Study of the Effects of Training for Adoption Competency on the Quality and Effectiveness of Clinical Services with Adoptive Families

Executive Summary

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Executive Summary

Background

The purpose of this study was to assess the effects of the Training for Adoption Competency (TAC) on the quality and effectiveness of clinical services with adoptive families in community-based outpatient treatment settings.

TAC is a 72-hour competency-based training for licensed clinicians that is designed to increase clinicians' effectiveness in providing pre- and post-adoption services to prospective adoptive parents, birth parents, adopted persons, and adoptive and kinship family members. The training was developed by the Center for Adoption Support and Education (C.A.S.E.) in direct response to widespread reports from adoptive families that mental health professionals did not "understand adoption" and that they were not benefitting from treatment they were experiencing and, in some cases, they reported were being harmed (Casey Family Services, 2003; C.A.S.E., 2012). A substantial body of research and practice literature attests to the importance of adoption competence of mental health professionals working with members of adoption kinship networks (Casey Family Services, 2003; Festinger, 2006; Tarren-Sweeney, 2010; NACAC, 2011; C.A.S.E., 2012; Brodzinsky, 2013; Atkinson et al., 2013; Ramsey et al., 2013; Siegel, 2013; Smith, 2014; Brodzinsky & Smith, 2018; Lee et al., 2018; LaBrenz et al., 2020; Atkinson, 2020; Riley & Singer, 2020).

The TAC curriculum design and content is informed by evidence that adopted children and their families represent a distinct population with elevated risk for a range of difficulties, that current standard clinical practices are often inappropriate and even damaging to some families, and that clinicians need specialized knowledge and skills to appropriately assess and intervene with adoptive families.

The TAC training model is comprised of (a) a 12-module curriculum that features Guided Notes for participants and Instructor Guides for trainers, (b) clinical case consultation designed to reinforce the transfer of learning to practice incorporated into six modules and facilitated by advanced practitioners, (c) a robust trainer credentialing and support process featuring selection in accordance with prescribed qualifications, a weeklong orientation, debriefing calls after delivery of modules, and ongoing supportive technical assistance; and (d) an ongoing multicomponent external evaluation that examines training delivery, effectiveness, and outcomes, producing data that informs training program management and curriculum refinement.

TAC modules are organized around core competency domains with learning objectives that are aligned with well-defined adoption knowledge, values, and skills competencies. Modules can be facilitated in-person or via remote platform and combine direct instruction, written handouts and resources, and experiential learning, including case studies, role plays, and introspective work. Pedagogically sound instructional strategies employed are consistent with competency-based learning principles that emphasize the application of learning to clinical practice and transfer of learning to day-to-day practice. All materials are accessed through a learning management system and CEUs are available for participants who seek them. In May 2019, TAC was recognized by the California Evidence-Based Clearinghouse as a program with promising evidence of effectiveness and high relevance to child welfare. Additionally, TAC has undergone an exhaustive review by the Institute for Credentialing Excellence (ICE) and is now recognized as an accredited, assessment-based certificate program.

Methods

The study assessed the effects of TAC on the quality and effectiveness of community-based outpatient mental health services with adoptive families, specifically examining:

- whether adoptive families have more positive treatment experiences with TAC-trained clinicians than with comparably qualified clinicians who have not completed TAC and
- whether outcomes for adoptive families treated by TAC-trained clinicians are more favorable than outcomes for adoptive families treated by comparably clinicians who have not completed TAC.

The four specific areas of inquiry were 1) adoptive parent satisfaction with treatment; 2) quality of the relationship/alliance between clinician and adoptive family members; 3) adoption relevance of treatment; and 4) family well-being and basic functioning of children/youth post-intervention compared to pre-intervention.

The research protocol included the following elements:

Demographic profiles – For clinicians, a 10-item questionnaire was used to collect data on education, licensing, length of relevant experience, and other variables that research suggests are relevant for adoption-related clinical work. For adoptive families, a 15-item questionnaire was used to collect basic demographic data for parents and children as well as data on the type of adoption, age at adoption, pre-adoption placement, birth parent and family contact, treatment history, types of therapy received and numbers of sessions.

Satisfaction/treatment quality – Client satisfaction with treatment was assessed using items from the Mental Health Statistical Improvement Program (MHSIP) Family Satisfaction Survey. Client satisfaction has been shown to be a good indicator of quality of service delivery, treatment compliance, and to be significantly linked to outcomes, including reduction in emotional difficulties. Studies have shown the MHSIP to have high levels of validity and reliability as a measure of consumer satisfaction with mental health services.

Therapeutic alliance - The quality of adoptive parents' relationships with their clinicians was assessed using the Therapeutic Alliance Scale for Caregivers and Parents (TASCP). A strong therapeutic alliance is considered to be crucial for client motivation and engagement and one of the most important variables influencing therapeutic outcomes. The TASCP has been shown to have good reliability, temporal stability, convergent validity, and discriminate validity, to have strong predictive value, and to be associated with more sessions attended, greater satisfaction with perceived improvement, and less drop-out.

Adoption relevance and client outcomes – The adoption relevance and sensitivity of therapy were assessed using the Adoption Relevance and Related Outcomes Questionnaire, an instrument designed for the study that is keyed to adoption-related therapeutic tasks and outcomes. Development of the instrument was informed by prior research on clinical work with adoptive families and the ongoing TAC evaluation that has illuminated areas of clinical practice that are strongly associated with adoption competence.

Families were recruited through 14 geographically diverse local and regional behavioral health agencies and through ten private practices of TAC completers. Participating organizations identified all adoptive families treated in the past 24 months and invited all identified to

participate in the study by completing the online study survey. Invitations included detailed information about the study and families completing the survey received a $25 gift card incentive.

A total 159 usable parent survey responses were collected over a nine-month period from 89 families treated by TAC-trained clinicians and 70 families treated by comparably qualified clinicians who were not TAC-trained. A total 34 TAC-trained clinicians and 36 not TAC-trained clinicians completed clinician profiles and had families they treated respond to the survey.

Comparisons of data from families treated by TAC- and not-TAC trained clinicians were analyzed using t-tests (if normality assumptions are met) for comparisons of mean differences. For data where responses were ordinal (i.e., ordered categories), the Mann Whitney U was used. Differences between TAC- and not-TAC trained conditions where categorical data was used (e.g., race/ethnicity, gender), chi-square analyses were used. The z-test for proportions was used for comparisons with a single category (e.g., *private clinical practice*). For all analyses, the threshold for statistical significance was set at .05.

Findings

Demographic differences likely to significantly affect outcomes and study findings were not found in the family groups compared – those treated by TAC-trained clinicians or those treated by not TAC-trained clinicians. Similarly, the two clinician groups (TAC-trained and not TAC-trained) did not differ significantly on demographic variables likely to substantially affect study findings.

Marked differences, however, were found in training and therapeutic orientation of study clinicians. TAC-trained clinicians reported significantly more hours of adoption-specific training – average 101 hours compared to 13.8 hours. When the 72-hours of TAC training are not considered, TAC-trained clinicians still had more than twice the hours of adoption-specific training as not TAC-trained clinicians (29 hours vs 13.8 hours). Personal connection to adoption may have contributed to this difference. TAC-trained clinicians were more likely to have a personal connection to adoption – 73.5 percent vs 41.7 percent – a variable likely to have increased their interest in adoption and contributed to their enrollment in not only TAC but also other adoption-related trainings.

The most notable difference in clinician groups was seen in theoretical orientation to clinical work in which 100 percent of TAC-trained clinicians reported family therapy as their primary orientation across all practice settings. In contrast, clinicians not TAC-trained reported their primary orientations to be interpersonal (44.4 percent) and cognitive-behavioral (33.3 percent) and only 11.1 percent reported family therapy or eclectic orientations as primary.

Families treated by TAC-trained clinicians sustained engagement in treatment over a higher average number of sessions (8.37) than families treated by not TAC-trained clinicians (6.47) and experienced significantly fewer individual child-only sessions and significantly more parent, family, and group sessions. These findings suggest much greater parent involvement and use of a broader range of therapeutic interventions such as support groups by TAC-trained clinicians. Consistent with findings that they remained engaged in treatment over more therapeutic sessions, families treated by TAC-trained clinicians were significantly more satisfied overall and with

services, with clinician performance, and with child and family outcomes. They also formed significantly stronger therapeutic alliances with their clinicians.

Ratings of adoption relevance of the therapeutic intervention from families treated by TAC-trained clinicians reflected a greater focus across all aspects measured -- normalization, trauma and attachment, loss and grief, uncovering the child's unique story, supporting communicative openness, family cohesion and attunement, and parent support and self-care. These families also reported more positive outcomes for their families on measures of communicative openness, adoption knowledge, relationships, and parenting skills and for their child on measures of daily functioning and relationships.

Discussion

Findings that families treated by TAC-trained clinicians sustained engagement in treatment over a higher number of sessions and experienced significantly fewer individual child-only sessions and significantly more parent, family, and group sessions suggest much greater parent involvement with treatment and use of a broader range of therapeutic interventions by TAC-trained clinicians. Consistent with these findings, families treated by TAC-trained clinicians were significantly more satisfied and form significantly stronger therapeutic alliances with the TAC-trained clinicians. These findings suggest a stronger engagement of parents in the therapeutic process – a factor broadly viewed as one of the most important variables influencing therapeutic outcomes.

The strong and consistent evidence that therapeutic intervention by TAC-trained clinicians is more adoption relevant reflects important distinguishing features of clinical practice that is regarded as adoption competent. Evidence of greater use of psychoeducation and strategies to develop parenting skills by TAC-trained clinicians is consistent with a strengths-based approach that recognizes parents as partners in the therapeutic process and as primary agents of healing.

Although parental claims of more positive outcomes for families and children were not independently verified in this study and must be taken at face value, they are very credible and significant indicators of more effective treatment being delivered by TAC-trained clinicians.

Strengths and Limitations of the Study – Family recruitment efforts produced a sample size sufficient to find statistically significant differences and the sample was geographically diverse within the study state. Additionally, the consistency in responses lends weight to the findings. Experience with a small-scale pilot study led to use of strategies that reduced confounding variables and selection bias; however, the sample was not nationally representative, limiting our ability to generalize findings.

Conclusions and Implications

The primary purpose of this study was narrowly defined to assess the effects of the TAC on the quality and effectiveness of clinical services with adoptive families in community-based outpatient treatment settings. Findings clearly and consistently support a conclusion that TAC does produce more effective clinical practice with adoptive families.

A secondary purpose of the study was to explore intervention methods and foci in light of known key features of adoption competent clinical practice. Findings confirm that the real-world clinical practices of TAC-trained clinicians in the study were consistent with key features of adoption competent clinical practice.

The primary implication from these findings is that TAC should be expanded to train additional clinicians in order to increase access for adoptive families to more effective adoption competent treatment.

Additionally, behavioral health organizations that treat adoptive families should ensure through their hiring and training practices that a sufficient number of clinicians in their organizations are qualified to provide appropriate assessment and effective treatment for these families. Adoption services providers, including child welfare agencies, that refer families for mental health assessment and intervention services should recognize those who have completed TAC as preferred providers and establish referral policies that reflect that preference. Online registries listing clinicians who have completed TAC should be further expanded so that adoptive families can more readily identify adoption competent clinicians.

There is also need for greater specification and standardization of our definitions of adoption clinical competence toward the potential establishment of more formal standards that clinicians would need to meet to be recognized as "adoption competent." More formalized credentialing standards that would ensure that those who claim adoption competency meet established standards and that adoptive families, as consumers of mental health services, are accessing effective services. More formal credentialing standards would likely advance recognition by insurance companies of adoption competent practice as a specialized practice, justifying higher reimbursement rates that would, in turn, likely encourage additional clinicians to seek training.

Although this study has clearly established an association between TAC and better adoptive family therapeutic experience and outcomes, deeper insights into the connections between therapeutic approaches and specific interventions and outcomes are needed.

Full Report Available Upon Request from Principal Investigator at
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