Social Security Act, enable greater flexibility in using these funds, and allow reinvestment of savings.

A second component of Michigan's waiver, to be implemented initially in Wayne County (Detroit), will provide better services for adolescents in the child welfare system who have been or are in danger of being adjudicated delinquents. The Community Services for Delinquent Youth component requires each child to have a plan that identifies the needs of both the child and the family, sets clear goals for the child, and describes the services and treatments necessary to meet the established needs and goals.

A broad range of child welfare services will be available, including family preservation, substance abuse treatment, family foster care, residential treatment, reunification, and independent living services. With approval of these waivers, a total of 10 states have received child welfare waivers, as allowed in the new Adoption and Safe Families Act signed into law by President Clinton in November 1997.

(From *This Week In Washington*, American Public Welfare Association, January 9, 1998.)



Roland Oliver, Adoption Supervisor at the Utah Division of Child and Family Services, is the recipient of AAICAMA's 1997 award for *Distinctive Contributions to Special Needs Adoption*. The award was presented at AAICAMA's 11th Annual Conference in Charleston, South Carolina last September.

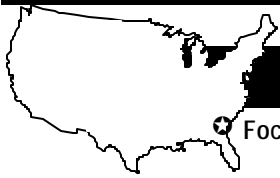
This award is presented annually to an individual who demonstrates excellence in the provision of services to special needs children and their adoptive families, leadership in the administration of one or more special needs adoption programs, or outstanding advocacy for special needs children needing adoptive placement or services.

Mr. Oliver has served in supporting adopting families since 1980. He previously served as Utah State Adoption Specialist from 1989 to 1995, serves on the Adoption Exchange Board, chairs the Utah Adoption Steering Committee, has organized several major super adoption events in Utah resulting in dozens of adoptions, wrote much of Utah's current adoption policy and procedures, provides technical assistance and support to many adoption workers and colleagues, and has adopted a special needs child.

In addition to his work for the state of Utah, Mr. Oliver has supported the work of AAICAMA. He served as Vice President from 1993-1994, served on many of AAICAMA's committees and has presented at several of the association's annual conferences.

AAICAMA applauds the continued effort of Roland Oliver and all adoption professionals who have made a difference in the lives of special needs adoptive children.





Focus on South Carolina

STATE INFORMATION EXCHANGE

FAMILY PRESERVATION: AN ADOPTION CHALLENGE

By Don Adams, South Carolina Department of Social Services

Child welfare services have experienced tremendous change during the past several years. There has been extensive well-placed attention on the protection of children with their biological parents and on seeking solutions for children who are in "foster care drift." However, no component of the system has experienced-nor is apt to experience-more change than adoption. Adoptive placement has become increasingly utilized as a permanent option for children who cannot return home. While adoption initially focused on young children, the realization emerged that all children needed permanency and must, therefore, be considered adoptable. As a result, an increasing number of children with special needs began to enter the adoption system. The benefits and costs of this approach are now becoming apparent.

Adoption has often been pursued for children with little or no consideration for potential problems which the adoptive family might encounter. Most agencies believed that problems (regardless of their origin) were solely within an adoptive family's purview and were no longer their concern. There was a common belief that the love and commitment of a new family would be the panacea for a child's existing or potential problems. Neither the long term effect of abuse and neglect, the impact of being in foster care, nor issues related to the adoption process itself were considered. These children often had behavioral problems which their birth and foster parents could not control and which resulted in intense difficulties and multiple placements in the foster care system. Placement disruptions occurred in spite of the fact that an agency provided intensive services to the family. Regardless of these problems, the belief prevailed that adoption would magically alleviate or modify the problems so a single family could function successfully and independently. Agency involvement after finalization was considered to interfere in a family's integration.

Experience has shown that adoption is not an end in itself, but rather a beginning. Many of the principles which previously governed the program have proven false. While most difficulties can and should be handled by families, some problems are so serious that a family must reach out for support. In such times of crisis, the agency must be seen as a resource to assist in preserving the adoptive family unit. Agency services must be viewed as preventive in nature, i.e., the avoidance of a child's possible reentry into the foster care system

and the preservation of a family unit. Adoption is not just a legal action nor a time limited social process, but rather poses peculiar issues at different developmental stages which biological families will not encounter. As more special needs children exit the foster care system into adoptive homes, the problems faced by families will multiply. An agency's commitment to preserve family units which they created will be tested.

During the recent past, several trends were noted in South Carolina adoption's centralized financial assistance unit. These patterns included an increased number of calls from families who had finalized an adoption and who requested assistance with a problem being experienced by their family. Families conveyed similar information: (1) A child's behavioral problems were becoming uncontrollable. (Physical safety, especially the mother's, was often a primary concern); (2) A child was having difficulty with the education system; (3) Problems began to occur at approximately 8 years of age and, often, became unmanageable by age 13 years; (4) Foster parent adopters were more apt to call than other families; and (5) Families were in a state of crisis and required immediate assistance. In response, the South Carolina Department of Social Services began development of an evolutionary program of family preservation services for adoptive families.

Receipt of several Adoption Opportunities grants from the U.S. Department of Health and Human Services enabled implementation of core components of adoption preservation services. The initial and ongoing programmatic guidelines were flexible to reflect the individual needs of each family. Initial steps focused on the coordinated development of adoption sensitive therapeutic intervention through the public mental health system. Often therapists were not cognizant of adoption issues which had to be addressed if intervention was to be effective. This endeavor resulted in closer coordination between the two programs and merged cross-training for therapists and adoption specialists. This initiative resulted in 6 adoption-mental-health therapist positions being allocated by the mental health system. Some therapists were co-located within the adoption office. Eventually, the focus of these positions became diluted and the function more decentralized. Annual cross training of these disciplines is currently conducted by Children Unlimited, a private child welfare agency.

The next step included the establishment of an adoption preservation pilot project in a ten county region of the state. As a result of minimal minority family participation in this project, however, a second pilot was established and was designed, developed and implemented by minority families within the community. The latter was accomplished through a contractual agreement with One Church/One Child. It was then determined that similar services are needed by all families, but that minority families are often more hesitant to turn to the public agency for assistance. The project proved that minority families primarily rely on the community and their church for supportive services and "connect" more readily with a same-race professional. Both pilot programs operated on the belief that adoption preservation services were different from other child welfare services. There were, however, basic premises which existed between these projects. These were: (1) All services must be adoption sensitive and adoption recognized as an issue at various developmental stages; (2) The service was voluntary and could only be provided at a parent's request; (3) Home-based services were to empower parents to overcome the presenting problem, learn from the experience and make decisions for their family. The role of the agency was to support parents in making and implementing their decisions; (4) Services would be designed to be as non-intrusive as possible; (5) An established program would not "box" the family into receiving "boilerplate" services. An array of services would be available but only those identified through an assessment with the family would be implemented. Rather than a single delivery approach, a coordinated array and delivery of community services was to be pursued; and (6) Treatment was to be family-and neither child nor parent focused. The entire family was to be involved in the assessment, development and implementation of a treatment plan and termination from participation.

An array of community based services and diverse preservation services has been developed in four regions of the state through utilization of family preservation funds. While some services are uniform, the method by which services are delivered vary. For instance, therapy is frequently requested but families disliked traditional office-based delivery of these services. They preferred community or home-based, activity-driven therapy, family retreats, or support groups. These services are not static and continue to evolve as the program develops. The following major services are currently being implemented.

(1) Information and referral provides guidance to families

who are unaware of available services within their community or are unsure where to obtain these services.

(2) Case management serves as a supportive function to assure that needed and timely services are received by the family.

(3) Advocacy for the parents is essential in many areas, but especially crucial when dealing with the education system. This does not always mean that staff would assume the lead, and might only entail staff attending a school conference with a parent in a supportive capacity.

(4) Education regarding pertinent adoption issues can serve as a method of family empowerment. Education might include obtaining a copy of the child's original background study or addressing adoption issues, educational rights, etc.

(5) Family retreats allow families to experience a weekend in a neutral setting with other families who have similar experiences. Retreats may be therapeutic in nature and may involve a therapist leading a group of children and/or parents. Issues may be addressed which range from communication to specific adoption issues. A retreat may be designed so that a family can have fun with one another. The life of an adoptive family is often tumultuous-a planned weekend retreat allows parents and children to have fun together without worrying about everyday responsibilities and problems;

(6) Support groups are therapeutic, educational or social. Support groups have been eight sessions, 2 to 2½ hours in length and have separate concurrent sessions for children and parents. Every third session is jointly conducted for parents and children. Parents are always apprised regarding the children's discussion topics before the discussion.

(7) Residential treatment can be provided for children who require this level of care without the state assuming custody. The major problematic behavior of children in residential treatment has often involved their being physically aggressive toward their adoptive mother. Many of these children were adoptively placed at a young age and were victims of sexual abuse or witnessed a murder while two years of age or younger.

(8) Respite care is a short term service providing a temporary break for children and families and provided by family members, other adoptive families or group care providers. Respite has usually been requested as a result of a family crisis and, until recently, was primarily needed for boys

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between 12-15 years of age. This has begun to change as families with younger children who have special problems are requesting this service. The concept of respite care has been broadened to include currently available resources within the community, i.e. day care centers, recreational activities, etc. This type of delivery setting is pertinent for families living in rural counties.

(9) Counseling is a mainstay service often requested by families. A therapist must be aware of adoption issues when working with the family and address these issues when appropriate. These services must be delivered in a method in which a family believes to be effective.

(10) Financial and medical assistance are often viewed as critical by families. A recent survey of 495 families found that 79% of those adopting special needs children in our state have an annual income of \$40,000 or less. Families (62%) have indicated that medical assistance is more important than financial assistance but 45% of families state that they would not have been able to adopt if financial assistance were not available.

Adoption agencies must commit to long term efforts to preserve families created through adoption. Services must be relevant, responsive, adoption cognizant, accessible, and culturally sensitive. Issues must be identified as problematic by families and services must be deemed necessary and appropriate. Families must retain control of their lives and their family. Agencies must be available when a family crisis occurs and be willing to respond to an adoptive family on their terms. The program not only focuses on the preservation of adoptive families but is also a preventive service. The preservation of adoptive families will present a new millennium challenge to adoption agencies. It is our responsibility to accept the challenge and be prepared to respond.



HHS Announces Adoption 2002 Excellence Awards

On November 21, 1997, HHS Secretary Donna Shalala announced the recipients of the Department of Health and Human Services' Adoption 2002 Excellence Awards. "These awards recognize extraordinary contributions to the national effort to support adoption and promote permanency for children in foster care," said Secretary Shalala. "We honor them today for their committment, vision and accomplishments."

A committee representing non-profit adoption agencies, child welfare and adoption advocates, adoptive parents, foundations, the business community, and state and federal offices reviewed and evaluated more than 100 nominations and selected the winners in seven categories. The winners are as follows:

SUPPORT FOR ADOPTIVE FAMILIES

North American Council on Adoptable Children, St. Paul, MN
Resources for Adoptive Parents, Minneapolis, MN
Athens County Children's Services, Athens, OH

PUBLIC AWARENESS

National Adoption Center, Philadelphia, PA

INDIVIDUAL CONTRIBUTIONS

Jack Williams, Senior Anchor, WBZ-TV 4, Boston, MA
Sherry Coy, Adoptive Mother, Las Vegas, NV

FAMILY CONTRIBUTIONS

The Badeau Family-Adoptive Family of 19, Philadelphia, PA
The Scott Family-Adoptive Family of 5, Scottsdale, AZ
The Neal Family-Adoptive Family of 11, Greensboro, NC

PHILANTHROPY

Wendy's Intl. & Dave Thomas Foundation, Dublin, OH

JUDICIAL OR CHILD WELFARE IMPROVEMENT

South Carolina Families for Kids, Columbia, SC

DECREASE IN THE TIME CHILDREN IN FOSTER CARE WAIT FOR PERMANENCY

Lucas County Children's Services, Toledo, OH

From Handsnet November 21, 1997: HN6904



CASES OF INTEREST

IN NEW JERSEY, MARRIED AND UNMARRIED COUPLES SEEKING TO ADOPT NOW TREATED EQUALLY

Holden v. The New Jersey Dep't of Human Services, No. C-203-97 (N.J. Super.Ct.Ch.Div., Dec.16, 1997).

New Jersey has become the first state to permit unmarried couples to adopt children on the same basis as married couples. The policy is based on a recent lawsuit brought by a gay couple seeking to adopt a foster child from the state's child welfare agency. The couple's efforts to adopt jointly were blocked by an agency policy permitting only one person to legally adopt a child in cases involving unmarried, cohabiting couples.

Under the settlement, the agency must remove its policy and start evaluating the suitability of married and unmarried couples in the same manner, without considering marital status or sexual orientation. The agreement gives lesbian or gay couples who have been denied the right to adopt in New Jersey based on marital status or sexual orientation a basis to appeal.

(From *ABA Child Law Practice*, January, 1998)

ADOPTION, STATUTE OF LIMITATIONS

Phariss v. Welshans (*In re Adoption of Welshans*), 1997 WL 634362 (Ore.Ct. App.).

Statute of limitations could not be applied to father's motion to vacate adoption, even though father brought motion more than one year after decree was entered; application of statute of limitations was unconstitutional since father was not notified of adoption until two years after decree was entered.

(From *ABA Child Law Practice*, December 1997)

VISITATION, GRANDPARENTS

Sowers v. Tsamolias, 941 P.2d 949 (Kan. 1997).

Biological grandparents lacked right to seek visitation with grandchild from his adoptive parents, even though grandparents asserted a "substantial relationship" existed and visitation would be in the child's best interest; since biological parent's rights were terminated, grandparents had no legal rights to grandchild, and visitation could occur only if the adoptive parents agreed.

(From *ABA Child Law Practice*, November 1997)

VISITATION, GRANDPARENTS

Dotson v. Rowe, 1997 WL 447682 (Ky.Ct. App.).

Maternal grandparents retained right to visit grandchildren after mother's parental rights were terminated, since there was no finding that denying grandparent's visitation would be in children's best interests.

(From *ABA Child Law Practice*, December 1997)

DEPENDENCY, PLACEMENT

Department of Social Servs. v. Superior Court, 68 Cal. Rptr. 2d 239 (Ct. App. 1997).

After trial court terminated parental rights and referred children to agency for adoption, it could not veto child welfare agency's temporary placement of children and order new placement; once court

refers children to agency for adoption, that agency has exclusive authority and discretion over adoptive and temporary placement decisions.

(From *ABA Child Law Practice*, December 1997)

DEPENDENCY, TREATMENT

S.G. v. Prince William County Dept. of Social Services, 488 S.E. 2d 653 (Va. Ct. App. 1997).

Juvenile court judge could require child welfare agency to provide treatment for minor in its custody under statute granting juvenile court judge authority to "review the status" of children in agency custody; although order granting legal custody of child to agency gives the agency authority to make placement decisions for the child, it does not deprive the juvenile court of its authority to oversee the child's status.

(From *ABA Child Law Practice*, November 1997)

TERMINATION OF PARENTAL RIGHTS, CHILD'S OPINION

Hawks v. Dinwiddie Dept. of Social Servs., 487 s.e.2D 285 (Va. Ct. App. 1997)

Trial court's decision that 11-year old child had not reached age of discretion to offer opinion about termination of mother's parental rights, which was solely based on child's age, was improper; focus of trial court's inquiry should be if child, regardless of age, is mature enough to intelligently consider circumstances and ramifications of terminating parent's rights.

(From *ABA Child Law Practice*, December 1997)

TERMINATION OF PARENTAL RIGHTS, CHILD'S WISHES

In re D.J.N., 568 N.W.2d 170 (Minn. Ct. App. 1997).

Trial court properly considered 14-year old child's expressed wishes to be reunified with mother and not be adopted before deciding to terminate mother's parental rights; termination was in child's best interests since child would be unlikely to pursue future goals of attending college and getting a job if returned to mother's care, and freeing child would permit him to enjoy the remaining years of childhood without having to act as surrogate parent to his siblings.

(From *ABA Child Law Practice*, December 1997)

TERMINATION OF PARENTAL RIGHTS, INCARCERATED PARENT

State v. K.H.C., 940 P.2d 1229 (Utah Ct. App. 1997).

Mother's incarceration did not represent willful conduct to warrant terminating her parental rights, since mother was involuntarily confined and was court ordered not to contact her children or any adults with custody of children during her incarceration; parental rights may not be terminated based on an incarcerated parent's failure to maintain contact with children when court order or circumstances prevent such contact.

(From *ABA Child Law Practice*, November 1997)

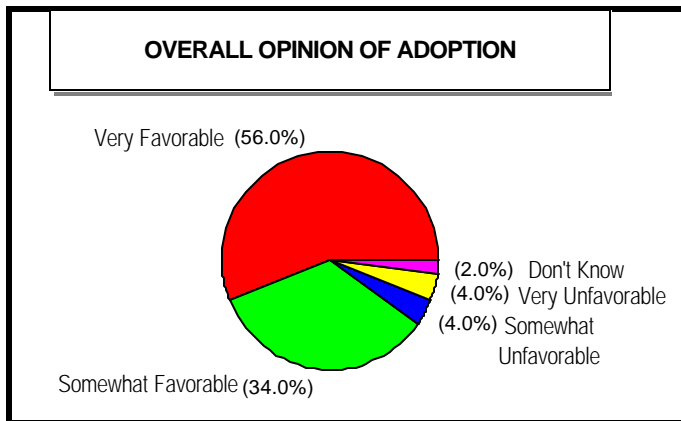
RESEARCH HIGHLIGHTS

STUDY LOOKS AT ATTITUDES TOWARD ADOPTION

Adoption is receiving a great deal of attention these days, from Capitol Hill to local agencies. The new Adoption and Safe Families Act includes requirements and incentives for states to increase and speed up adoptions of abused and neglected children. More adoptive families will be needed to provide homes for children waiting in foster care. While most Americans agree adoption fills an important need in society, there has been little information available regarding people's opinions about adopted children, adoptive parents and parents who place their children for adoption.

A recently released survey by the Evan B. Donaldson Institute gives the first in-depth look at attitudes towards adoption and members of the adoption triad. The survey was conducted through telephone interviews with a representative sample of 1,544 adults in the United States.

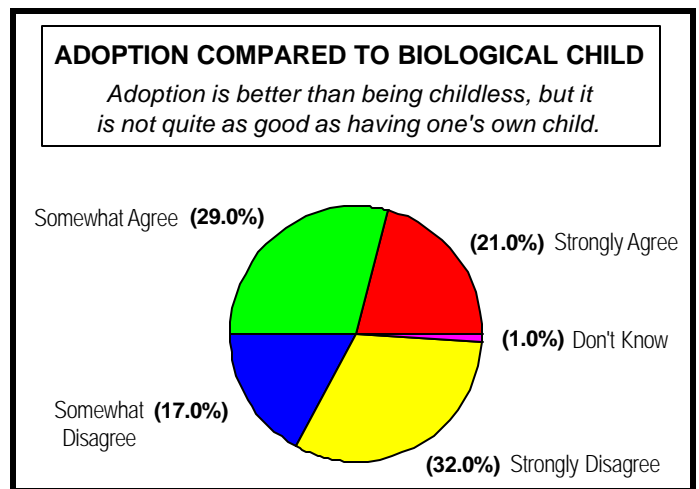
From the research findings, the authors were able to divide attitudes on adoption into the following three groups. One in three (32%) Americans is a **Full Supporter**. "*Full Supporters* voice a favorable opinion of adoption, strongly agree adoption serves a useful purpose in society and think adoption is as good as having one's own child." Thirty-seven percent are **Qualified Supporters**. "Some in this group express a very favorable opinion of adoption but think adoption is not as good as having one's own child; others in this group voice a somewhat favorable or even unfavorable opinion of adoption but do think adoption is as good as having one's own child." Thirty-one percent are **Marginal Supporters**. "*Marginal Supporters* believe adoption is less desirable than having one's own child, hold less than a favorable opinion of adoption, and agree only somewhat that adoption serves a useful purpose in society."



Support for adoption differed by social demographic characteristics. Americans with a college degree (48%) are more

likely than those with a high school education (23%) to be **Full Supporters** of Adoption. A larger percentage of Women (36%) than men (27%) are **Full Supporters**, and Whites (35%) are three times as likely as blacks (11%) to be **Full Supporters**. Married Americans (36%) were more likely to fully support adoption than unmarried (27%) and 43% of Americans in the western part of the U.S. are **Full Supporters**, compared to 25% in the South and 28% in the Northeast.

A majority of Americans (58%) have had personal experience with adoption-meaning they themselves, a family



member or a close friend was adopted, adopted a child, or put a child up for adoption. Almost three in four (72%) **Full Supporters** of adoption have had intimate experiences with adoption, and over a third (36%) say they have given very or somewhat serious consideration to adopting a child. Half the Americans surveyed say they would be likely to place a child for adoption, and half would be unlikely to do so, including more than a third who say they would be very unlikely to place their child for adoption. Americans say their family and friends (45%) are their main source of information about adoption, followed by the news (30%), books and magazines (16%), and movies and entertainment programs (6%).

Most people believe adoptive parents get the same amount of satisfaction (46%) or even more satisfaction (33%) out of raising an adopted child than a child born to them. Yet, almost a quarter (23%) agree it is sometimes harder to love an adopted child, because that child is not your own flesh and blood. Likewise, although a majority (67%) say it is very likely adopted children love their adoptive parents as much as they would have loved their birth parents, a third are less optimistic-25% say it is only somewhat likely the love will be as strong, and 5% say it is unlikely.



People are divided as to whether adopted children are more likely than other children to have problems at school (35%), less likely (36%) or equally likely (21%). There is disagreement as to whether adopted kids are more likely (39%), less likely (34%) or equally likely (19%) to have behavioral problems. By contrast, more people say adopted kids are less likely to develop drug and alcohol problems (39%) than say they are more likely to (28%).

Most Americans have positive opinions about birth parents, and are supportive of the decision to place their child up for adoption. One in four (23%) of Americans generally disapproves of a birth mother's decision to place a child for adoption, and the disapproval rate increases to 29% for the fathers who place their children for adoption.

Just as many think it is best for a teenage mother to place the child for adoption (37%) as believe she is better off raising the baby herself (39%). Slightly more of the public think the baby is better off being placed for adoption (42%) than being raised by the teenage mother (36%).

A slim majority of Americans (54%) oppose a proposal by California Governor Pete Wilson to encourage welfare mothers to place their children for adoption, but a sizable minority (43%) somewhat or strongly support the idea. Two in three (67%) would support a plan to encourage pregnant teens who are unable to provide for their newborn to place the baby for adoption.

Additionally, previous surveys found that 30% of those surveyed felt it should be as easy for gay couples to adopt as heterosexual couples while 20% felt it should be more difficult and 44% believed it should not be allowed at all.¹ The majority of the public supports white couples adopting black children (80%) and black couples adopting white children (77%).²

If you would like a copy of the survey report please contact Shannon Gultinan at 202/682-0100 or sgultinan@apwa.org.

¹ (May 1996 Princeton Survey Research Associate survey for Newsweek magazine)

² June 1995 survey by Yankelovich for Time Magazine and CNN.

Brian's Kids: How to Develop A Weekly Television Program to Recruit Foster & Adoptive Parents

The Community Task Force on Homes for Children has released a manual and video tape on a "waiting child" program called *Brian's Kids*. *Brian's Kids* is broadcast weekly on the CBS network affiliate, KPIX TV, in San Francisco and highlights adoptive children in need of homes. The regional program is a collaborative effort among five San Francisco Bay Area counties. It airs brief TV spots during the news program and advertises a hotline with staff standing by to respond to callers as the program airs. A database program facilitates matching callers with children in the county system who are awaiting placement.

Brian's Kids has successfully placed 80% of children aired; created awareness and general interest in foster parenting and adoption; and increased collaboration among counties in using broadcast media to effectively recruit new adoptive families.

The manual is divided into three sections. The first section provides an overview of the *Brian's Kids* history and development, defines the program's key players and describes how the program enhances traditional strategies for recruiting foster and adoptive families. The second section explains how to start the project, identify children for taping, respond to callers, develop a database and staff the program. The third section, an appendix, contains samples of *Brian's Kids* materials—a caller intake record, charts and reports.

For more information, contact the Community Task Force on Homes for Children/408 Columbus Avenue, Suite 3/San Francisco, CA 94133/ (415) 296-8744.

Parents in Prison: Children In Crisis

An Issue Brief

Cynthia Beatty, CWLA, 1997 (e-mail: books@cwla.org)

It is estimated that nationally there are 1.53 million minor children who have a father or mother in prison. There is another, much larger population of children that has experienced incarceration of a parent at some point in their lives. This issue brief describes what happens to children—physically and emotionally—when their parents go to prison and offers suggestions on how to improve child welfare practices to better address the needs of these children.

PART II

MEDICAL ASSISTANCE FOR CHILDREN RECEIVING STATE-FUNDED ADOPTION ASSISTANCE: CURRENT PRACTICE AND REQUIREMENTS UNDER THE ADOPTION & SAFE FAMILIES ACT

Intrastate Coverage

Forty-five (45) states and the District of Columbia currently provide Medicaid to children adopted by families within their state, who receive state-funded adoption assistance, and who the state determined could not be placed for adoption without Medicaid because the child has special needs for medical or rehabilitative care. These states have elected the option to provide Medicaid for this optional category of children provided for in Section 1902(a)(10)(A)(ii)(VIII) of the Social Security Act (hereinafter, the “COBRA option”)¹ The other five states provide medical assistance to children receiving state-funded adoption assistance, but do so through programs established by the state and funded solely by state dollars.

Section 306 of the Adoption and Safe Families Act of 1997 (ASFA)² requires that states provide health insurance coverage for “any child who has been determined to be a child with special needs, for whom there is a state-funded adoption assistance agreement between the State and an adoptive parent(s), and who the State has determined cannot be placed without medical assistance because the child has special needs for medical, mental health, or rehabilitative care. Such coverage may be provided through Medicaid or a state health insurance program, as long as the medical benefits of the state program (including mental health) are of the same kind and type provided under Medicaid.

The 45 states that have elected the COBRA option are in compliance with the new mandate of Section 306 of ASFA. The other five states are in compliance as long as their state programs cover the group of children for whom health insurance is mandated in section 306, and the benefits are of the same kind and type that the children would receive if they were provided medical assistance through the COBRA option (Medicaid). (*see chart on pg. 11*)

Interstate Coverage

States with the COBRA option *can* provide Medicaid to children residing in their state with adoption assistance agreements from other states, upon certification from the adoption assistance state³ that the child met the eligibility criteria. Currently, 9 states⁴ provide Medicaid to *any* children residing in their state who were receiving Medicaid in the adoption assistance state through the COBRA option with proper certification from the adoption assistance state. Nine other states⁵ provide this benefit to children residing in their state, *but only if* the adoption assistance state is a party to the

Interstate Compact on Adoption and Medical Assistance (ICAMA). The remaining 32 states and the District of Columbia do not provide Medicaid to children residing in their state with state-funded adoption assistance agreements with other states, even if the child was eligible for Medicaid under the COBRA option in the adoption assistance state.

Sections 201(b)(4) and 301(a)(4) of the ASFA provide that in order to be eligible to receive child welfare demonstration waivers or adoption incentive payments in the years 2001 and 2002, States must “provide health insurance to any child with special needs (as determined under section 473 (c)) for whom there is in effect an adoption assistance agreement between *a* state and an adoptive parent or parents.” [emphasis added].

An easy way for most of the states, that is, states with the COBRA option, to meet the mandates of Sections 201(b)(4) and 301(a)(4) of the ASFA is to enact a policy/regulation that provides that: Medicaid will be provided to any child with special needs residing in their state, for whom it has been determined by another state that the child has special needs for medical or rehabilitative care, and who is the subject of an adoption assistance agreement with another state, when a certified copy of the adoption assistance agreement from the adoption assistance state has been received by the residence state. As discussed above, 9 states already have such a policy and 9 others have such a policy but limit it to children coming from states that are members of the Interstate Compact on Adoption and Medical Assistance. For the five states that do provide health insurance for special needs children receiving state-funded adoption assistance through programs other than the COBRA option, they will need to ensure (1) that these programs provide services of the same kind and type that the children would receive if they were provided Medicaid, and (2) that they will provide this health insurance to special needs children with state-funded adoption assistance agreements with other states residing in their state.

Some Issues Raised by ASFA

In contrast to Section 306 of ASFA, Sections 201(b)(4) and 301(a)(4) do not include some of the language that qualifies the type of children that need to be provided with health insurance. Section 306 of ASFA, in defining the children that need to be provided with health insurance, articulates three criteria: (1) the child must be a child with special needs, (2) the child must have an adoption assistance agreement (other than through title IV-E), and (3) the child must be a child for

whom the state has determined cannot be placed with an adoptive parent(s) without medical assistance because such child has special needs for medical, mental health, or rehabilitative care. Sections 201(b)(4) and 301(a)(4) include criteria #1 and #2, but do not contain the language of #3. The issue raised by the non-conforming language is whether children that have been determined to have special needs and have state-funded adoption assistance agreements, but do not have special needs for medical, mental health or rehabilitative care, have to be covered to meet the requirements of sections 201(b)(4) and 301(a)(4). Other issues/questions raised include: (1) the meaning of Parts (C) and (D) of Section 306 that discuss problems that may arise if a State chooses to provide the health insurance through a state medical assistance program, and (2) the year in which the states must be providing health insurance on an interstate basis in order to be eligible for the adoption incentive payments.

The Interstate Compact on Adoption and Medical Assistance

Given these new mandates, the Interstate Compact on Adoption and Medical Assistance (ICAMA) will become more important in ensuring that geographic boundaries do not become barriers to children receiving these benefits. ICAMA provides the necessary substantive guarantees and workable procedures for interstate cooperation. In fact, these provisions have provided another impetus for non-member states to join. Currently, there are 32 member states and 8 states currently are pursuing joinder.

Conclusion

States will not have great difficulty in coming into compliance with these provisions, even though some questions remain. Hopefully, the questions will be clarified by the legislative drafters of PL.105-89 and the U.S. Department of Health and Human Services through regulation.

¹ See, *Bridges*, summer 1997 for full discussion on the COBRA option.

² P.L. 105-89

³ "Adoption Assistance State" means the state that is signatory to an adoption assistance agreement in a particular state.

⁴ Alaska, Arkansas, Idaho, Massachusetts, Minnesota, Missouri, Oklahoma, South Dakota, Wyoming

⁵ Kansas, Kentucky, Maine Montana, Rhode Island, South Carolina, Utah, Virginia, and Wisconsin.

We welcome any comments and contributions.

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