*Strengthening*
Families &
Communities

Promising Practices in
Adoption-Competent
Mental Health Services

A White Paper

Casey Family Services
The Casey Center
for Effective
Child Welfare Practice

# Table of Contents

# Acknowledgements

# Promising Practices in Adoption-Competent Mental Health Services

## *A White Paper*

*T*he Casey Commitment to Adoption and Post-Adoption Services. Casey Family Services, the direct service arm of the Annie E. Casey Foundation, understands that adoption is a life-long process and that children's needs for ongoing mental health supports and services do not end when their adoptions are legalized. Developmental challenges that emerge prior to and during the foster care experience are bound to have an impact on children's relationships prior to, during, and throughout the adoption experience. These challenges have lifelong implications for their adoptive family relationships.

Since 1976 Casey Family Services has provided an array of child welfare and family services. In 1991, Casey Family Services began to provide a comprehensive approach to post-adoption services within six of its eight divisions. In December 2000, Casey Family Services held the first National Conference on Post-Adoption Services. More than 500 people, who attended in state teams, came to learn from, and network with, one another. State Adoption Program Managers and others from state teams who attended the conference shared practice, policy, and research concerns. The availability and accessibility of quality adoption-competent mental health services for adopted children and their families was a high priority.

Across the country, children are finding families through adoption in unprecedented numbers. According to the most recent federal data, 51,000 children were adopted through the child welfare system in the year 2000, more than twice as many

as the 24,000 children who were adopted through our public child welfare systems in 1996.[1] While many children who are adopted from the child welfare system do not require ongoing mental health services, there are a significant number of children adopted from the public child welfare system who need these services.

**Purpose and Focus.** This paper responds to this growing concern by highlighting promising practices in adoption-competent mental health services – creative services, training initiatives supports and treatment practices and collaborations – that can emerge among child welfare, mental health and Medicaid systems to address the complex mental health needs of adopted children and their newly formed adoptive families. It also builds a strong case for adoption-competent mental health services and identifies the gaps that exist in current systems of mental health services for the vulnerable children adopted through public and nonprofit child welfare systems, as well as those adopted privately in this country and from other countries. While many of these "promising" practices have yet to be evaluated, their efforts are worth highlighting as a stimulus to state child welfare, mental health and Medicaid systems to more strategically fund similar programs and to evaluate their effectiveness over time.

While this paper reviews relevant literature on the need for adoption-competent mental health services, the primary focus is on the perspectives and experiences of adoption professionals and families who have adopted children through the child welfare system. Families have thoughtfully shared what works for them, what has been difficult, where gaps exist, and where they see practices that give them hope. Thus, the stories of adoptive families provide wisdom and guidance on how child welfare and mental health systems can be more collaboratively integrated. Their experiences also highlight the need for adoption-competent mental health professionals who can see beyond troubling diagnoses.

In many ways, the struggles adoptive families face in accessing adoption-competent mental health services mirror the challenges other families face in accessing competent mental health services. All families seeking mental health services for their children confront a patchwork of underfunded services and supports, guided by an often-bewildering mix of theories, philosophies, and treatment interventions. The vast majority of families – adoptive or otherwise – inevitably rely on publicly funded services or services available through private health insurance programs. Thus, they routinely face limitations in the availability, intensity, and duration of mental health services. The challenge of finding competent mental health services is even more complex when adoption-related issues are a component of mental health needs.

**Audience.** This paper is written for state adoption program managers, child welfare directors, mental health and Medicaid managers, advocates, and adoptive families who can make these promising practices a reality in each state. It is our hope that these nuggets of creative practices can be adapted, evaluated and, eventually, sustained in communities across this country. For without the availability of, and accessibility to, quality, adoption-competent and family-centered mental health supports and services, many of these newly created adoptive families may not thrive. It is our hope that this paper will be useful in advancing local, state and national efforts to support adopted families so they can reach their hopes and dreams.

Raymond L. Torres
Executive Director
Casey Family Services

Sarah B. Greenblatt
Director
The Casey Center for Effective
Child Welfare Practice

> "Supporting and preserving adoptive families is a topic that traditionally receives less attention than the process of adoption itself. We are convinced that, in some cases, post-adoption services are essential to helping children and families address problems and build healthy relationships."
>
> — Raymond L. Torres
> Executive Director

[1] U.S. Department of Health and Human Services, Administration for Children and Families. Adoption and Foster Care Analysis and Reporting System (AFCARS). (September 2000).

# Exploring Promising Practices in Adoption-Competent Mental Health Services

*One Adoptive Family's Story*

*To begin the discussion of the challenges of finding adoption-competent mental health services, one family's story (names changed to respect confidentiality) provides an example of the complex experiences many adoptive families confront.*

"Our daughter Shannon was abandoned at the hospital at the age of three. Prior to that, she had been found by the police lying naked with her biological mother's pimp. She also had recently received a liver transplant due to biliary atrasia. Shannon had a series of placements during her first two years in foster care, with no placement lasting very long. Shannon believed that nobody would love her because she was going to die anyway of her liver condition, and that she was 'going to hell' because of her behavior.

"During our first visit with Shannon (she was 5 at that time), she screamed the entire time – she was like a wild animal. Shannon's case manager told us that structure and love would help to settle her down. Shannon did settle down for a short time after moving to our home, but within a few months her behavior became violent and intolerable. We looked to counseling to help us. The counselor that she was seeing was ill-informed and ill-prepared to deal with Shannon and her history. We proceeded to go through 10 counselors without finding one who understood Shannon or the issues we as her adoptive family were facing. Every time we took her to a new counselor, she would portray the 'perfect' victim and convince them that we were mistreating her. Several of the counselors reported us to child protection due to Shannon's very creative imagination.

"At one point, Shannon refused to take the liver medications that kept her alive – she needed inpatient help. The psych (sic) ward refused to take her because of her liver problem and the med/surg (sic) floor refused to take her because of her psych problem. The hospital staff told us she was our problem ... and if she doesn't get her medication, they would file a report with CPS. Finally, when she took a knife to school and a 'hit list' of people she intended it for, we were able to place her in the psychiatric ward for two weeks. Her doctor diagnosed her with RAD (Reactive Attachment Disorder). He also said, 'Don't bring her back because there is nothing we can do for her.' I was forced to the Internet and the library but at least now I had a diagnosis ... something to help us understand Shannon's behavior. I found one facility in our state that specializes in RAD … there was a dim light at the end of the tunnel. Then I was told that the price was $22,000, and they did not take Medicaid. I called the State Office of Family and Children Services and informed them that I loved Shannon but my family could not continue this way. I told them that we needed help now, and they finally agreed to help … as a result, Shannon's behavior became less violent over time.

"Although I have become sarcastic and angry … I am also much more informed. I wish that someone had told us more, at the beginning, about what we would face. We needed the system to be our teacher and our supporter, yet, all they did was judge us. Thank God for my parent support group and for the adoptive parents who have traveled this road before me. Because of them I have a place to go and so … I will pave a path for others also."[2]

[2] Personal communication with an adoptive mother. (November 2001).

# Research Perspectives on the Need for Adoption-Competent Mental Health Services

The following discussion briefly explores trends in the need for adoption-competent mental health services emerging from a small but significant body of literature on adoption practice and post-adoption services. Data can be used as a template to document trends and needs at a state and local level in combination with perspectives of adoptive families themselves.

### Demographics of Children Adopted From the Child Welfare System

Since 1995, there has been a dramatic increase across the country in the numbers of children adopted through public child welfare systems. This has created a burgeoning need for services to support these often-vulnerable families. In Federal Fiscal Year (FFY) 2000, an estimated 51,000 children achieved permanency through adoption,[3] with an additional 50,000 estimated to have been adopted in Federal Fiscal Year (FFY) 2001.[4] Those children adopted in FFY 2000 were on average 6.9 years of age when adopted, had been in foster care an average of 3.3 years prior to their adoption finalization and had experienced 2.9 moves while in out-of-home care.[5] The majority had entered foster care due to a finding of neglect or abuse.[6] Eighty-eight percent of the children adopted in FFY 2000 received a special needs adoption subsidy related to one or more of the following characteristics or conditions: medical/psychiatric or emotional conditions (21 percent); age (31 percent); membership in a sibling group (20 percent); and minority status

(12 percent).[7] Thirty-nine percent of the children adopted in FFY 2000 were Black/non-Hispanic, 38 percent were White/non-Hispanic, 14 percent were Hispanic, 2 percent were Asian/Pacific Islander/non-Hispanic and American Indian/non-Hispanic, 5 percent were unknown, and 2 percent were of two or more races/non-Hispanic.[8]

These data speak to the complex special needs and circumstances of the children being adopted through the public child welfare system. Many are older children of color. Most have had multiple relationship disruptions, troubled past life experiences and present life adjustment challenges. They are children who need families who can understand their past experiences and present adjustment needs. They also need families who can form nurturing relationships that will help them to manage their feelings of loss and grief—and to heal. They are extremely vulnerable children who, first and foremost, need a safe and loving family that is permanent. A mix of services and supports will be needed to meet the ongoing needs of these vulnerable children and help their adoptive families sustain a commitment to them. Service providers that are family-centered, culturally sensitive and adoption-competent are essential. These professionals must be able to see beyond troubling diagnoses to find the children's competencies and families' strengths.

### Experiences of Children in Foster Care

Over most of the past 40 years, there has been a significant increase in the number of children entering and remaining in state foster care systems. This increase has been due, in part, to the emergence of child abuse and reporting laws in the 1960s as well as the negative impact of persistent poverty, racism and a changing sociopolitical environment. In addition, many children in foster care have been diverted from other systems, specifically the mental health and juvenile justice systems. Increasingly, the child welfare system is being used to care for children and youth who previously would have been served through children's mental health or correctional facilities.[9]

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[3] U.S. Department of Health and Human Services. Adoption and Foster Care Analysis and Reporting System (AFCARS). Report #7.
[4] U.S. Department of Health and Human Services. Preliminary AFCARS Report #8.
[5] AFCARS Report #7.
[6] Barbell, K. and Freundlich, M. (2002). *Foster Care Today.* Casey Family Programs.

[7] AFCARS Report #7.
[8] Ibid.
[9] Barbell, K. and Freundlich, M. (2002). *Foster Care Today.* Casey Family Programs.

Thus, with exception of a short period during the mid-1980s, the number of children in foster care has steadily increased from 272,000 in 1962 to 319,800 in 1972 to 502,000 in 1977[10] and approximately 556,000 in FFY 2000.[11] This growth can also be attributed in part to the reality that many children who enter foster care remain for significant periods of time. Throughout the 1980s, after passage of the federal Adoption Assistance and Child Welfare Act of 1980, the length of time children spent in foster care decreased. However, beginning in the early 1990s, the average length of time children spent in foster care began to increase[12] due to the emergence of inexpensive, highly addictive drugs and the continued effects of persistent poverty and discrimination.

Recent studies have contributed to a broader understanding of the extent to which children in foster care experience emotional, behavioral and developmental problems.[13] For example:

- In a 1990 study Dubowitz found that the incidence of emotional, behavioral and developmental problems among children in foster care (including depression, conduct disorders, difficulties in school and impaired social relationships) was three to six times greater than the incidence of these problems among children not in out-of-home care.[14]
- A 1994 study by the U.S. Department of Health and Human Services found that 27 percent of the children in foster care were emotionally disturbed; 18 percent had learning disabilities; 11 percent had developmental disabilities; 8 percent had hearing, speech or sight impairments; and 4 percent had other disabilities.[15]
- And more recently, the American Academy of Pediatrics estimated that 30 percent of children in foster care have severe emotional, behavioral or developmental problems.[16]

"This is complicated work that requires thoughtful and planful intervention."

— Debbie Riley
Executive Director
Center for Adoption Support
and Education

Additionally, the number of children affected by prenatal drug exposure, mental health, developmental and physical health problems has increased over time as has the severity of these problems. An estimated 60 to 80 percent of the children in foster care today come from families affected by drugs or alcohol.[17] In 1990, child welfare experts testified before the U.S. House of Representatives Budget Committee that "children coming into the system today are significantly different from the children we saw five years ago … a growing number of seriously handicapped infants at one end of the spectrum, and a preponderance of emotionally disabled teenagers at the other end."[18] These children are at high risk for developing maladaptive outcomes, including socio-emotional, behavioral and psychiatric problems that require ongoing mental health treatment, because of their traumatic experiences prior to and, in many cases, after entering the child welfare system.[19]

With trends to deinstitutionalize children from large psychiatric institutions, child welfare systems across the country are under pressure to find family resources able to meet children's complex needs, even as the needs of children in the foster care system have become more challenging. At the same time, in much of the United States, finding and supporting competent foster and adoptive parent resources has become more challenging. In the 1970s and 1980s, unrelated foster families provided care for most foster children. However by 1999, an estimated 142,000 licensed foster families cared for less than half (47 percent) of the children in care.[20] Although the number of children in foster care increased by 68 percent between 1984 and 1995, the number of foster parents decreased by 4 percent.[21]

[10] Ibid.
[11] AFCARS Report #7.
[12] Tartara, T. (1993). *Characteristics of children in substitute and adoptive care: A statistical summary of the VICS National Child Welfare Data Base.* Washington, DC: American Public Welfare Association.
[13] Barbell, K. and Freundlich, M. (2002). *Foster Care Today.* Casey Family Programs.
[14] Dubowitz, H. (1990). *The physical and mental health and educational status of children placed with relatives.* Baltimore MD: Department of Pediatrics, School of Medicine, University of Maryland.
[15] Barbell, K. and Freundlich, M. (2002). *Foster Care Today.* Casey Family Programs.
[16] Ibid.

[17] U.S. General Accounting Office. (1998). Foster care agencies face challenges securing stable homes for children of substance abusers. Report to the Chairman, Committee on Finance, U.S. Senate. Washington DC: Government Printing Office.
[18] American Public Welfare Association. (1990). *A Commitment to Change.* Report of the National Commission on Child Welfare and Family Preservation. Washington, DC.
[19] Trupin, E.W., Forsyth-Stephens, A. and Benson, P.L. (1991). "Service Needs of Severely Emotionally Disturbed Children," American Journal of Public Health.
[20] AFCARS Report #7.
[21] Barbell, K. and Freundlich, M. (2002). *Foster Care Today.* Casey Family Programs. (Child Welfare League of America, 1997; U.S. House of Representatives, 2000).

**Changing Adoption Trends**

Adoptions of children in foster care have increased dramatically: 28,000 in Federal Fiscal Year (FFY) 1996 to 31,000 in 1997; 36,000 in 1998; 46,000 in 1999; 51,000 in FFY 2000, and an estimated 50,000 in FFY 2001.[22] The Adoption 2002 Initiative in 1996 followed by the Adoption and Safe Families Act of 1997 has encouraged states to find adoptive families for children who are unable to remain with or return to their biological parents. To expedite these adoptions, the Federal government offers states financial incentives for each foster child adopted above a baseline number.[23] As more children find permanent families through adoption, states have become eligible to receive increased funds to promote and enhance adoption services and supports. These funds can be used to support adoptive placements as well as sustain adoptive families after legalization. Yet, in FFY 2000, the Adoption and Foster Care Analysis Reporting System (AFCARS) reported that 131,000 children were waiting for an adoptive family placement,[24] and an estimated 126,000 children were waiting to be adopted at the end of FFY 2001.[25]

**Who is Adopting Children from the Foster Care System?**

The profile of people adopting children from the foster care system in FFY 2000 indicates that children are increasingly being adopted by families known to them: 61 percent are adopted by their former foster parents, 21 percent by relatives and 18 percent by non-relative family resources recruited for them.[26]

While the emerging field of post-adoption services requires better empirical information on the characteristics of adoptive families, Barth, Gibbs and Siebenaler provide valuable

information about the pool of families who are, or might become, post-adoption service users. In the states researched, more than 70 percent of the families adopting children under the age of 6 are married couples, with both parents working outside of the home. Between 35 to 40 percent of the families in this study adopting older children are single-parent households, where the parent works outside the home. Between 30 to 40 percent of families in this study adopting children have other foster children or birth children living in the home. Further, a substantial proportion of adoptive families have relatively low incomes. Because the mean household size of adoptive families in the samplings is nearly twice the statewide average in states where this study was conducted, financial adoption assistance appears to be an important source of support for families raising adopted children.[27]

These findings imply a substantial change in the financial circumstances of adoptive families during the last decade. Earlier research tended to describe adoptive families as more middle class and affluent than the general public. This may be due, in part, to the shift which began in the late 1970s from viewing adoption as a service for white, middle class, two-parent families to a service to find permanent families for a more challenging population of older and disproportionately minority children in foster care. The shifts in who becomes foster and adoptive resource families may also be due to changing policies and practices across the country encouraging foster parent adoptions (relative and non-relative). Therefore, demographic changes in the circumstances of who adopts children from the public child welfare systems would imply that an array of services will be needed to sustain the adoptions of older children with special support needs.

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[22] AFCARS Report #7 and 8.
[23] *A Carrot Among Sticks: The Adoption Incentive Bonus.* (2001). Cornerstone Consulting Group. Houston, Texas.
[24] AFCARS Report #7.
[25] Preliminary AFCARS Report #8.
[26] AFCARS Report #7.

[27] Barth, R., Gibbs, D. and Siebenaler, K. (April 2001). *Assessing the Field of Post-Adoption Service: Family Needs, Program Models, and Evaluation Issues.* Research Triangle Institute and University of North Carolina School of Social Work.

**Post-Adoption Service Needs of Adopted Children and Their Families**

As states have increased the numbers of adoptions with legislative mandates and fiscal incentives, this push for more timely permanence for children in foster care has not been accompanied by parallel mandates or incentives for states to support families once the adoption is legalized. Historically, formal ongoing information, services and supports for adopted children and their families served by public agency systems stopped at the point of the legalized adoption. Efforts to provide post-adoption services for families were not always considered necessary or the responsibility of the public child welfare agency.

*"We need to have voluntary foster care … the idea of giving up custody to get my child's needs met is fundamentally wrong … relinquishment of custody nearly broke my heart."*

— Adoptive Parent

Yet, over the past decade, an increasing number of public and private child welfare and adoption agencies have begun to view post-adoption services as an essential component of the service continuum if the lifelong process of adoption is to succeed. According to adoption professional Kenneth Watson:

*"Agencies have learned that adoption is not just a legal act that transfers parental rights but an event that profoundly changes all of the participants for the rest of their lives. They have come to realize this truth as a result of the painful experience of denying it. The bottom line is that adoption, no matter how early or how successful, means that the child always experiences a painful loss of the birth family. When families fall apart and their children move to foster homes the children do not leave their trauma behind. Such a loss can be a serious blow to an adopted person's self-esteem. They were 'given up' or 'given away.' Children and families need help from qualified professionals to deal with the long-term ramifications of these feelings and experiences."* [28]

Research from a variety of sources raises concern about the developmental challenges of many adopted children. In general, adopted children were more likely to be diagnosed with Attention Deficit Hyperactivity Disorder (ADHD)[29] and to experience dramatically higher rates of "acting out" behaviors – including defiance, running away, sexual acting out, and aggressive and antisocial behavior – than children who were not adopted.[30] And yet, in one study, Barbara Ingersoll found that only one-half of eligible adoptive families used post-adoption mental health services within five years of the adoption.[31]

Ingersoll's research further indicates that adopted children generally are disproportionately represented in child psychiatric populations. Her analysis of the literature supports the view that adopted children are particularly prone to developmental adjustment challenges. Both genetic and environmental factors contribute to the manifestation of these challenges.[32] She comments that *"abundant research exists to suggest that environmental adversities such as abuse, neglect, malnutrition, poor medical care, lack of adequate stimulation and weak or ruptured relations with caregivers were associated with later life problems."* [33]

Adoption of children with prenatal alcohol exposure presents particular challenges to adoptive families. Cadoret and Riggins-Casper found that children with this history have a much greater likelihood of having multiple psychiatric symptoms throughout their lives, especially if they remain in families facing difficulties ranging from parent-child conflict to divorce.[34]

[28] Watson, K. (Winter 1992). *Providing Services After Adoption.* American Public Welfare Association.

[29] Deutsch, C.K. (1990). *Adoption and Attention Deficit Disorder.* New York: Pergamon Press.
[30] Benson, P.L., Sharma, A.R. and Roehlkepartain, E.C. (1994). *Growing Up Adopted: A portrait of adolescents and their families.* Search Institute. Minneapolis Minnesota.
[31] Ingersoll, Barbara, D. (1997). *Psychiatric Disorders Among Adopted Children: A Review and Commentary.* Adoption Quarterly, Vol. I (1). Haworth Press, Inc.
[32] Ibid.
[33] Ibid.
[34] Cadoret, R.J. and Riggins-Casper, K. (2000). *Fetal Alcohol Exposure and Adult Psychopathology: Evidence From an Adoptive Study.* Washington DC: Child Welfare League of America.

Children who were adopted from the child welfare system face many of these issues. In addition, they have a higher risk of diagnoses of attention deficit and learning disorders, depression, and chemical dependency than children who were raised by their biological families.[35] Thus, it is important to recognize that it is *not the adoption itself* that poses the core challenge these children and their families face. Rather, it is likely the effects of neglectful early life experiences, combined with the trauma of multiple relationship disruptions while in foster care, that may result in challenging behaviors and developmental adjustment reactions once adoptions are legalized. Adoption remains a viable way to form a family: It offers permanent, lifetime family connections for a child who might otherwise not have had the opportunity to belong to a family.

### Finding Adoption-Competent Mental Health Services and Post-Adoption Supports

Obtaining quality mental health services for any child in this country is challenging. The Federation of Families for Children's Mental Health, the National Alliance for the Mentally Ill (NAMI) and other national and local advocacy groups have been fighting for decades to improve access, quality and availability of child and family mental health services, regardless of the families' circumstances. The availability of clinicians skilled in the provision of culturally sensitive and adoption-competent mental health services is even more limited.

In a study conducted in Massachusetts in 1986, Frey found that the most common post-adoption need was for mental health services with *qualified adoption-sensitive mental health professionals*. Some families reported seeking services from up to 10 practitioners before locating one who understood their unique circumstances; some were unable to ever find such a professional.[36]

Nelson's study of 177 adoptive parents found that mental health counseling was cited by parents as their major unmet need following adoptive placement.[37] An Ohio project that established adoption referral networks reported that about 75 percent of initial calls requested referrals to a therapist who "knows something about adoptive families."[38] Another small study asked 20 adoptive families about their experiences with mental health professionals. Some of these families reported that mental health professionals were unfamiliar with issues related to older child adoption and adoption of sibling groups. Parents reported that they were sometimes made to feel "freakish." The study suggested that, far too often, families themselves have to teach therapists about the most basic issues of adoption: trust, loss, rejection and divided loyalties.[39]

### Post-Adoption Services: Helping to Prevent Adoptive Relationship Disruptions

Studies using different methods and samples find similar conclusions that from 10 to 16 percent of special needs adoptions will disrupt.[40] These studies identify several risk factors for disruptions in adoptive placements and family relationships that should be addressed during the adoption preparation and post-placement support process. These risk factors may result in disruptions in adoptive placements prior to legalization, temporary placements outside the adoptive family once the adoption has been legalized or, in some cases, legal dissolution of the adoption.

*"We've been pretty much on our own since we adopted these children."*

*— Adoptive Parent*

[35] Dalby, J.T., Fox, S.L., and Haslam, R.H.A. (1982). Adoption and foster care rates in pediatric disorders. Developmental and Behavioral Pediatrics, 3.
[36] Frey, L. (1986). *Preserving Permanence:* A survey of post-adoption services in Massachusetts. Massachusetts Department of Social Services.

[37] Nelson, K. (1985). *On Adoption's Frontier:* A study of special needs adoptive families. New York. Child Welfare League of America.
[38] Frans, K. (1993). Final Report: Warren Ohio: Northeast Ohio Post Adoption Family Support Project.
[39] Howard, J. and Livingston-Smith, S. (1997). *Strengthening Adoptive Families.* A synthesis of post legal adoption opportunity grants.
[40] Barth, Richard, Gibbs, Deborah and Siebenaler, K. (April 2001). *Assessing the Field of Post-Adoption Service: Family Needs, Program Models and Evaluation Issues.* Research Triangle Institute and University of North Carolina School of Social Work.

Barth, Smith and others identify risk factors for disruptions in adoptive family relationships, including:

- *Children with special needs.* When foster children have emotional, behavioral, social, medical or psychiatric challenges, they are at higher risk of experiencing difficulty forming and sustaining family relationships.
- *Children who are older.* Numerous studies have concluded that the older the child at the time of placement, the more likely the risk of placement disruption.[41] When children are older at the time of adoption, they are more likely to have been older when separated from their biological families and may have experienced deleterious effects of abuse and neglect. They may also have closer ties to biological families and may have developed behavioral reactions that make integration into a new family home more difficult.[42]
- *A child placed in a family with biological children.* When only one of the children within the family is adopted, stressors are created within the family system that may be difficult to address.[43]
- *Incomplete disclosure of information regarding the child's history and problems.* The more that families know and understand the needs and history of the child before adoption, the better informed their decision will be and the more prepared they will be to face the challenges that lie ahead.[44]
- *More highly educated mothers.* The studies that cite this phenomenon theorize that this could be in part due to the heightened expectations which more educated parents may have for their children and the accompanying lack of effective community resources available to these mothers.[45]

- *Family is unable to obtain needed support.* The support required to successfully meet the needs of children adopted from the child welfare system is often significant. Lack of provision of this support places the permanence of the adoption at risk.[46]

Barth also identifies characteristics of adoption preparation and support services which are associated with reduced risk of disruption, including:

- Comprehensive and realistic information about the child,
- Educational support throughout the adoption process, and
- Timely, flexible and long lasting adoption preservation services (including mental health services).[47]

Yet even in those circumstances where there is significant emphasis on finding and preparing families who can meet children's special needs, it often remains difficult for many adoptive families to find adoption-competent post-adoption mental health services as the need arises throughout the phases of the child's development and the family's adjustment to the lifelong process of adoption.

**Relinquishing Custody to Access Mental Health Services**

Adoption professionals and adoptive families alike report that in order to access necessary in-patient psychiatric or residential mental health treatment, many states still require adoptive parents to relinquish custody to the public child welfare or juvenile justice systems.[48] It is difficult to envision a more agonizing decision for any parent (birth or adoptive) to make than to *have* to give up the custody of a child to the state in order to access desperately needed mental health treatment services. The Commonwealth Institute for Child and Family Studies conducted a survey of 45 states and found that within 62 percent of them

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[41] Ibid.
[42] Smith, S.L., Howard, J.A. (1994). *The adoption preservation project.* Normal, Il: Illinois State University.
[43] Barth, Richard. (August 2001). *Designing Post Adoptive Services and Supports (PASS).* Presentation at Annual NACAC Conference.
[44] Ibid.
[45] Barth, Richard, Gibbs, Deborah and Siebenaler, K. (April 2001).

[46] Barth, R. and Brooks, D. (1997). "A Longitudinal Study of Family Structure and Size and Adoption Outcomes." Adoption Quarterly 1, 29-56.
[47] Barth, Richard. (August 2001). *Designing Post Adoptive Services and Supports (PASS).*
[48] See GAO Report, (April 2003). *Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services.*

(28 states) at least one agency used custody transfer to gain access to state funding for services for children with serious emotional and behavioral problems.[49] According to the report, parents face this dilemma because limits in private health care plans and unenforced entitlements in public health care plans deprive many children of access to needed mental health care, regardless of the family's financial circumstances. Yet, upon entering the juvenile justice or child welfare system, a child qualifies to receive publicly funded mental health services.

Thus, in the process of desperately seeking help for their children, adoptive as well as birth parents are often treated as abusive or neglectful, and deprived of the legal ability to raise their child.[50] Given the past history of abandonment and multiple relationship disruptions, the "return to state custody" is highly contraindicated, especially for adopted children. It is unlikely that such draconian conditions would be placed on access to physical health care. The stigma of psychiatric disability and the inadequacy of coverage for mental health in public and private insurance have made custody relinquishment all too common among parents of children with behavioral health needs.

**The Impact of Managed Care Within Child Welfare Systems**

Over the course of the past 15 years, state Medicaid systems have been enrolling consumers in managed care programs. In the past five to seven years, many children served within the child welfare system, whose health care is supported though Medicaid, have been included in these managed care reforms. While managed care reforms vary widely across the nation, the Health Care Reform Tracking Project 2000 State Survey reports that the services *most likely* to be covered by managed care reforms include:[51]

- Assessment and diagnosis
- Outpatient psychotherapy
- Crisis services
- Medical management
- Day treatment and partial hospitalization
- Inpatient hospitalization

Limitations on the length of time these services can be provided vary from contract to contract and state to state. No managed care contract allows unlimited access to these services regardless of the presenting need of the child. According to the survey, the services *least likely* to be covered by managed care reforms include:

- Respite services
- Therapeutic group or foster care
- Residential treatment

Because all of the services in the category least likely to be covered by the managed care system may be critically needed service components for children adopted from public child welfare systems, families are often forced to access these services outside the managed systems of care, either through private payment at exceedingly high costs, or as a last resort, allowing the public child welfare agency to take custody of their child.

The Health Care Reform Tracking Project also identifies a troubling trend in managed care network provider panels: just over one-half of the reform projects reportedly include child welfare providers (i.e., behavioral health providers that traditionally serve the child welfare population).[52] This finding has tremendous quality-of-care implications when those providers with experience and expertise in foster care and adoption are not included in the managed care provider networks. Adoptive families are then forced to seek help from professionals who do not understand the complexities of families built through adoption. Therefore, a significant amount of additional training in the delivery of culturally sensitive, adoption-competent mental

*"The sense of isolation is incredible … I just did not know so many others were experiencing what I have been experiencing."*

*— Adoptive Parent*

[49] Bazelon Center for Mental Health Law. (March 2000). *Relinquishing Custody. The Tragic Result of Failure to Meet Children's Mental Health Needs.*
[50] Ibid.
[51] Stroul, B., Pires, S. and Armstrong, M. (August 2001). Health Care Reform Tracking Project: *Tracking States Managed Care Reforms as They Affect Children and Adolescents with Behavioral Health Disorders and Their Families.* University of Southern Florida.

[52] Ibid.

health services will be needed by managed care providers because this training may not be included in the financial arrangements that states have with the managed care entities.

A number of additional concerns emerge from the Health Care Reform Tracking Project:

- In just over half of the reforms, the child welfare system is not significantly involved in planning, implementing and refining the behavioral health managed care systems. This means that the needs of children in the child welfare systems, especially those with special needs, such as post-adoption services, may not be adequately addressed.
- Fundamental services used by children in the child welfare systems and in post-adoption services are not covered in nearly half the managed care systems.
- Although most managed care reforms track utilization of services by children in the child welfare system (such as those with adoption subsidies), only 35 percent of those that track utilization actually use this information for ongoing system planning.
- Half of the managed care systems do not pay for services to family members of the identified child, unless the family is covered under the plan.[53]

On the more positive side, the Health Care Reform Tracking Project found that:

- Nearly two-thirds of the reforms have incorporated strategies for clarifying responsibilities for service provision and payment across child-serving systems.
- Most reforms are beginning to introduce special provisions for children in the child welfare system.
- Most reforms include "medical necessity" criteria that allow for consideration of psychosocial and environmental factors in clinical decision making regarding service authorization and access.[54]

"You simply cannot expect a child to attach to a new family when he/she has not faced and healed from the grief and loss of not being a part of his/her birth family."

— Debbie Riley
Executive Director
Center for Adoption Support
and Education

These data suggest that families with children adopted from the child welfare system, using Medicaid as their primary source of health care coverage, may have a difficult time accessing the services they need in general, particularly adoption-competent support and treatment.

**Availability of Post-Adoption Services and Implications for Practice and Policy**

The table below was developed by the American Public Human Services Association's Association of Administrators of the Interstate Compact on Adoption and Medical Assistance. It provides insight into the various post-adoption services available through state and local public child welfare agencies between March and October 1999.[55]

| Service | Number of States Providing the Service | Services Available Statewide | Services Provided by Public Agency | Services Provided by Private Agency |
|---|---|---|---|---|
| Adoption Search | 31 | 29 | 25 | 6 |
| Child Care | 20 | 18 | 14 | 6 |
| Crisis Intervention | 31 | 21 | 16 | 15 |
| Day Treatment | 11 | 9 | 7 | 4 |
| Educational Support | 19 | 15 | 5 | 19 |
| Family Therapy | 32 | 27 | 20 | 12 |
| Individual Therapy | 36 | 28 | 27 | 9 |
| In-home Services | 19 | 16 | 10 | 9 |
| Medical Services | 29 | 26 | 24 | 5 |
| Parent Training | 20 | 14 | 11 | 9 |
| Post-Adopt. Case Man. | 28 | 19 | 14 | 14 |
| Residential Treatment | 29 | 25 | 16 | 13 |
| Respite Care | 28 | 22 | 16 | 12 |
| Summer Camp | 18 | 15 | 12 | 6 |
| Supplies/Equipment | 29 | 26 | 24 | 5 |
| Support Groups | 26 | 15 | 11 | 15 |

[53] Ibid.
[54] Ibid.

[55] Oppenheim, E., Gruber, S., Evans, D. (October 2000). Report on Post-Adoption Services in the States. Association of Administrators of the Interstate Compact on Adoption and Medical Assistance, Inc. APHSA.

A report published by Illinois State University describing the array of post-adoption service efforts funded through the post-legal Federal Adoption Opportunity Grants[56] shows that the many innovative three-year programs funded through these grants had minimal sustainability after the funding ran out. Many programs no longer existed, the staff who envisioned the programs were no longer employed by the agency, and in some instances, the funded community-based provider was no longer in business. It becomes clear that greater investments are needed to find ways to sustain post-adoption services, especially adoption-competent mental health services and supports.

*"Delays [in adoption] cause more damage and trauma to children…"*

*— Adoptive Parent*

The information reviewed here highlights the reality that first, there are many states where post-adoption mental health services simply do not exist. Second, if they do exist they may be very difficult to access. Third, if accessed, there appears to be no guarantee that mental health practitioners have an adoption-sensitive understanding of the complex needs of adoptive families whose children face challenges to the stability of their mental health and well-being.

The preservation of adoptive families needs to be seen as one more component of a successful child-serving system of care. Since the experience of adoption has an impact at every developmental period and level, behavioral and emotional problems can occur at any point. The system of care for children and families – including the medical, social services, educational and behavioral health communities – needs to understand the impact of adoption on children and families (birth and adoptive) and be available to provide professional counseling, coaching, therapy, and support. A sense of urgency is needed within communities of legislators, policymakers, practitioners and advocates if adoption is to result in true permanency for children adopted from the public child welfare system.

# Adoptive Families' Perspectives on the Need for Adoption-Competent Mental Health Services

*T*he perspectives of adoptive families are critical to deepening the growing national understanding of their needs and experiences. The comments in this section are drawn from a diverse array of families whose adopted children have experienced significant mental health challenges. The voices of adoptive families were included from the following sources:

- A focus group convened by Casey Family Services with adoptive families who attended the Federation of Families for Children's Mental Health Conference in December of 2001;
- A review of a survey commissioned by the National Alliance for the Mentally Ill (NAMI) to draw attention to the mental health service needs of families of children and adolescents with serious mental illness in general;
- A review of a summary of conversations with foster/adoptive families in the state of Illinois collected by the North American Council for Adoptable Children (NACAC); and
- Personal conversations with adoptive families from across the country through a conference call co-sponsored by Casey Family Services and the NACAC, as well as follow-up conversations with these parents.

[56] Howard, J. and Livingston-Smith, S. (1997). *Strengthening Adoptive Families: A Synthesis of Post-Legal Adoption Opportunities Grants.* Center for Adoption Studies. Illinois State University.

These conversations reflect the struggles adoptive families' face in meeting the mental health needs of their children. Adoptive parents repeatedly report running into policy barriers, resource barriers and inadequacies in the competency of the mental health professionals around the issues of adoption and their children's mental health. As adoptive parents shared their stories, these core needs emerged:

- Increased adoption expertise within systems of health and behavioral health care;
- Better integrated health and mental health systems of care;
- Improved accessibility for adoptive parents to better information about their children's past experiences and present needs, and information about how to manage their children's developmental challenges; and
- Greater opportunities for adoptive family support from one another and from adoption-competent professionals who can see beyond troubling diagnoses.

**Feedback from Adoptive Families**

In November of 2001 Casey Family Services brought together a group of adoptive families at the annual national conference of the Federation of Families for Children's Mental Health to learn more about their needs, and more importantly, what works when it works. The 22 families involved in the focus group came from all over the country. They had diverse backgrounds and had adopted children from the public child welfare system as well as the private sector. Consultant Pamela Marshall facilitated the meeting. During the discussion, adoptive families shared stories of pain and struggle, as well as love and commitment, as they explained how they've learned to get their needs met.

"The system of care philosophy and value base that promote individualized care, partnerships with families, cultural competence, interagency collaboration and community-based services offer the opportunity to find allies and to work with both providers and policymakers to build the full range and type of services needed."

— Jan McCarthy
National Technical Assistance Center for Children's Mental Health
Georgetown University

The following includes samples of comments shared by this group of adoptive families:

*"The sense of isolation is incredible … I just did not know so many others were experiencing what I have been experiencing."*

*"I am so tired of being offered what is not needed and never being offered what is really needed!"*

*"Some of the agencies just don't get that they have to work with families … we are part of the problem and the solution."*

*"The system supports the child and blames parents: it is a nightmare."*

*"We need information about the behavioral health issues – the path of progression from birth to age 18 and the interventions needed along the way. We need competent mental health professionals who also understand this progression as adoptive families experience it."*

*"There is so little history provided about the child."*

*"We need to have voluntary foster care … the idea of giving up custody to get my child's needs met is fundamentally wrong … relinquishment of custody nearly broke my heart."*

Recommendations from this focus group of adoptive families focused on a system of health and mental health care which should, at a minimum, include these services:

- Offer coordinated services. Families are required to tell their stories repeatedly, with minimal collaboration among service providers.
- Provide adequate information about the mental health needs of their child in the context of the adoption experience.
- Facilitate opportunities for family support, from professionals and from one another, especially when the days seem too long and the problems seem too big.

Adoptive parents in the focus group reported that the educational system is often where children's mental health needs become most obvious. This is also where there is a disconnect between an understanding of the adoption experience and links to adoption-competent mental health services. One adoptive mother commented that *"schools have the opportunity to serve as a gateway to mental health services … but they often refuse."* Parents of children with serious mental illness – adopted or not – also confirm that they have experienced difficulty accessing the special education and mental health services needed by their children. The NAMI survey indicates that parents have found that individualized education plans are not responsive to children's individualized needs and that schools often resist identifying children with serious mental illness and thus miss opportunities to provide appropriate preventive or ongoing services.[57]

The North American Council on Adoption (NACA) asked adoptive families in Illinois to identify characteristics and circumstances where adoption support is successful or has the optimal chance of success. The families made the following recommendations to facilitate successful post-adoption support programs:

- *Access to Information.* Extensive and early information on their child's background, training and education on the behaviors to anticipate and appropriate interventions are provided. A "Personal Resource Package" with information about their child might include: the background[58] of their child; possible behaviors that may emerge; where to get further information about these behaviors; therapists in the community with expertise in adoption issues; contact numbers of other parents and/or local parent support groups who have children with similar issues; and information on siblings or extended family.
- *Knowledge of Systems.* Parents are educated on the system of care and how to advocate for their child/family.
- *Access to Support.* Parents also suggested other kinds of support that would be helpful to them including but not limited to: training on the delivery system and how to access services; and an adoption clearinghouse of information.
- *Access to Services.* Parents have access to more Intensive Adoption Preservation services. (Illinois has a statutory mandate to provide post-adoptive services in every county of the state. See Promising Practices Section on page 34 for full description).
- *Comprehensive Networks.* Parents are supported by all facets of the service system including respite options, networks of support and financial subsidies that meet needs.
- *Access to Advocacy.* Parents are provided advocates when needed. When parents get tired of advocating for services, they need support to sustain the battle.
- *Child Welfare Support.* Parents are supported specifically by the child welfare system.

*"For many parents this understanding [of the child's current behavior in light of the child's history] enables them to de-personalize their children's anger or emotional distance, allowing them once again to feel empathy for the child."*

— J. Howard and
S. Livingston Smith
The Illinois
Adoption/Guardianship
Program: The First Ten Years

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[57] "Families on the Brink: the Impact of Ignoring Children With Serious Mental Illness" - Results of a National Survey. (July 1999). National Alliance for the Mentally Ill.

[58] Background information would include: medical, developmental and birth history; social, psychological and trauma history; a behavioral assessment; and important information about the child's family constellation and extended family connections.

• *Openness in Services*. Parents wanted openness between the serving systems: professionals that talk to one another about a child and family they are serving. They don't hide behind the guise of confidentiality.

• *Continuity of Service with Adoption-Competent Professionals*. Parents wanted helping professionals who understand the unique issues that adoptive families face, are available over time, and can customize practice interventions.[59]

## Adoptive Families' Definition of Adoption-Competent Professionals

Adoptive families and adoption professionals alike have begun to define what adoption-competent mental health professionals do that makes their work with adoptive families responsive and helpful. This emerging list of characteristics of adoption competence includes mental health professionals who:

• Know that adoption is one way to form a family and know that adoption is a life long process, with remarkably universal experiences as well as unique individual feelings and perceptions;

• Recognize that parenting relationships and family connections are the single most therapeutic element in the life of a child over time;

• Understand that there are common developmental challenges in the experience of adoption;

• Help families promote secure attachments and healthy relationships no matter what the developmental challenges;

• View adoption from a culturally competent *family perspective*: understanding the power of the triad of family relationships;

• "Balance the power" with adoptive families, collaborating with them as team players and colleagues toward the mutual goal of helping a child to heal;

• Avoid blaming adoptive parents for their children's behaviors, reframe everyone's goal as being "part of the solution";

• Help adoptive parents honor their child's past and talk with their child about separation, loss and feelings about birth parents;

• Support adoptive parents in assuming parental entitlement and authority, fully empowering them as decision makers and "experts" when it comes to their child and family;

• Recognize and respect the characteristics and skills that make adoptive families successful and assist families in developing and practicing those skills;

• Work to provide in-home and outreach services to families that meet them "where they are"; and

• Recognize that temporary out-of-home treatment may be essential (not a "failure" in the adoption) and work to keep the child and family connected and reunified as soon as possible.[60]

"We need information about the behavioral health issues – the path of progression from birth to age 18 and the interventions needed along the way…."

— Adoptive Parent

[59] Howard, J. and Livingston-Smith, S. (1995). *Adoption preservation in Illinois: Results of a four-year study.* Springfield, Ill. Department of Children and Family Services.

[60] Characteristics of adoption competent professionals build on the following research:
Howard, J. and Livingston-Smith, S. (1997). *Strengthening Adoptive Families: A Synthesis of Post-Legal Adoption Opportunities Grants.* Center for Adoption Studies. Illinois State University.
Spaulding for Children and the National Consortium for Post-Legal Adoption Services. (1996). Adoption Support and Preservation Services: A Public Interest.
Conversations with adoptive families and adoption professionals.

# Promising Practices in Adoption-Competent Mental Health Services: A Beginning Look

Families' stories about their experiences and recommendations regarding adoption-competent mental health services have guided this exploration of promising practices in adoption-competent mental health services across the country. Through conversations with adopted families and a variety of adoption professionals who work with them, this search for "Promising Practices in Adoption-Competent Mental Health Services" has identified a blend of public policies, funding strategies and mental health programs that promote exciting and innovative practices with adopted children and their families. Together these strategies can improve the breadth and responsiveness of services to adopted children and their families. Partnerships are needed with state child welfare agencies and their counterparts in mental health and Medicaid to engage in planning and implementation of an array of adoption-competent mental health services, supports and educational opportunities for adoptive families and professionals alike. The following discussion highlights an array of specific examples of promising adoption-competent child welfare and mental health programs and practices that can serve as a guide to states as they plan strategies to meet the ongoing mental health needs of adopted children and their families.

**Low-Cost Family Education, Support and Networking Group Opportunities**

Research has begun to show that support groups for adoptive parents and children are a major component of successful adoption services and one of the most powerful and helpful preventive interventions available to adoptive families.[61]

The range of prevention-oriented adoptive family support and education services falls into several categories including: Information and Referral, Support Groups, Internet Chat Rooms and Educational Materials via the Internet.

For adoptive parents, support groups serve to normalize children's behavior or to provide positive comparisons. They provide parents a safe place to express their feelings with others who share similar concerns and parenting experiences. Parents can also gain a sense of being understood and supported and get practical advice from other parents on how to handle challenging behaviors. Parent support groups provide the essence of a normative approach to the delivery of mental health services and can lead to the early identification of issues that may need more frequent or intensive intervention, as well as links to resources in the community. Outreach both before and after adoption legalization helps families become involved as early as possible in this key preventive services strategy. These efforts can help keep adoptive families together.

While there are many types of adoptive parent support groups in existence across the country, three examples of support groups from the states of Minnesota, Illinois and Pennsylvania are highlighted here.

**Parent Support Groups: Minnesota Adoption Support and Preservation**

In Wright and Sherburne counties of Minnesota (northern suburbs of Minneapolis), a support group has been funded– through the state and resources from NACAC – called Minnesota Adoption Support and Preservation (MN ASAP). Julie Pribyl, a parent liaison with MN ASAP, reports that after receiving the funds, the first challenge was to find adoptive families that needed support. They put advertisements in newspapers, radios and notified community-based counselors and school counselors, churches, etc. to get the word out about the new support group. According to Prybil, it did not take long:

*"This was one of the biggest gifts that this program gave to our family…early and effective diagnosis and intervention."*

— Adoptive Parent

[61] Livingston-Smith, Susan and Howard, Jeanne. (1998). *An evaluation of the Adoption Preservation Program.* Illinois State University.

*"We have been thrilled by the numbers of parents who attend the group. They really see the group as a form of self-care. Sometimes we share heartbreaking stories, sometimes we share resources tips and sometimes we laugh so hard that we cry."*

Adoptive parents are provided written information on problem solving and behavioral interventions. They also learn tips from one another on which interventions have been most (or least) successful with their adopted children. They share information about adoption-competent primary care physicians, mental health therapists or schools that understand the educational needs of adopted children. *"It's our place to get recharged,"* says Prybil, *"to celebrate even the smallest successes. Soon these families learn to lean on one another at difficult times outside of the group. They become one another's life line when things seem very hopeless."* [62]

**Supports for Children and Parents: Illinois Adoption Preservation Services Support Groups**

Communities in Illinois spent several years struggling to develop their support group programs for adopted families as part of their overall adoption preservation programs. According to Susan Smith and Jeanne Howard, who conducted the research on Illinois Adoption Preservation Programs, the reports from social workers and feedback from adoptive parents suggest that the child and parent support groups are powerful in helping families work through their issues and stay together. Workers cited the value of the support groups in helping parents see the behavior of their child in a new context (i.e. making sense of behaviors in light of the child's history).[63] Further, these groups provide a supportive structure for family members to share their feelings of shame and guilt. Finally, the groups have provided the opportunity to learn from other parents and develop strategies for dealing with family problems.

> *"We have been thrilled by the numbers of parents who attend the group. They really see the group as a form of self-care. Sometimes we share heartbreaking stories, sometimes we share resources tips and sometimes we laugh so hard that we cry."*
>
> — Julie Pribyl
> Parent Liaison
> Minnesota Adoption Support
> and Preservation

Numerous families report that family support throughout their child's development is tremendously helpful, especially talking to parents who have already gone through a particular developmental period or crisis. One parent was quoted as saying, *"I would have liked this kind of support 12 years ago when we first adopted and wish that it could have continued through each stage of development."* Adoptive parents requested that groups be established that were specific to developmental periods such as going off to school, onset of puberty, leaving the house for college, etc. Some families expressed difficulty getting to the support groups due to the travel time, conflicts with mealtime and cost of transportation. Various sites in Illinois try to minimize these challenges by having families eat meals together at the beginning of the group and by subsidizing, in part, the cost of transportation.

According to Smith and Howard, the children's support groups also have a positive track record. Workers report that for many children the group is the child's first real contact with a peer network of other adopted children. The groups help children see that other children share their fears and feelings. They have an opportunity to safely talk about their birth families and their feelings of loss, fear, longing and confusion that they may be uncomfortable expressing within their adopted families.

Surveys of adoptive parents regarding their children's support group provided some interesting feedback about the benefits of support groups for adopted children. Parents provided the following responses when asked, "As a result of the support group my child is …":

| Item | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| Better able to understand adoption | 15% | 50% | 35% | 0% | 0% |
| Better able to talk to me about concerns | 15% | 29% | 34% | 17% | 5% |
| Helped by being with other adoptees | 32% | 46% | 22% | | |
| Better able to understand his/her feelings | 8% | 40% | 40% | 13% | 0% |

[62] Personal communication with Julie Prybil, parent liaison with Minnesota Adoption Support and Preservation program. (December 2001).
[63] Howard, J. and Livingston-Smith, S. (1995). *Adoption Preservation in Illinois: Results of a Four-Year Study.* Illinois Division of Children and Family Services. Springfield, Illinois.

**Internet Technology Opportunities to Link Families with Information and Support: Together as Adoptive Parents: Pennsylvania**

Phyllis Stevens, director of Together as Adoptive Parents in Harleysville, Pennsylvania, reports that Together as Adoptive Parents helps adoptive families to find adoption-competent community mental health practitioners. Funded by the State, the organization has created an interactive website that provides data on therapists from around the state. Prospective adoption therapists were sent a survey developed by adoptive families that included the following questions:

- How many adoptive families do you work with on a regular basis?
- Where did you get your training?
- Have you presented at any training conferences?
- What do you think are the most significant issues facing adoptive families?
- What are your two most effective intervention strategies?

As of 2002, the website had profiles of over 140 adoption-competent therapists and their responses to the survey questions. The data is broken down by county, and according to Stevens, the site reaches almost all of the counties in the state. Any adoptive family needing a mental health practitioner can check the website to conduct their own evaluation of the therapists in their area based on the data provided.

Also included in the website are an array of service options and funding information for families including camps that are sensitive to the mental health needs of children; schools that do a good job of serving special needs children (public and private); day treatment centers; and tutors who can assist children struggling academically. Recently the website added a chat room called "Adopt Talk" where families can talk to other families struggling with similar issues. *"We want to provide hope and*

*"We are seeing almost a daily growth in the use of the chat room. Families want to talk to other families and know that they are not alone and not crazy."*

— Phyllis Stevens
Director
Together as Adoptive Parents

*education to families,"* states Stevens. *"We are seeing almost a daily growth in the use of the chat room. Families want to talk to other families and know that they are not alone and not crazy."*

**Comprehensive Approaches to Adoption-Competent Support, Education and Mental Health Services**

The comprehensive services approach to post-adoption services is best described in a 1996 monograph published by Spaulding for Children and developed by the National Consortium for Post-Legal Adoption Services[64] and enhanced by the work of Howard and Smith of the Center for Adoption Studies at Illinois State University.[65] They describe a multi-level approach to adoption-competent service delivery. Elements of this approach are reflected in practice around the country as states struggle to maximize their limited resources to meet the complex needs of adoptive children and families. The following diagram, adapted from the work of Smith and Howard and the National Consortium, represents the mix of components of this comprehensive approach which includes a strong family-centered philosophy about the unique aspects of adoption as one way to form a family, partnerships needed to implement comprehensive adoption-competent services and the array of prevention and intervention services needed episodically by adopted children and their families. The National Adoption Consortium for Post-Legal Adoption Services also found that when a comprehensive array of adoption-competent post-adoption services and supports are available, certain positive outcomes for adoptive families are likely to be present, including:[66]

- Strengthened family integration
- Strengthened attachment
- Strengthened family functioning
- Strengthened parental entitlement and claiming
- Strengthened identity formation of family members
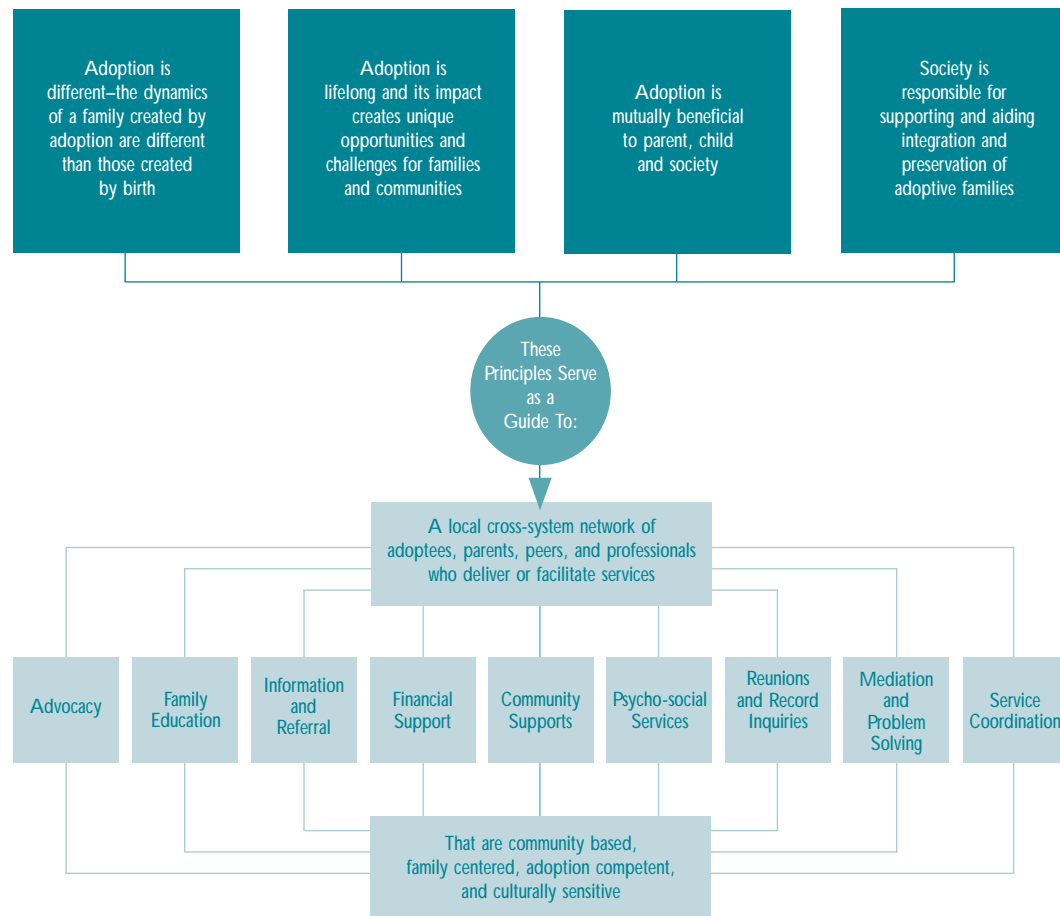- Strengthened community networks

*"Every child has different life experience and therefore has different needs to be addressed."*

— Adoptive Parent

[64] Spaulding for Children & the National Consortium for Post-Legal Adoption Services. (1996). *Adoption Support and Preservation Services: A Public Interest.*
[65] Livingston-Smith, S. and Howard, J. (1997). Strengthening Adoptive Families: *A Synthesis of Post-Legal Adoption Opportunity Grants.* Center for Adoption Studies; Illinois State University.
[66] Spaulding for Children & the National Consortium for Post-Legal Adoption Services. (1996). p. 19.

Adoption is different—the dynamics of a family created by adoption are different than those created by birth

Adoption is lifelong and its impact creates unique opportunities and challenges for families and communities

Adoption is mutually beneficial to parent, child and society

Society is responsible for supporting and aiding integration and preservation of adoptive families

These Principles Serve as a Guide To:

A local cross-system network of adoptees, parents, peers, and professionals who deliver or facilitate services

| Advocacy | Family Education | Information and Referral | Financial Support | Community Supports | Psycho-social Services | Reunions and Record Inquiries | Mediation and Problem Solving | Service Coordination |

That are community based, family centered, adoption competent, and culturally sensitive

It is extremely challenging for any single agency to develop this comprehensive array of post-adoption services primarily due to funding limitations. While achieving more timely permanency through adoption has been a federal priority for close to a decade, there is not one federal funding stream dedicated to adoption or post-adoption services. However, states are increasingly using a mix of federal funds (e.g., Title IV-B, Parts 1 & 2; Title IV-E, Maintenance, Training and Administration; Medicaid; TANF; Social Services Block Grants; Adoption Incentive dollars; and Discretionary funds), as well as their own state resources and staff development time to create comprehensive post-adoption services. Agencies appear somewhere along this continuum in their development of the component parts of this comprehensive array. Several are highlighted here, including the Centers for Adoption Support and Education and Casey Family Services' post-adoption service approaches.

**Center for Adoption Support and Education:
Silver Spring, Maryland**

The Center for Adoption Support and Education (CASE) is one example of an agency that has been successful in developing a comprehensive approach to adoption-competent mental health, educational and supportive pre- and post-adoption services. Located in Silver Spring, Maryland, CASE is a nonprofit organization serving families in Maryland and Virginia. CASE infuses adoption-competent practice into all facets of its work, providing a strong array of adoption-competent mental health services, and is funded through a mix of grants, fee-for-service contracts and Medicaid funds. Executive Director Debbie Riley reports that finding a steady stream of funds to support the agency's efforts is a great challenge. In addition to its direct services, CASE is committed to providing national consultation and training to increase the adoption competence of other child welfare and mental health programs.

The CASE array of comprehensive adoption-competent services involves a four-pronged approach with the following components:

1. *Adoption-related mental health services with individuals, groups and families.* The mental health interventions of CASE address the grief, loss, abandonment and identity issues of the adoptive child and his/her adoptive family. According to Riley, *"You simply cannot expect a child to attach to a new family when he/she has not faced and healed from the grief and loss of not being a part of his/her birth family."* CASE therapists are trained extensively to look at child behavioral issues through a developmental lens (both cognitive and behavioral) and to provide an intense therapeutic focus on ways to understand and manage feelings of grief and loss. Adoptive parents are helped to work through their own struggles of lost dreams and feelings of shame and guilt. Children and families also are involved in group activities that seek to normalize their experiences. Strong treatment plans with clear treatment objectives are key to the work at CASE.

"You simply cannot expect a child to attach to a new family when he/she has not faced and healed from the grief and loss of not being a part of his/her birth family."

— Debbie Riley
Executive Director
Center for Adoption
Support and Education

According to Riley, *"This is complicated work that requires thoughtful and planful intervention."*

2. *Adoption-competent consultation with child welfare agencies.* Over the past several years, CASE has responded to requests from public and private child welfare agencies for training and case-specific consultation regarding ways to help adoptive families stay together. CASE has worked with the states of California, Connecticut and Delaware to train staff in adoption-competent mental health issues and to map out their post-adoption strategies based on the nuances of populations they serve, existing partnerships and the expectations of adoptive families. According to Riley, *"States are hungry to better understand both the components of a comprehensive post-adoption system of services and supports and how to educate providers throughout this system of care."*

3. *Educating and working with school systems.* Staff at CASE have observed that there is a strong correlation between disruptions in adoptive family relationships and school problems. Thus, to prevent relationship disruptions and adoption dissolutions, CASE clinicians work with school system personnel in both the regular and special education settings. Clinicians are trained to understand the Individualized Educational Planning process, as well as the treatment planning process within a school setting. Staff help families better communicate with educators about the needs of their adopted children.

Recently, CASE implemented a training program for the school environment that targets teachers, school social workers and psychologists. The training seeks to influence their diagnoses, evaluations and educational and treatment strategies. The training model includes

five themes aimed at creating an adoption-sensitive environment in schools including: acceptance, accuracy, assignment, assistance and advocacy. This comprehensive focus helps school personnel understand children's behaviors in the context of adoption and learn ways to provide opportunities for adopted children and their classmates to better understand and normalize the adoption experience.

4. *Publications and Articles.* CASE has made a strategic decision to increase its publication efforts. By sharing the lessons learned in their mental health services with adoptive families, they hope practitioners will better understand the issues faced by adopted children and their families. Then, they will be able to develop more adoption-competent therapeutic models and mental health service arrays.

**Casey Family Services: Comprehensive Post-Adoption Services Programs**

For more than a decade, Casey Family Services has provided comprehensive post-adoption services throughout New England. In 1991, the Bridgeport and Hartford Divisions began their Post-Adoption Programs by responding to the needs expressed by adoptive families in those Connecticut communities. These families had come together through the efforts of the Department of Children and Families or had adopted children through other domestic or inter-country means. Regardless of the circumstance of their adoption, coaching families reported that they needed specialized education and supports, service referrals and sometimes more intensive therapy to better understand and cope with the ongoing process of adjustment. Casey Family Services initially provided training for staff in adoption-competent social work practice that was guided by the theories and practices of many in the adoption world.

> "States are hungry to better understand both the components of a comprehensive post-adoption system of services and supports and how to educate providers throughout this system of care."
>
> — Debbie Riley
> Executive Director
> Center for Adoption
> Support and Education

Casey Family Services now provides an array of comprehensive post-adoption programs within six of its eight divisions. Casey Post-Adoption Programs in Bridgeport, Hartford, Maine, New Hampshire, Rhode Island and Vermont have invested in developing partnerships with each respective state, with a particular interest in meeting the needs of the increasing number of children who have been adopted through state child welfare systems, their contract agencies, and Casey Family Services' foster care programs.

Each of Casey's divisions has a unique approach to working with adoptive families. However, each division provides a core array of adoptive family supports, including:

- Individual family counseling
- Advocacy efforts – case, interagency and systems
- Adoption-competent training for mental health and education professionals
- Community adoption awareness and education
- An array of support groups for parents and children, and workshops for parents
- Community activities for children and families

*"There is so little history provided about the child."*

*— Adoptive Parent*

Over time, staff have learned from the experiences of seasoned adoption professionals, therapists and families themselves that adoption is a lifelong process, and thus, families need episodic assistance at different points in their family life cycle. Staff also have expressed the need for specialized adoption-competent training and support to better assist adopted children and their families in understanding and sustaining their family relationships.

For example, the Vermont Division offers an array of services and supports organized through a "levels of service" approach. Families can participate in groups and individual family-centered services of varying levels of intensity. They can also be connected to a network of therapists across the state who have been specially trained (through an Adoption

Opportunities grant partnership) in adoption and attachment theory/strategies. Families engage in an array of services for as long as they need them, or episodically.

In 1997, a group of Vermont's adoptive parents met with the leadership of Vermont's Mental Health, Social and Rehabilitative Services (child welfare) and Education Departments to heighten their awareness of the need for adoption competency throughout the life cycle of adoptive children among therapists, educators and child welfare staff. The Vermont Division's Post-Adoption Services Program is a member of the Vermont Adoption Consortium, a collaboration of agencies, funded in part by the State of Vermont's Social and Rehabilitative Services, which provide coordinated information, intakes, groups, services, supports, therapy, training and educational advocacy with pre-adoptive and adoptive families throughout the state.

The Bridgeport Division's Post-Adoption Services Program provides an array of in-home and office-based services and supports with adopted children and families. Staff provide individual and family counseling and support as well as focused and ongoing groups that address families' special concerns. Bridgeport staff also link families with therapists within the community who have received specialized training in adoption-related theory and interventions (a network initially developed through an Adoption Opportunities grant). In addition, Bridgeport post-adoption staff provide many opportunities for the general community to understand adoption through public speaking engagements, community forums and technical assistance with community agencies.

The Rhode Island and New Hampshire Divisions provide opportunities for adoptive families to engage in a range of comprehensive supports, educational groups and advocacy efforts, as well as individual and family counseling. In Rhode Island, children with serious mental health issues may be evaluated by the division's consulting psychiatrist. The Rhode Island

Post-Adoption team helps adoptive parents understand and address issues related to the impact of early trauma, separation and loss on child development and the new adoptive family's emerging relationships. The team in Rhode Island has provided many one-day training workshops across the country related to trauma, attachment and child development. The New Hampshire Post-Adoption Program staff also work with mental health clinicians to increase their competency in providing therapy with adoptive families and access to respite services.

Post-Adoption Programs in Bridgeport and Hartford, Connecticut, and Rhode Island, have developed relationships with their respective state child welfare departments to accept referrals of foster families transitioning to adoption. They help to prepare children and families for what to expect and provide the comprehensive post-adoption services they will need once their adoptions are finalized. (The Maine Division's Title IV-E Waiver Post-Adoption Services partnership with the Department of Human Services is described in a later section.)

Staff from Casey Family Services' Post-Adoption Programs also are engaged as consultants with the Casey Center for Effective Child Welfare Practice to provide technical assistance to public and private agencies around the country related to post-adoption services policy and practice-related issues. The Casey Center provides consultation related to strategic planning, policy analysis and adoption-competent training to improve the likelihood that the increasing number of adoptive families across the country will have the supports, education and treatment services needed to sustain their new families.

**Adoption-Competent In-Home Therapeutic Intervention Programs**

There are several examples of adoption-competent mental health assistance provided through intensive in-home adoption preservation programs. These services offer hands-on crisis intervention and long-term support with pre-adoptive

and adoptive families through challenging times. Two unique examples are highlighted below, including programs in Boulder County, Colorado, and within the state of Illinois. In Boulder County, when indicated, in-home health and mental health services are provided immediately upon the foster, pre-adoptive or adoptive placement of young children in order to address developmental and behavioral concerns in a preventive way. In Illinois, the statewide in-home adoption preservation program, which evolved from the family preservation movement, is available to families voluntarily seeking services when the stability of the adoptive family is at risk. A description of these programs follows.

**Early In-Home Intervention: The Community Infant Program of Boulder County, Colorado**

The Community Infant Program in Boulder County, Colorado, is a collaborative effort of the Mental Health Center of Boulder County Inc., Boulder County Health Department and Boulder County Department of Social Services. The program is funded through Medicaid resources, state and county funds and Maternal and Child Health Title V dollars. Through this collaborative effort, nurses are assigned to high-risk young children and families identified through hospitals, community health settings and child welfare services.

Deborah, an adoptive parent from Boulder County who has cared for her adopted daughter "Sarah" since she was 5 months old, described her family's experiences with this in-home program:

*"When we first took Sarah into our home, she was awake every hour, constantly crying, with severe stomach pains. The most she would take was two 15-minute naps during the day. She simply refused to fall asleep … Sarah's birth parents reportedly had used drugs, engaged in a considerable amount of domestic violence and had been homeless on and off during the baby's first months of life."* [67]

[67] Personal communication with Deborah, an adoptive parent. (November 2001).

A nurse from the Community Infant Program was assigned to work with Sarah when she was placed with Deborah. A nurse also was assigned to work with Sarah's birth father, who remained interested in gaining custody of his child. The two nurses, while assigned to the different families, worked collaboratively with one goal in mind: to provide assessment and therapeutic services that would contribute to decisions about the child's best interest.

By the time Sarah was 1 year old, she had been assessed by speech and occupational therapists. The family was involved in therapy to learn how to adjust to Sarah's needs, a service which was funded by Medicaid. The case team involved Sarah's birth father, Deborah, the Boulder County child welfare social worker, the Court-Appointed Special Advocate (CASA) worker, the nurse and the speech and occupational therapist. While it was decided by Sarah's father over time that the final permanency plan would be adoption, the father was respectfully included in the treatment and decision-making process.

As Sarah grew, this team of professionals helped Deborah and her family understand and differentiate between "normal" toddler behavior and those behaviors that may have been caused by trauma. Play therapy was used as a strategy to help Sarah work through behaviors that appeared to be related to early trauma. Deborah reported that the most important benefit of the team approach to early in-home intervention involved the capacity to address trauma experiences early on in Sarah's life, before the range of negative behaviors had a chance to broaden. *"This was one of the biggest gifts that this program gave to our family … early and effective diagnosis and intervention,"* [68] said Deborah.

When asked if the team met consistently to review case progress, Deborah indicated that though they tried, this was an area where the team struggled.

*"I pretty much had to serve as the linchpin keeping things together, making sure that they all knew what the other was doing … It was a lot of work … However, thanks to the work of this team, by the time that Sarah was 6 years old and free to be adopted by our family, she was a stable and healthy 6-year-old …."* [69]

### Statewide In-Home Support and Treatment Services: Illinois Adoption Preservation Program

The Illinois Adoption Preservation Program was initiated in the summer of 1991 with funding for programs in Cook County and Metropolitan Family Services in DuPage County. By 1994, the program was expanded to every Department of Children and Family (DCFS) region and most counties in Illinois. The state legal mandate for providing family preservation services to adoptive families specifies that services are provided to adoptive families who are at risk of child placement disruption or adoption dissolution. The state law reflects the understanding that children who have experienced the range of negative early-life experiences, such as those common to children in the child welfare system, are at risk of later challenges. [70]

Research about the Adoption Preservation Program by the Center for Adoption Studies at Illinois State University indicates that families served have complex problems which put them at risk of adoption placement disruption or dissolution. For example, the majority of families served have children who were previously served by DCFS, with just over one-quarter adopted by relatives. Children were reported to have experienced an array of factors that may have put them at risk of adoption placement disruption or dissolution, including: multiple types of prior maltreatment, the presence of attachment problems, a diagnosis of mental illness including child depression, the presence of symptoms of Post Traumatic Stress Disorder, one or more disabilities with Attention Deficit Hyperactive Disorder, and older age at placement.

[68] Ibid.

[69] Ibid.
[70] Howard, J. and Livingston-Smith, S. (June 2001). *The Illinois Adoption/Guardianship Preservation Program: The First Ten Years.* Center for Adoption Studies, Illinois State University.

One-quarter of the children served have required out-of-home treatment services since the adoption, with psychiatric hospitalization the most common type of placement. At the end of services, 87 percent were again living in their adoptive families' homes. The remaining 13 percent of the children were not living with their adoptive families at the end of services (2/3 were placed in residential and foster family care, and 1/3 living with relatives or in hospital care).

From its inception, Adoption Preservation in Illinois has had three integrated service components: 1) time-limited intensive services with crisis response capacity, 2) adoption support groups and 3) linkage to community resources. Intensive therapeutic services involve traditional casework services, such as family and individual counseling, as well as therapeutic interventions specific to common issues related to adoption. Smith and Howard report that many parents come to this program emotionally exhausted and unsure of their ability to take care of their children. Workers help these adoptive parents establish or re-establish a sense of empowerment and competence.[71] The intensive services include in-home family counseling, individual work with children and parents and crisis intervention as needed. The program begins with an in-depth assessment that builds on past assessments and helps families understand the information that has been compiled about their child and their family. In addition, workers may conduct additional assessments or verify the accuracy of prior assessments. Twenty-four-hour availability to adoptive families is part of each adoption preservation program.

The overarching strategy of the Illinois model is to work with adoptive parents to reinforce their sense of competence as parents and their ability to act effectively on their child's behalf. The work includes educating parents about adoption and its impact on children, helping them revisit their child's pre-adoptive history and interpreting their child's current behavior in the context of this history. They also help parents gain behavior management skills, break ineffective cycles of parenting and gain access to community resources that can help them help their child.[72] In addition, children are provided with separate opportunities to manage their grief and loss.

While many families have received assistance from helping professionals prior to this service, according to the families served, those professionals rarely addressed issues related to the child's past history. Adoption Preservation workers help the families reconstruct their children's histories. They help parents and children understand their child's current behavior in light of the child's history. For many parents this understanding enables them to "de-personalize" their children's anger or emotional distance, allowing them once again to feel empathy for the child.[73]

**Training Partnerships to Develop Innovative Adoption-Competent Professional Educational Models**

To develop and sustain community-based adoption-competent mental health services, some jurisdictions have chosen to invest in the adoption competence of existing child welfare and mental health practitioners within their communities. The following section describes several innovative strategies for educating and supporting child welfare practitioners, community-based providers and mental health professionals to increase the capacity of existing community service providers to meet the complex mental health needs of the increasing numbers of adopted children and their families. More states are exploring ways to implement these exciting learning and capacity building opportunities. (For example, Oregon and Rhode Island Adoption Managers have been planning professional education programs that may be implemented within the 2003-2004 program years.)

*"The odds of a child having pre-adoption abuse are very high. The odds of an older child being unable to form a healthy family attachment without long and expensive support services are very high. The odds that a family who adopts that child will not live in a community with other adults who understand what children with those experiences look like in a family setting and what they need to survive are very high."*

*— Adoptive Parent*

[71] Ibid.

[72] Ibid.
[73] Ibid.

**Adoption Practice Certificate Program for Public Agency and Mental Health Professionals: The State of New Jersey/Rutgers University School of Social Work**

The State of New Jersey's Division of Youth and Family Services' (DYFS) Adoption Program has used a federal Adoption Opportunities Grant to partner with the School of Social Work at Rutgers, the State University of New Jersey, to develop an Adoption Practice Certificate Program for child welfare practitioners and community mental health providers. The DYFS Adoption Program used the grant funds to support development of the curriculum and to pilot the training with 11 community agencies that presently provide post-adoption services under contract with the state. Approximately $28,000 was provided to fund the initial pilot year. The first group of trainees offered constructive feedback regarding the course format and content. Continuing Education Units fees/tuition will sustain this Adoption Opportunities Grant-funded project at the end of the three-year grant period.

The grant's consulting psychologist took the lead in formulating the overall course outline and identifying adoption-experienced instructors. Individual instructors then developed their part of the course curriculum. Rutgers sponsors an Advisory Group to oversee the development of the Adoption Practice Certificate Program. The curriculum is intended both to increase the knowledge that mental health practitioners have regarding the core issues facing many adoptive families and to expand their clinical skill regarding attachment-focused, family-centered and culturally sensitive therapeutic interventions.

The certificate training effort began in September 2001 initially funded with grant dollars, while the second program year was funded through a blend of the federal funds and tuition payments. The program includes nine full-day classes (one per month) that address theory and research, as well as therapeutic skills courses. Each one-day course earns partici-

"There is just not enough investment in post-adoption child welfare services….It will be wonderful when we get to a time where the schools of social work and the child welfare system as a whole invests time and resources in this under-funded, under-taught piece of the service link."

— Christine Gradert
Vice President
Family Resources, Inc.

pants five continuing education hours. At the completion of the 45-hour course work, participants receive an Adoption Practice Certificate from the Rutgers University School of Social Work, Continuing Education Program. The nine one-day courses form the core curriculum of the Adoption Practice Certificate Program and include:

- The Psychology of Adoption
- Issues of Adoption with Older Children
- Life Cycle Experience of Adoption/Children Adopted as Infants
- Life Cycle Experience of Adoption for Older Children
- Attachment-Focused Therapy with Adoptive Families
- Family-Focused Therapy for International or Post Institutionalized Children
- Management of Behavior Problems & Discipline for Traumatized Child
- Individual and Group Therapy with Adopted Children, Teens & Families
- Special Clinical Issues in Adoption

Over 30 clinicians attended the first year's Certificate Program, and according to Ellen Kelly, DYFS case practice specialist, participant evaluations indicated that satisfaction with the training/continuing education was extremely high. The second program year is booked to capacity with community-based post-adoption services clinicians and community mental health practitioners.

**Post Graduate Certificate in Foster Care and Adoption Therapy: Antioch University and the Northwest Adoption Exchange**

The Northwest Adoption Exchange has partnered with Antioch University in Seattle, Washington, to secure funding from the Bill and Melinda Gates Foundation and the M.J. Murdock Charitable Trust to create the Post Graduate Certificate in Foster Care and Adoption Therapy. According to Mary Carter-Creech, Antioch University:

*"The Northwest Adoption Exchange (NWAE) provided leadership to develop this certification program to expand and enrich mental health practitioners' therapeutic knowledge and skill in providing therapy with foster children and the families who come forward to adopt them. Together, NWAE and Antioch University/Seattle designed the curriculum, building on the university's expertise and experience in developing other certification programs."*

To assure that the curriculum addresses the needs of the foster care and adoption provider community, NWAE conducted research and surveyed foster care and adoption workers, therapists and families about what they viewed as the relevant issues and concerns related to working with families transitioning to and choosing adoption. The program was launched in October 2001. Classes of 20 practitioners meet once a month for nine months for 10 hours over a Friday and Saturday. Instructors are national and local experts in the field of foster care and adoption therapy.

The certificate curriculum includes the following sampling of course topics:

- Foster care and adoption from the child's and parents' perspective
- Normal vs. abnormal child psychological development
- Child sexual development and impact of sexual abuse
- Fetal Alcohol Syndrome/Effect (FAS/E) and other neurological issues
- Attachment and the assessment and diagnosis of Reactive Attachment Disorder
- Trauma and the assessment and diagnosis of Post-Traumatic Stress Disorder
- Childhood disorders and other mental health issues
- Learning development and Attention Deficit Hyperactive Disorder
- Adapting theoretical perspectives to work in foster care and adoption therapy

Therapists who complete the certification program are awarded a certificate and expected to meet to required post-graduate educational requirements. Further, the names of therapists who have completed the curriculum are shared with the Washington State Adoption Support Program, which can, in turn, share the list with adoptive families who call them requesting community-based mental health resources.

The Northwest Adoption Exchange believes that by increasing the number of therapists who have completed a certification program designed to educate them to the singular needs and special needs of adoptive families, the options will increase when families need adoption-competent therapy. By marketing and sustaining this certification program within an established educational institution, the adoption community is assured that there will be therapists in practice who will be competently educated and trained to work with the growing number of adoptive families in Washington state.

**Outreach, Training and Support with Agency Staff and Social Work Students: The Center for Adoptive Families: Baltimore, Maryland**

The Center for Adoptive Families (CAF) is the first comprehensive pre- and post-adoption counseling and education center in the Baltimore/Washington area. It is a program of Adoptions Together, Inc. Since 1993, CAF has supported all members of the adoption triad including adoptive parents, birth parents and adoptees. The Center also provides outreach to schools, medical providers and the general community to ensure success in maintaining strong and healthy adoptive family relationships. According to Center Director Louise Fleischman, *"Adoption is the ultimate merger of nature and nurture, where genetic heritage and parenting come together to form the individual. As such, we take a "wellness" approach and view adoption as a one-time event with lifelong implications."* [74]

*"Adoption is the ultimate merger of nature and nurture, where genetic heritage and parenting come together to form the individual. As such, we take a 'wellness' approach and view adoption as a one-time event with lifelong implications."*

— Louise Fleischman
Director
Center for Adoptive Families

[74] Personal communication with Louise Fleischman, Director of Center for Adoptive Families. (November 2001)

To become more confident in the adoption competence of practitioners hired by the agency, CAF developed a unique process to assess and develop the adoption competency of its clinicians, which includes:

- An informal interview to assess the practitioner's knowledge about adoption and whether he/she is open to learning. Some of the open-ended assessment questions posed include: tell me your experiences with adoptive families; tell me what you know about a particular adoption circumstance; tell me what you know about attachment.
- Required participation in an adoption-related training program developed by CAF with a curriculum that covers the core practice elements of adoption-competent mental health services including:
  - Understanding children's reactions to separation, loss and grief and its relationship to attachment;
  - Understanding the individualized emotional issues of the adoptive family;
  - Working with community systems to ensure adoption-related concerns are understood and addressed;
  - Comprehension of developmental stages and what to expect from children who have a history of neglect or abuse as well as separation, loss and grief;
  - Readings on adoption for the adoptive families;
  - Use of children's and parents' support groups to normalize their experiences;
  - Required "shadowing" of staff members during home visits to better understand the adoption practice orientation and experience;
  - Required participation in groups where children share their experiences; and
  - Required exposure to the language and concepts of post-adoption services.

According to Fleischman, the thoroughness of screening and preparation during the hiring process helps CAF recruit and retain quality staff able to meet the unique and complex needs of adoptive families served. CAF has been authorized by the Maryland Board of Social Work Examiners to grant Continuing Education Units for Maryland social workers.

Even more recently, CAF training curricula materials have been used at Catholic University and the University of Maryland to include issues of adoption and attachment content within the academic curricula of their schools of social work. The goal is that with exposure to adoption theory and practice, and new graduate social workers will have a deeper understanding of the complexities of adoptive families and mental health concerns involved.

**Maine IV-E Waiver for Post-Adoption Services and Training of Community Professionals: A State Partnership Involving Casey Family Services and the University of Southern Maine**

States receive Federal Title IV-E funds to cover room and board for eligible children receiving out-of-home care and child welfare training. Under the Adoption and Safe Families Act of 1997, Congress granted authority to the Department of Health and Human Services to approve up to 10 additional demonstration waivers per year for five years to test alternative ways to use IV-E dollars to improve the flexibility and quality of child welfare services. The state of Maine has developed a Title IV-E waiver and Medicaid Targeted Case Management demonstration project to address the growing need for post-adoption support and mental health services, as well as the need for training on adoption for community mental health providers.

Maine is using its Title IV-E waiver to provide post-adoption services, and other traditional training funds funneled through the Maine Child Welfare Training Institute at the

University of Southern Maine to train community providers and mental health and Medicaid Targeted Case Management professionals and to engage in an evaluation to test the efficacy of the services and training. The Maine Adoption Guides Demonstration Project is a partnership among the Maine Department of Human Services, the Maine Division of Casey Family Services, the University of Southern Maine and participating adoptive families. The hypothesis behind the waiver is two-fold:

1. Post-adoptive services, when provided early in the adoption process, will result in more successful adoptions over time.

2. If children require out-of-home treatment after adoption, the provision of flexible services and supports will help these adopted children return to live with their adoptive families earlier and more successfully.

The IV-E waiver has three components:

1. Medicaid dollars are used for enhanced "case management" services with an "experimental" group of adoptive families (randomly selected) who need support to maintain an adopted child in the home and to navigate the system of services and supports.

2. Training of community providers in adoption-competent child welfare and mental health practice.

3. Research related to the experimental and control groups in collaboration with the University of Southern Maine to assess which flexible supports make the most difference to adoptive families.

During the first year of the project, the Maine Department of Human Services worked in partnership with Casey Family Services to design and implement statewide adoption-competency training. Adapting materials from the

Adoption Support and Preservation (ASAP) Curriculum (developed with a Federal Adoption Opportunities Grant by the National Resource Center for Special Needs Adoption at Spaulding for Children in Southfield, Michigan), the Maine team worked to ensure that public and private child welfare providers and community mental health practitioners would learn about the range of experiences that adopted children and their families normally encounter and be able to help adoptive families build strong relationships over time. Teams consisting of an adoptive parent, an adoption-competent post-adoption clinician and an adoption caseworker conducted the training statewide. To date, over 300 public and private practitioners from across the state have participated in the three-day training.

To create a link between this Title IV-E project and the state's mental health and Medicaid system, the initial training was focused on the state's community mental health centers. Most of the families who adopt children from the public child welfare system use the benefits of Medicaid for the child's special medical and mental health services. Through the Targeted Case Management program, the use of Medicaid funds to support behavioral health services for adopted children becomes a viable option to serve adoptive families in Maine. This could sustain these needed services when/if the IV-E Waiver does not continue after its five-year duration. Through this agreement between the Child Welfare and Medicaid divisions, families are more likely to receive the kinds of adoption-competent and Medicaid-supported services they need without having to go outside of the Medicaid funding stream.

Casey Family Services' Post-Adoption Program has provided a comprehensive array of post-adoption services, including case management, information and referral, support groups, respite care, individual and family therapy relating to adoption issues, rehabilitative support, residential treatment, recreational services, advocacy services and research/search assistance with respect to birth families.

"Some of the agencies just don't get that they have to work with families….We are part of the problem and the solution."

— Adoptive Parent

Diane Kindler, deputy director at the Maine Division of Casey Family Services, relates that:

*"We now have a growing pool of clinicians and practitioners in the state to whom adoptive families can turn to who understand the attachment and grief and loss issues of children adopted from the child welfare system. The response to the training, especially by the leadership of the community mental health centers, has been excellent!"* [75]

When asked what services appear to be making the greatest difference to families, Kindler indicated that the first review of data suggests that support groups and respite are most important to families' sense of well-being. According to Kindler, *"families have really appreciated getting together with other families to talk about their experiences and struggles. We have tried to make these support groups appealing by making them 'pot luck dinners' and by providing child care and opportunities for children to break into different age groups to talk about their developmentally specific struggles. We hope to enhance the youth group components over the course of the next year. Respite in the way of short-term breaks, summer camps, etc., is also perceived as extremely beneficial."* [76]

**Partnerships with Mental Health and Medicaid Managed Care Plans to Include Adoption-Competent Contracting Expectations**

Discussions with adoptive parents and professionals across the country have revealed many opportunities for creating adoption competence within existing mental health and Medicaid systems without reinventing the wheel. State child welfare agencies can partner with state Medicaid and mental health agencies to creatively *share responsibility* for serving adopted children with serious emotional, behavioral and psychiatric conditions. Through their partnerships, children can remain safely within their families and

communities and be protected from the added trauma of unnecessary out-of-home placements. Two examples hold great promise and are reviewed below.

**Adoption Competence in Mental Health and Medicaid Managed Care: The Colorado Experience**

The state of Colorado offers a unique example of collaborations among child welfare, mental health and Medicaid systems, which have worked together strategically to strengthen the capacity of the mental health managed care systems to meet the complex mental health needs of families who have come together through adoption.

The public mental health system in Colorado provides a comprehensive range of mental health services to Colorado citizens who are in need of these services. One component is the Medicaid Mental Health Capitation Program, which provides mental health benefits and services to Medicaid recipients in Colorado through a managed care organization. The Program began in 1995 in 51 Colorado counties and was expanded to the remaining 13 counties in 1998. Colorado established a managed care system when it appeared that the more traditional Medicaid fee-for-service program limited consumers from accessing the individualized mental health services. In addition, as program costs increased rapidly, the state believed that a managed care system would be more likely to make efficient use of available funds.

Under the new Medicaid Mental Health Capitation Program, managed care organizations and service providers have the flexibility to provide many more types of services than they could provide under the traditional Medicaid program. They are now required to have available a full complement of services that include residential care options, respite care, consumer clubhouses and drop-in centers, home-based services, specialized services to adoptive families and vocational services. This

[75] Personal communication with Diane Kindler, Deputy Director, Maine Casey Family Services. April 2002.
[76] Ibid.

structure consists of eight Mental Health Assessment and Services Agencies (MHASAs) covering the 64 counties of the state. The MHASAs were selected through a competitive bid process and are required to provide all medically and clinically necessary mental health services.

During the last contracting cycle, the child welfare system convinced the mental health system to require that the MHASAs offer adoption-related services. Adoption competence was enhanced through a federal Adoption Opportunities Grant to train the mental health center staff around issues related to the attachment, loss and grief that children in the child welfare system experience. Staff from the Child Protection Intake programs also were trained concurrently, which promoted an integrated approach to serving adopted children and their families. The state of Colorado also shared this training model with the state of Utah in an effort to spread the learning from their Adoption Opportunities Grant. While the training associated with the Adoption Opportunities Grant has ended, the adoption competence of those mental health providers trained by the program continues. They are sustaining an effort to better meet the ongoing mental health needs of adopted children and their families.

**Specialized Outpatient Mental Health Clinic to Support Permanency: Kinship Center of California**

In early 2000, the Kinship Center, a child placement and mental health organization, launched California's first mental health clinic dedicated to foster children permanently placed with relatives, foster and new adoptive parents. The Adoption Clinic was established to address the medical and social risk factors of children being adopted from the child welfare system. The director of the program is a clinical social worker who is also an adoptive parent.

> "It was a challenge to help staff engaging family assessment to understand the importance of the child's adoptive status. …Now when a child says that he/she is adopted, staff pay attention and the information assists in formulating treatment plans."
>
> — Christine Gradert
> Vice President
> Family Resources, Inc.

The experiences of the Adoption Clinic have substantiated that many children who are adopted from the foster care system of California have a variety of psychiatric disorders. Located in Orange County, the program serves approximately 125 children and their families each week through clinic-based, mental health services funded by Early Periodic Screening Diagnosis and Treatment (EPSDT). The clinic was developed as a joint project among the Orange County Social Services Agency, Health Care Agency, Agency for Children and Youth Services and Kinship Center. The clinic is designed to serve 66 children. Capacity was exceeded in the first six months and the program has been expanded through funding by a grant from the Children and Families Commission, a public/private partnership that provides funding, quality assurance oversight and outcomes measurements.[77]

Therapeutic interventions by the Adoption Clinic staff have resulted in stabilization of families in crisis; increase in self-regulatory behaviors of children; improvement in children's adjustment and functioning in school settings; and progress in healing trauma resulting from prior neglect, abandonment and abuse. The majority of children are treated without medication.[78]

Based on the lessons learned within the Adoption Clinic, and in response to a lack of consistent and adequate follow-up for children in foster care, the Kinship Center recently created the Seedling Project. The Seedling Project, also funded through EPSDT, ensures that infants and young children in foster care have early comprehensive screening, developmental and mental health assessments and appropriate mental health intervention when needed. The project also provides caretakers with access to highly skilled training and individual coaching. The multidisciplinary staff for the project includes case managers, child assessment specialists, a psychologist, a parent educator, a pediatrician and an occupational therapist.

[77] Biddle, C. and Silverstein, D. (Spring 2002). *Bridges*. Association of Administrators of the Interstate Compact on Adoption and Medical Assistance.
[78] Ibid.

**Partnerships with Systems of Care Initiatives to Create Opportunities for Adoption-Competent Mental Health Services**

The Comprehensive Community Mental Health Services for Children and Their Families Systems of Care Initiative, funded by the Child, Adolescent and Family Branch of the Substance Abuse and Mental Health Services Administration (SAMHSA), offers an exciting opportunity within an existing structure of mental health service delivery for increasing adoption-competent services and supports for children and families experiencing mental health challenges.

*"I am so tired of being offered what is not needed and never being offered what is really needed!"*

*— Adoptive Parent*

This multi-million-dollar federal grant program supports Systems of Care initiatives in 41 states, Guam, Puerto Rico and the District of Columbia. Several of the fundamental principles and practices of this Systems of Care Initiative is highlighted here because this program approach, with sites throughout the nation, has the potential to be an excellent vehicle to house the responsibility for building and sustaining adoption-competent mental health services within states, counties and communities.

Over the past decade, families of children with mental health needs have gained knowledge, skills and access to influence systems of care so their children receive better services and more effective family-centered supports. There are many places in the country where families have become strong partners and serve as collaborators, advisors, providers, planners, administrators, evaluators and advocates within systems of community mental health services.[79]

The chart below shows how the family's role is evolving under the systems of care model. This approach holds important potential in serving adoptive families.

| Family as Client | Family as Guest | Family as Participant | Family as Full Partner |
|---|---|---|---|

The Systems of Care Initiative embodies the many values and practice orientations described as needed by adoptive families as they struggle to get their needs met in unresponsive, judgmental service systems. Systems of Care should be:

- Child centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.
- Community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.
- Culturally competent, with agencies, programs and services that were responsive to the culture, race and ethnic differences of the population they serve.

In addition, the Systems of Care Initiative is committed to providing a range of wraparound services to support children and their families within their communities. This approach to service delivery mirrors the vision of adoptive families as they describe efforts to find comprehensive services for their children. The definition of wraparound within the Systems of Care Initiative is as follows:

*Wraparound is a philosophy of care that includes a definable planning process involving the child and family and that results in a unique set of community services and natural supports individualized for that child and family, to achieve a positive set of outcomes.* [80]

[79] *Systems of Care: Promising Practices in Children's Mental Health: New Roles for Families.* (1998). SAMHSA. www.samhsa.gov/centers/cmhs/cmhs

[80] Ibid.

For example, an adoptive family may be provided with an array of services, supports, education and even respite in an attempt to keep their 11-year-old daughter who is emotionally disturbed and suicidal from re-entering in-patient psychiatric care. Wraparound services could include targeted case management, in-home family therapy, medication management through a local psychiatrist, educational support/classroom aid and an after-school program in a local church. This mix of services wraps support around the family and alleviates stressors during particularly vulnerable times.

Jan McCarthy, from the National Technical Assistance Center for Children's Mental Health at Georgetown University's Child Development Center, comments that:

*"Adoptive families in search of appropriate mental health services for their children with special needs might look toward a 'system of care' as a family-friendly framework for reform in which to 'house,' develop and sustain adoption-competent mental health services. The system of care philosophy and value base which promote individualized care, partnerships with families, cultural competence, interagency collaboration and community-based services offer the opportunity for adoptive families to find allies and to work with both providers and policymakers to build the full range and type of services needed."* [81]

Increasing the adoption competence of the existing System of Care initiatives will involve deepening the understanding of existing practitioners already committed to engaging in community-based and family-centered mental health practice. While a specific link between the Systems of Care initiatives and adoption-competent training for these mental health providers could not be found, this innovative children's mental health effort holds great promise for collaborations with child welfare systems looking to maximize resources for adoptive families of children with mental health needs. Systems of Care initiatives that exist in communities and have a strengths-based approach to working

with families and children would be an ideal place for adoption-competency training and program enhancement. These initiatives could be an "opportunity waiting to happen!"

**Family-Centered, Adoption Competency within Residential Care Programs**

There are times when children's mental health treatment may require a very structured residential environment with services wrapped around them to help stabilize their behavior and emotions and where they can learn better self-regulation skills. While this may not be the first treatment option, the reality cannot be ignored that for some children time-limited, intensive residential treatment care may be needed as part of their array of adoption-competent mental health services. When an adoptive family makes the decision to place their child in an out-of-home treatment setting, their sense of loss and failure is significant. When custody has to be relinquished in order to get this help, the sense of loss is even more overwhelming – for adoptive parents and their children. When the child enters or re-enters the world of publicly funded residential care, the likelihood is great that the family of that child will experience tremendous trauma and disempowerment. Additionally, many residential care facilities struggle with simply understanding, or even believing in, the importance of working in partnership with the child's family.

Given this reality, in order to learn about adoption-competent mental health services in residential care facilities, examples of facilities/agencies that honored the role of the family in the treatment process were sought. Some examples were found of residential programs that not only honor the role of families in their children's recovery, but also have made efforts to honor the adoption experience and relationship dynamics as they help children to heal.

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> — Jan McCarthy
> Director
> National Technical
> Assistance Center
> for Children's Mental Health

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[81] Personal communication with Jan McCarthy, Director of Child Welfare Policy at the National Technical Assistance Center for Children's Mental Health at Georgetown University's Child Development Center. (May 2002).

**Building A Family-Centered Treatment Approach:**
**The Nashua Children's Home Experience**

In 1998, the Child Welfare League of America published a book entitled *Family-Centered Practice in Out of Home Care.* One of the fundamental messages of this work was the importance of developing meaningful ways to engage families in the process of the treatment and service provision in out-of-home care settings. Dave Villiotti, executive director of the Nashua Children's Home in Nashua, New Hampshire, a contributing author to this work, addresses the changes that his agency has undergone in their quest to engage families in the treatment process in their Family Preservation and Residential Care Programs. In his paper, "Embracing the Chaos: Moving from a Child-Centered to Family-Centered Treatment Model in Residential Care," Villiotti writes that there were three structural culture changes that the agency made in incorporating family-centered practice. These shifts emerged during the mid-1990s when the leadership at the State of New Hampshire Division of Children, Youth and Families challenged foster care and residential programs to incorporate family-centered practice into all phases of their work with children.

> *"...schools have the opportunity to serve as a gateway to mental health services...but they often refuse."*
>
> — Adoptive Parent

- *Changing the supervisory process:* Integration of the supervision within the Family Preservation and Residential clinical programs to ensure a cross-fertilization of ideas and skill sets, all building on the family-centered model of treatment;
- *One therapist/One family clinical assignment:* Assigning therapists to families, rather than to programs, ensuring that the family would not have to change therapists if the level of care changed; and
- *Educating the key stakeholders:* Re-educating the agency's Board of Directors, juvenile court judges, families of children in care and agency staff about the importance of engaging families as partners in the service delivery process.[82]

Villiotti suggests that it was from this newly developed emphasis on families that the issues surrounding adoptive families arose. "*As the number of adoptees in our care has increased over the past three years, we have made a concerted effort to better understand attachment disorders and grief and loss.*" Staff are trained on how loss and grief affects child behavior and adoptive parents' reactions. Staff ask adoption-related questions at intake to learn whether a child has been adopted, when and how/whether people feel the adoption is impacting the current situation. Staff also assist children and families to address unresolved birth family concerns and early traumatic experiences that may be impeding the attachment process.

Additionally, staff address adoptive family disappointment and frustrations with service systems that previously were perceived as unhelpful and/or dishonest in sharing information about the child's past history. Villiotti describes the feelings of betrayal by the system that families often express and the resulting feelings of wanting to simply "give the child back" when turning to residential treatment options. Family work with adoptive families involves not only engaging the adoptive family, but also considering when and how to engage the birth family in efforts to help children and youth work through loss and grief associated with the past. Leadership at Nashua Children's Home continues to strive to address creatively the families' issues of betrayal by the state system and seeks to ensure that staff are sensitized to adoption issues.

**Iowa's Service Integration and Adoption-Competent**
**Mental Health Treatment: Family Resources, Inc., Experience**

Family Resources, Inc., a large not-for-profit organization located in Davenport, Iowa, provides a comprehensive array of children's services. The organization underwent a significant practice shift over the past three years as it struggled to become a more integrated organization. According to Tom Wilson,

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[82] Personal communication with Dave Villiotti, Executive Director of Nashua Children's Home. (April 2002).

President and CEO, *"the goal of this massive cultural shift was to ensure that 1) regardless of which door of the agency the child/family entered, and 2) regardless of how many services in which the child and family were involved, there would be a single process of assessment, and a coordinated and seamless approach to service delivery."* [83] This organizational change process served as the cornerstone for their post-adoption efforts. Because of the commitment to seamless service delivery, agency leadership studied the kinds of services that were most frequently provided to a single family during the course of treatment. Residential care, foster care, adoption and day treatment became one consolidated treatment team. These teams are absolutely critical in helping program staff see the "big picture" while struggling to implement services for children and their families.

When these teams were first developed, the different ways that programs viewed children were glaringly evident. For example, if a child came into the residential program with a history of placements, runaways and acting-out behavior, members of the residential team would suggest a strong behavior modification program including medication and "time outs." Members of the adoption program would suggest that maybe the child was struggling with loss and grief and needed clinical intervention that focused on these issues. Residential staff would talk about appropriate "treatment milieu," while staff from the adoption program would ask questions about the state's permanency plan. Over time, because of this effective model of cross-discipline social work, every program now assesses for the impact of adoption on the behavior of the child and addresses adoptive family issues from a different systemic framework than they assess birth family issues. The agency has become significantly more adoption sensitive because those staff who understand adoption and its impact on children and families have been integrated into all aspects of residential care programming.

According to Christine Gradert, vice president of Professional Services for the agency:

*"It was a challenge to help staff engaging in family assessment to understand the importance of the child's adoptive status. While we always asked the question, 'Were you adopted?' it was like asking about hair color – just not considered a critical piece of information. Now when a child says that he/she is adopted, staff pay attention and the information assists in formulating treatment plans. It also greatly informs our work with the families. We spend less time on the specific behavioral issues that brought the child into care and more time on the families' sense of loss, guilt about their ambivalence, and fear that they made a mistake."* [84]

The post-adoption program of Family Resources, Inc. is funded predominantly by United Way. According to Gradert:

*"There is just not enough investment in post-adoption child welfare services. In order to bring this critical component to our service array we have sought outside resources. It will be wonderful when we get to a time where the schools of social work and the child welfare system as a whole invests time and resources in this under funded, under taught piece of the service link. I am amazed at how many graduates of even Masters Social Work programs have no sense of the importance of adoption to the emotional psyche of a child or adolescent. So often we hear adolescents say, 'I don't want to be adopted,' and we believe it. How different the lives of those children might be if we heard those words, and also heard the unspoken words, 'I don't want to ever experience loss again – so I won't let myself get close to anyone.'"* [85]

[83] Personal communication with Tom Wilson, President and CEO of Family Resources, Inc. (April 2002).

[84] Personal communication with Christine Gradert, Vice President of Professional Services for Family Resources, Inc. (April 2002).
[85] Ibid.

# Summary & "Can Do" Recommendations

One key intent of the Adoption and Safe Families Act of 1997 (ASFA) was to facilitate permanency for children through family preservation and support, reunification, adoption or a legal guardianship relationship when that is an appropriate goal. As a result of ASFA, as well as the Adoption 2002 Initiative (which challenged states to double the number of public child welfare adoptions for waiting children), permanency through adoption has been achieved for many children who might otherwise have not found safety and stability within a lifetime family. While this is indeed good news, these accomplishments bring additional federal, state and local community challenges – and obligations.

For more than a decade, Casey Family Services has engaged in providing and learning about the comprehensive array of post-adoption services and supports together with families built through adoption. We have learned that adoption is a lifelong process which begins when children are placed with prospective adoptive families and continues beyond legalization. From our literature reviews, our own program research and our ongoing experiences with adopted children and their families, we have learned that adoptive families have a need for an array of education, support and therapeutic community services. And they need to be able to access this array episodically. Joyce Maguire Pavao from the Center for Family Connections in Cambridge, Massachusetts, describes this as "brief long-term therapy." This mix of services must be provided by service providers and therapists with an adoption-competent knowledge base and core values, who can see child and family strengths amidst complex circumstances and concerning diagnoses. Families who have come together through adoption need to be understood, encouraged and supported as they are empowered to fulfill their roles as the single most therapeutic influence in the life of their child over time.

This paper identifies an array of promising practices in adoption-competent mental health services. These collaborations have maximized existing resources, developed new strategies and made an incredible difference in the lives of adoptive families. It is clear that child welfare, mental health and Medicaid agency partnerships *can* create innovative strategies that respond to the complex needs of today's adoptive families. And it is clear that creative use of revenue resources[86] *can* be identified to fund these innovative strategies.

The following recommendations are steps that public child welfare, mental health and Medicaid agencies can implement now. These "Can Do" recommendations can be implemented with existing funding resources as long as there is a shared agreement that adoption-competent mental health services and supports are a priority for all three systems and must be sustained over time to preserve the permanency of the increasing number of families coming together through adoption. These are strategies that Casey Family Services and the Annie E. Casey Foundation are committed to helping states implement through ongoing research, policy, technical assistance and training.

[86] Title IV-B, Parts 1 & 2, Title IV-E Administration and Training; Medicaid; TANF; Social Services Block Grant; and Adoption Incentives funds.

## "Can Do" Recommendations

State Child Welfare, Mental Health and Medicaid Programs Can:

1. Partner with adoptive parents as full members of the professional team, meaningfully engaging and involving them at all levels of program design, policy development and evaluation as well as individual treatment planning intervention;

2. Fund and support low-cost family education, support and networking groups;

3. Fund and develop Internet-based opportunities that link families with information and support;

4. Fund and support comprehensive approaches to adoption-competent support, education and mental health services, including in-home therapeutic interventions;

5. Partner with schools of social work and/or private agencies to develop innovative adoption-competent professional educational models for child welfare practitioners, community providers and mental health professionals;

6. Partner together to include mental health services for adopted children within the state Medicaid and Managed Care Plans and to identify a group of mental health providers who are certified as adoption competent and required to continue learning through specialized professional development opportunities;

7. Partner with Systems of Care Initiative implementation teams to include a focus on adoption-competent mental health services for children and families;

8. Improve the family centeredness and adoption competency of residential treatment providers, enhancing the creative and strategic use of residential treatment to return youth to their adoptive families as soon as it is safely possible and/or to participate in an array of wraparound services designed optimally to keep adopted youth in their own homes;

9. Partner together to evaluate and monitor the effectiveness of public and private social services and mental health programs in the area of adoption competence; and

10. Promote legislative reform to ensure that families do not have to relinquish custody to secure needed services for their children.

## Contact Information

Jan McCarthy
Director of Child Welfare Policy
National Technical Assistance
Center for Children's Mental
Health at Georgetown
University's Child
Development Center
3307 M Street NW
Suite 401
Washington, DC 20007
202-687-5062

Julie Prybil
Parent Liaison
Minnesota Adoption Support
and Preservation
3286 37th Street NW
Maple Lake, MN 55358
320-963-6055

Debbie Riley
Executive Director
Center for Adoption
Support and Education
1120 Hampshire Avenue
Suite 205
Silver Spring, MD 20904
301-593-9200

Phyllis Stevens
Director
Together as Adoptive Parents
478 Moyers Road
Harleysville, PA 19438
215-256-0669

Dave Villiotti
Executive Director
Nashua Children's Home
Nashua, NH 03064
603-883-3851

## Promising Practices in Adoption-Competent Mental Health Services National Advisory Committee

Mary Lee Allen
Director of Child Welfare and
Child Mental Health
The Children's Defense Fund

Kathy Barbell
Senior Program Director
Program Operations
Child Welfare League of America

Eileen Crutchlow
Adoptive Parent
Associate Professor
Family Nurse Practitioner
Southern Connecticut
State University
Department of Nursing

Doyle Evans
American Public Human
Services Association

Frank Farrow
Director of TARC
The Annie E. Casey Foundation

Sharen Ford
Program Administrator
Colorado DHS
Division of Child Welfare Services

Jean Hoffman
Director
Adoption Services Division
Family Independence Agency

Barbara Huff
Executive Director
Federation of Families for
Children's Mental Health

Diane Kindler
Deputy Division Director
Casey Family Services

Susan Klickman
Adoption Program Specialist
Texas Department of Protective &
Regulatory Services

Joseph Kroll
Executive Director
North American Council on
Adoptable Children

Kathy Ledesma
Program Manager for Permanency
and Adoption
Oregon State Office for Services
to Children and Families

John Levesque
Consultant
NRC for Special Needs
Adoption at Spaulding
for Children

Lorrie Lee Lutz
Consultant/Author
Managing Sr. Partner
L3P Associates, LLC

Jan McCarthy
Director
Child Welfare Policy
Georgetown University
Child Development Center

Patrick McCarthy
Director of Policy Reform and
Initiative Management
The Annie E. Casey Foundation

Judith Meyers
President and Executive Director
Child Health and Development
Institute of Connecticut

Mary Harris-Miller
Team Leader
Post-Adoption Services
Casey Family Services

O. Jane Morgan
Adoption Specialist
Child Welfare Capacity
Building Division
Children's Bureau

Elizabeth Oppenheim
Program Director
Adoption
American Public Human
Services Association
810 First Street NE

Debbie Riley
Executive Director
Center for Adoption Support and
Education, Inc. (C.A.S.E.)

Sally Tubbesing
Consultant
6 Scotch Pine Road

Ada White
Director of Adoption Services
Child Welfare League of America

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