Strengthening Families and Communities…A White Paper

Promising Practices in Adoption-Competent Mental Health Services

Casey Family Services
The Casey Center for Effective Child Welfare Practice

In Collaboration with
American Public Human Services Association & the Association of Administrators of Interstate Compact and Medical Assistance

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INTRODUCTION

Casey Family Services, the direct services 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 finalized. 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 – with life-long implications for their newly created families.

Casey Family Services has provided an array of child welfare and family services since 1976, and since 1991 has engaged in a comprehensive approach to post-adoption services within 6 of its 8 Divisions. In December 2000, Casey Family Services held the first national conference on Post-Adoption Services with over 500 people who attended in state teams to learn from and to network with one another. Practice, policy and research concerns were shared by the State Adoption Program Managers as well as others from state teams who attended the conference. Accessing quality adoption-competent mental health services for adopted children and their families was a high priority.

This paper responds to this urgent concern by highlighting promising practices in adoption-competent mental health services – creative services, training initiatives and collaborations which can emerge among Child Welfare, Mental Health and Medicaid systems to address the complex mental health needs of adopted children and their newly created families across the country. As such, the audience for this paper includes State Adoption Managers and their Child Welfare Directors, Mental Health and Medicaid Managers, advocates and adoptive family members who together can make these promising practices a reality in each state.

Casey Family Services collaborated with the American Public Human Services Administrators (APHSA) and its Association of Administrators of Interstate Compact and Medical Assistance (AAICAMA) to explore what works in the provision of adoption-competent mental health services. Other collaborators include colleagues across the country affiliated with the National Association of State Adoption Programs. While this paper builds an urgent case for this focus and summarizes the gaps that exist in present systems of care for these vulnerable adopted children and families – the main intent has been to identify examples of 'promising' practices, programs and initiatives that have

emerged to creatively meet the complex mental health needs of an increasing number of families who have come together through adoption – those adopted through our public and non-profit child welfare systems as well as those adopted privately in this country and from other countries as well.

Collectively, Casey Family Services, the Annie E. Casey Foundation, and the American Public Human Services Association hope that through our respective venues these nuggets of good and creative practice can be adapted, tried, and sustained in communities across this country. From urban neighborhoods to rural counties, increasing numbers of children who might have remained in foster care are finding opportunities for safe, stable and nurturing family relationships through adoption – opportunities for the stability, sense of belonging, and love they might otherwise not have had. Adoption offers a promise of new beginnings, reconnections, and new attachment experiences through families intended to last a lifetime. But, for some, maybe not. For without the availability of and accessibility to quality, culturally-sensitive, adoption-competent and family-centered mental health supports and services, many of these newly created families may not thrive or be sustained.

This paper describes the circumstances of children being adopted from the foster care system, how many are doing post-adoption finalization, the perspectives of families as they seek support in meeting their children's mental health needs, and what is working in the field of adoption-competent mental health services across the country. While this work relies on a review of relevant literature, it also includes perspectives and experiences of both adoption professionals and the families who have adopted children through the child welfare system. Families have thoughtfully shared what works for them, what has been difficult, and where they see practices that give them hope.

While many children who are adopted do not require ongoing mental health services, there are a significant number of children adopted from the child welfare system who do. This paper addresses the complex and comprehensive mental health needs of these vulnerable children and their families, and describes promising practices that are strengths-based, family-centered and have at their core culturally-sensitive and adoption-competent mental health services with professionals who can see beyond troubling diagnoses.

It is our goal that State Adoption Managers and their Child Welfare Directors, Mental Health and Medicaid Managers, advocates, and adoptive family members alike will find this paper useful in advancing local, state and national efforts to support and preserve the adopted families of today to reach their hopes and dreams for tomorrow.

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UNDERSTANDING THE NEED FOR ADOPTION-COMPETENT MENTAL HEALTH SERVICES

One Family's Story

To begin the discussion of understanding the characteristics of the children who are adopted today from the child welfare system and their urgent need for adoption-competent mental health services, the following story highlights one adoptive family's complex experiences (names changed to respect confidentiality).

"*Our daughter Shannon was abandoned at the hospital at the age of three. Prior to this she had been found by the police lying naked with her biological mothers 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 was told 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 five 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 her 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 it was a psych problem. They 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, I was 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 was nothing he could 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. At the writing of this message to you, Shannon has not been violent for about a year.

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, they were was our judge. Thank God for my parent support group and for the adoptive parents that 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."[1]

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 – giving rise to the need for services to support these newly formed and often vulnerable families. In FY 2000, an estimated 51,000 children achieved permanency through adoption. These children 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.[2] The majority of these children had entered foster care due to a finding of neglect or abuse[3]. Eighty-eight percent of the children adopted in FY 2000 received a special needs adoption subsidy related to one or more of the following characteristics or conditions:

- medical/psychiatric or emotional conditions (21%)
- age (31%)
- membership in a sibling group (20%), and
- minority status (12%) [4]

Thirty-nine percent of the children adopted in FY 2000 were Black/Non-Hispanic, 38% were White/Non-Hispanic, 14% were Hispanic, 2% of were Asian/Pacific Islander/Non-Hispanic and American Indian/Non-Hispanic, 5% unknown, and 2% of the children were of two or more races/Non-Hispanic.[5]

These data speak to the complex special needs of the children being adopted through the public child welfare system – they are older children of color who have had multiple relationship disruptions. In many ways, they are the most vulnerable of an already vulnerable population. They are children who will need families who can understand their past experiences and present adjustment needs, and who are comfortable forming nurturing relationships that help children manage their feelings of loss and grief. They are children who, in many cases, will need an ongoing mix of services and supports from community providers that are family-centered, culturally sensitive and adoption-competent – and can see beyond troubling diagnoses.

[1] Personal communication with an adoptive mother. November 2001.
[2] U.S. Department of Health and Human Services. AFCARS. (August 2002
[3] Barbell, K. and Freundlich, M. (2002) Foster Care Today. Casey Family Programs.
[4] U.S. Department of Health and Human Services. AFCARS. (August 2002).
[5] U.S. Department of Health and Human Services. AFCARS. (August 2002).

Experiences of Children in Foster Care

Over the past 40 years, there has been a significant increase in the number of children entering and remaining in state child welfare systems. This increase has been due in part to the emergence of child abuse and reporting laws in the 1960s and the negative impact on family and child development of persistent poverty, racism, and a changing socio-political 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. [6] Thus, the number of children in foster care has increased since the 1960s – from 272,000 in 1962, to 319,800 in 1972, to 502,000 in 1977 [7] and approximately 556,000 in FY 2000.[8]

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. [9]

Recent studies have contributed to a broader understanding of the extent to which children in foster care experience emotional, behavioral, and developmental problems.[10] A 1990 study 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.[11] A 1994 study by the U.S. Department of Health and Human Services found that 27% of the children in foster care were emotionally disturbed; 18% had learning disabilities; 11% had developmental disabilities; 8% had hearing, speech, or sight impairments; and 4% had other disabilities.[12] The American Academy of Pediatrics estimates that 30% of children in foster care have severe emotional, behavioral, or developmental problems.[13]

Additionally, the number of children affected by pre-natal drug-exposure, mental health, developmental, and physical health problems, as well as the severity of these problems, has increased over time, with an estimated 60-80% of the children in foster care today

[6] Barbell, K. and Freundlich, M. (2002) Foster Care Today. Casey Family Programs.
[7] Barbell, K. and Freundlich, M. (2002) Foster Care Today. Casey Family Programs.
[8] U.S. Department of Health and Human Services. AFCARS. (August 2002).
[9] 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.
[10] Barbell, K. and Freundlich, M. (2002) Foster Care Today. Casey Family Programs.
[11] 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.
[12] Barbell, K. and Freundlich, M. (2002) Foster Care Today. Casey Family Programs.
[13] Barbell, K. and Freundlich, M. (2002) Foster Care Today. Casey Family Programs.

coming from families affected by drugs or alcohol.[14] 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".[15] 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. [16]

As the needs of children in the foster care system have become more complicated and the move to de-institutionalize children from large psychiatric institutions, child welfare systems across the country are under pressure to find family resources who are able to meet these complex needs. Yet, increasingly in much of the U.S., competent foster (and adoptive) parent resources are in short supply. 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%) of the children in care.[17] Although the number of children in foster care increased by 68% between 1984 and 1995, the number of foster parents decreased 4%.[18]

Changing Adoption Trends

Adoptions of children in foster care have increased dramatically – from 28,000 in fiscal year 1996 to 31,000 in 1997; 36,000 in 1998; 46,000 in 1999; and 51,000 in fiscal year 2000.[19] President Clinton's 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.[20]

The table below provides a snapshot of 6 large states that have experienced tremendous growth in Adoptions between 1997 and 1999 and the accompanying bonuses. The data was compiled in 2001 in part by Cornerstone Consulting Group and in part by the North

[14] 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.
[15] American Public Welfare Association. (1990). A Commitment to change. (Report of the National Commission on Child Welfare and Family Preservation). Washington, DC: Author.
[16] Trupin, E.W. Forsyth-Stephens, A. and Benson, P.L. (1991). Service Needs of Severely Emotionally Disturbed Children, American Journal of Public Health.
[17] U.S. Department of Health and Human Services. Administration for Children and Families AFCARS. (August 2002).
[18] Barbell, K. and Freundlich, M. (2002) Foster Care Today. Casey Family Programs. (Child Welfare League of America, 1997; U.S. House of Representatives, 2000).
[19] US Department of Health and Human Services, Administration for Children and Families. AFCARS. (August 2002).
[20] A Carrot Among Sticks: the Adoption Incentive Bonus. (2001). Cornerstone Consulting Group. Houston, Texas.

American Council on Adoptable Children. As more children find permanent families through adoption, states have become eligible to receive increased funds to promote and enhance adoption services and supports.

State	Baseline 1997	1998 Adoptions	Bonus for 1998 Efforts	1999 Adoptions	Bonus for 1999 Efforts	2000 Adoptions	Bonus for 2000 Efforts
Michigan	1,905	2,254	$2,004,000	2,446	$1,108,000	2,800	$1,920,000
Missouri	557	616	$ 236,000	817	$1,150,000	1,205	$2,054,000
Minnesota	258	427	$1,022,000	539	654,000	615	$460,000
Oklahoma	338	456	$ 596,000	854	$2,234,000	995	$564,000
Texas	880	1,365	$2,872,000	1,902	$2,990,000	2,010	$498,000
Wisconsin	467	589	640,000	622	$ 302,000	712	$562,000

Yet, in FY 2000, AFCARS reports that 131,000 children remained free for adoption and waiting for an adoptive placement.

Who is Adopting Children from the Foster Care System?

A glimpse of who is adopting children from the foster care system reflects that children are increasingly being adopted by families known to them – with 61% adopted by their former foster parents, 21% adopted by relatives, and 18% adopted by non-relative family resources recruited for them .[21]

While the emerging field of post-adoption services requires better empirical information on the characteristics of adoptive families, the work of Barth et. al. provides a growing understanding of these families and their needs. In their paper entitled "*Assessing the Field of Post-Adoptive Services: Family Needs, Program Models and Evaluation Issues"*, Barth, Gibbs and Siebenaler provide emerging information about the pool of families who are, or might become, post-adoption service users.

Of the states researched, over 70 percent of the families adopting younger children under the age of six are married couples, with both parents working outside of the home. Between 35-40 percent of the families adopting older children are single parent households, where the parent works outside the home. Between 30-40 percent of families adopting children have other foster children or birth children also 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 averages, where this study was conducted, Adoption Assistance appears to be an important source of support for families raising adopted children.[22]

These findings imply a substantial change in the material circumstances of adoptive families during the last decade in comparison to earlier research, which tended to

[21] US Department of Health and Human Services, Administration for Children and Families. AFCARS. (August 2002).

[22] 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.

describe adoptive families as more middle class and affluent than the general public. This may be due, in part, to the shift away from adoption as a service for two-parent, middle class, white families to a service for a changing population of children in foster care who need families. The shifts in who provides foster and adoptive care may be due as well to the changing policies across the country encouraging foster parent and relative caregiver adoption.

Demographic changes in the circumstances of who is adopting the increasing number of vulnerable children waiting for adoption would imply that community-based services will be needed to support and sustain these children and families with special needs.

After Adoption – Service Needs of Adopted Children and Their Families

States have increased the numbers of adoptions with legislative mandates and incentives to do so. However, within this push for more timely permanence for children in foster care, there has been no similar incentive for states to support these families once the adoption is finalized. Historically, formal ongoing information, supports and services for adopted children and their families stopped at the point of the legalized adoption. Efforts to provide post-adoption services with families were not always considered necessary, nor the responsibility of the child welfare agency.

Yet, over the past decade, an increasing number of public child welfare and adoption agencies have begun to view post-adoption services as an essential piece of the service continuum if the life-long process of adoption is to succeed. According to Kenneth Watson in his article published by the American Public Human Services Association:

"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."[23]

Given the increased need for and focus on post-adoption services, current and emerging research on how adopted children are doing – in general and those adopted through the public child welfare system more specifically – provides a compelling argument for the need for adoption-competent and culturally-sensitive mental health services. Research from a variety of sources raises concern about the challenges to the developmental well-being of many of the children who have been adopted. In general, adopted children who were more likely to be diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), [24] and to experience dramatically higher rates of "acting out" behaviors (including

[23] Watson, K. (Winter 1992). Providing Services After Adoption. American Public Welfare Association.
[24] Deutsch, C.K. (1990). Adoption and Attention Deficit Disorder. New York: Pergamon Press.

defiance, running away, sexual acting out, aggressive and antisocial behavior) than children who were not adopted.[25] In addition, one study found that only one half of eligible adoptive families used post-adoption mental health services within 5 years of the adoption.[26]

According to Barbara Ingersoll in her paper "*Psychiatric Disorders Among Adopted Children"*, research 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 challenges and that both genetic and environmental factors contribute to the manifestation of these problems.[27] 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*."[28]

Additionally, adoption of children with prenatal alcohol exposure present particular challenges to adoptive families. Cadoret and Riggins-Caspers found that children with this history have a much greater likelihood of having multiple psychiatric symptoms as they grow up and when they become adults, especially if these children remained in families who had some difficulties – ranging from parent-child conflict to divorce.[29]

Children who were adopted from the child welfare system face many of the aforementioned issues and in addition specifically are found to have a higher risk of diagnoses of attention deficit and learning disorders, higher risks of depression, and higher risks of chemical dependency than children who were raised by their biological families.[30]

It is important to recognize, however, that it is *not the adoption* itself that poses the core challenge these children and their families face. Rather, it is most often the life experiences and early trauma that occurred prior to the adoption that may result in behaviors and ongoing developmental challenges that require culturally-sensitive, adoption-competent attention and intervention. Adoption remains a special and viable way to form a family – one that offers a permanent, lifetime family connections for a child who might otherwise not have had the opportunity to belong to a family.

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[25] Benson, PL. Sharma, A.R., and Roehlkepartain, E.C. (1994). Growing Up Adopted: A portrait of a Adolescents and their Families. Search Institute. Minneapolis Minnesota.
[26] Ingersoll, Barbara, D. (1997). Psychiatric Disorders Among Adopted Children: A Review and Commentary. Adoption Quarterly, Vol. I (1). Haworth Press, Inc.
[27] Ingersoll, B. (1997). Psychiatric Disorders Among Adopted Children: A Review and Commentary. Haworth Press.
[28] Ingersoll, B. (1997). Psychiatric Disorders Among Adopted Children: A Review and Commentary. Haworth Press.
[29] 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.
[30] 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.

The Challenge of 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 for Families, 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. 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 the State of Massachusetts in 1986, Lauren Frey found that the most common post-adoption need was for mental health services with qualified adoption-sensitive mental health professionals. Her study "*Preserving Permanence: A Study of Post Adoptive Services in Massachusetts*" found that 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.[31]

Nelson in her study of 177 adoptive parents found that mental health counseling was cited by parents as their major unmet need post-adoption placement.[32] 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".[33] Another small study asked 20 adoptive families about their experiences with mental health professionals. Some of these families expressed 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 – issues related to trust, loss, rejection, and divided loyalties.[34]

Post-Adoption Services – Helping to Prevent Adoptive Relationship Disruptions

A review of the research suggests that there are indicators for disruptions in adoptive family relationships and placements that should be attended to in the adoption preparation and post-placement support process. These indicators often result in disruptions in adoptive placements prior to adoption finalization, temporary placements outside the adoptive family once the adoption has been finalized, or, in some cases, legal dissolution of the adoption. Three federally funded studies completed in the late 1980s and one completed more recently used different methods and samples, but all arrived at similar

[31] Frey, L. (1986). Preserving Permanence: A survey of post-adoption services in Massachusetts. Boston Massachusetts Department of Social Services.
[32] Nelson, K. (1985). On Adoption's Frontier: A study of special needs adoptive families. New York. Child Welfare League of America.
[33] Frans, K. (1993). Final Report: Warren Ohio: Northeast Ohio Post Adoption Family Support Project.
[34] Howard, J. and Livingston-Smith, S. (1997). Strengthening Adoptive Families. A synthesis of post legal adoption opportunity grants.

conclusions about the approximate rate of disruptions: somewhere between 10-16 percent of special needs adoptions will disrupt.[35]

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

- Children with special needs – emotional, social, medical, psychiatric.

- 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.[36] When children are older at the time of adoptive placement, 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.[37]

- One child placed in families with other biological children.[38] When only one of the children within the family is adopted, stressors are created within the family system that may be difficult to address.

- Partial disclosure of information regarding the child's history and problems. [39] The more that families know and understand the needs and history of the child before adoption, the better informed their decision and the more prepared they are to face the challenges that lie ahead.

- 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.[40]

[35] 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.
[36] 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.
[37] Smith, S.L., Howard, J.A. (1994) The adoption preservation project. Normal, Il: Illinois State University.
[38] Barth, Richard. (August 2001). Designing Post Adoptive Services and Supports (PASS. Presentation at Annual NACAC Conference.
[39] Barth, Richard. (August 2001). Designing Post Adoptive Services and Supports (PASS). Presentation at Annual NACAC Conference.
[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.

- Family is unable to obtain needed support.[41] 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 child permanence at risk.

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

- Family receives comprehensive and realistic information about the child.

- Family receives educational support throughout the adoption process.

- Family has access to and pursues timely adoption preservation services (including mental health services) that are flexible and long lasting. [42]

Yet even in those circumstances where there is significant emphasis on preparing and selecting the right families to meet children's special needs, and educating families about their service options, it often remains difficult for many of adoptive families to find adoption-competent post-adoption mental health services when the needs arise throughout the adjustment to adoption and the developmental stages of their child. Adoption-competent services are needed to help these families cope with the varied adjustment phases associated with coming together and staying together through adoption.

A Challenging Catch-22: Requiring that Families Relinquish Custody to Access Needed Mental Health Services for Their Children

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 that adoptive parents relinquish custody to the public child welfare system. 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 (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.[43] According to the report, parents face this dilemma because limits in private healthcare plans and un-enforced entitlements in public health care plans deprive many children of access to needed mental health care. Yet, upon entering the juvenile justice or child welfare system, a child qualifies to receive publicly-funded mental health services.

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[41] Barth, R. and Brooks, D. (1997). A longitudinal study of family structure and size and adoption outcomes. Adoption Quarterly 1, 29-56.

[42] Barth, Richard. Designing Post Adoptive Services and Supports (PASS). (August 2001). Presentation at Annual NACAC Conference.

[43] Relinquishing Custody. The Tragic Result of Failure to Meet Children's Mental Health Needs. (March 2000). Bazelon Center for Mental Health Law.

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.[44] 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 5 to 7 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, according to the Health Care Reform Tracking Project 2000 State Survey, the services *most* likely to be covered by managed care reforms include:[45]

- 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 – with no managed care contract allowing 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, often at exceedingly high costs.

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[44] Relinquishing Custody. The Tragic Result of Failure to Meet Children's Mental Health Needs. (March 2000). Bazelon Center for Mental Health Law.

[45] Stroul, B. Poires, 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.

The Tracking Reform Project also identifies a troubling trend in managed care network provider panels: that only just over one half of the reforms reportedly include child welfare providers (i.e. behavioral health providers that traditionally have served the child welfare population).[46] 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, and adoptive families are forced to seek help from ill-informed professionals who do not understand the nuances and complexities of adoption from the child welfare system. Therefore, a significant amount additional training in the delivery of culturally-sensitive, adoption-competent mental health services will be needed by managed care providers – as 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 Tracking Report:

- 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 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.[47]

On the more positive side the Tracking Reform 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.[48]

[46] Stroul, B. Poires, 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.
[47] Stroul, B. Poires, 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.

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, and particularly adoption-competent support.

A Review of the Services Available Within States for Adoptive Families

Research regarding the services that actually are available to families who have adopted their children from the public child welfare system has been conducted by the American Public Human Services Association and its Association of Administrators of Interstate Compact and Medical Assistance. The table below is a result of the Report on Post-Adoption Services developed by the American Public Human Services Association (APHSA).[49] This report responds to a need for greater understanding of the various post-adoption services that are available through state and local public child welfare agencies. The survey was conducted between March and October 1999.

Service	# 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

A report published by Illinois State University describing the array of post-adoption service efforts funded through the post-legal Federal Adoption Opportunity Grants 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

[48] Stroul, B. Poires, 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.

[49] 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.

greater investments are needed to find ways to sustain post-adoption services – especially adoption-competent mental health services and supports.

Implications for Practice and Policy

The information reviewed here highlights the reality that 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. And, third, if accessed, there appears to be no guarantee that mental health practitioners have a culturally-sensitive understanding of the complex needs of adoptive families whose children face challenges to the stability of their mental health and well-being.

Since adoption has an impact at every developmental period and level, behavioral and emotional problems may occur at any point – and do. The system of care for children and families – including the medical, social services, educational and behavioral heath communities – needs to understand the impact of adoption on children and families (birth and adoptive) and be available to provide professional counseling, therapy, and support, system direction and understanding. A sense of urgency is needed within communities of legislators, policy makers, practitioners and advocates resulting in an ongoing commitment to support adoptive families. The preservation of adoptive families needs to be seen as one more component of a successful child-serving system of care in this country.

FAMILIES' PERSPECTIVES – THE NEED FOR ADOPTION-COMPETENT MENTAL HEALTH SERVICES

This White Paper includes the perspectives of adoptive families – a key component to deepening a growing understanding of their needs and experiences. Comments from a diverse array of families whose adopted children have experienced significant mental health challenges have been included – from families who were contacted directly by the authors and families whose circumstances were described by others' reports. The primary sources of material for this section include:

- Focus group convened by Casey Family Services with adoptive families who attended the Federation for Families conference in December of 2001;

- 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);

- Personal conversations with adoptive families from across the country through a conference call co-sponsored by Casey Family Services and the North American Council on Adoptable Children (NACAC), and personal follow-up conversations; and

- 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 synthesis of these conversations suggests that adoptive families are struggling to meet the mental health needs of their children. They repeatedly report running into policy barriers, resource barriers, and inadequacies in the competency of the mental health professionals around the issues of adoption and children's mental health. As families talked about what they need, three themes emerged:

- The need for increased adoption expertise within systems of health and behavioral health care.

- The need for health and mental health systems of care to become much more integrated.

- The need for information about their children's past experiences and present needs, and information about how to manage their developmental challenges.

- The need 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, in an effort to learn more about the experiences of families who have adopted children, Casey Family Services brought together a group of adoptive families at the annual national conference of the Federation for Families of Children with Mental Illness 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 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 they explained how they've learned to get their needs met.

The following are a sampling of the insightful comments that this group of adoptive families shared:

- "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 it is really needed!"

- "Some of the agency's 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 – their 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 the following:

1. Offer what is needed by adoptive families in a coordinated manner. Families are required to tell their stories repeatedly, with minimal collaboration among service providers.

2. Provide adequate information about the mental health needs of their child in the context of the adoption experience.

3. Facilitate opportunities for family support – from professionals and from one another, especially when the days seem too long and the problems too big.

Adoptive parents in the focus group reported that the educational system is often where children's mental health needs become most obvious, and where an understanding of the adoption experience and links to adoption-competent mental health services break down. 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. [50]

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

[50] 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.

- *Access to Information.* Extensive and early information on their child's background is provided as well as training and education on the behaviors to anticipate, and the appropriate interventions. A "Personal Resource Package" with information about their child might include: the background 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 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: 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 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.

- *Openness in Services.* There is an openness between the serving systems – they talk to one another about a child they are all serving. They don't hide behind the guise of confidentiality –we want them to talk!

- *Continuity of Service with Adoption-Competent Professionals.* Helping professionals understand the issues that adoptive families face, are available over time and can individualize practice interventions.[51]

Families' Definitions of Adoption-Competent Professionals

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

[51] 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.

- Know that adoption is one way to form a family, and that adoption is a life-long process.

- Understand that adoptive families face very unique and very real issues related to the process of coming together as a family.

- View adoption in a cultural and family context over several generations.

- Understand the complexities of adoption as they emerge at each developmental stage of the adoptive family's adoption adjustment.

- Help adoptive families honor the adopted child's past – through sharing information and acknowledging birth family connections.

- Promote more secure attachments and address challenges to adjustment, including, early childhood trauma, loss, grief, blame and mistrust.

- Provide access to information about culturally-sensitive, adoption-competent family supports and services including: adoptive family support groups, respite options, linkages between child welfare and other systems.

- Avoid blaming adoptive parents for their children's behaviors; rather understand that the child's behaviors (such as hoarding food or lying) may be connected to past trauma and losses – and may be 'survival' behaviors for that child.

- Advise parents to talk about the adoption and the feelings the child has about his or her birth parents – the longing and the wishing.

- Seek out options other than out-of-home placement which can perpetuate a child's feelings of abandonment and rejection. [52]

Families' stories about their experiences and recommendations regarding adoption-competence have guided the exploration of promising practices in adoption-competent mental health services. The next chapter of this paper is devoted to a description of a sampling of "Promising Practices in Adoption-Competent Mental Health Services".

[52] Certain portions of the description of these characteristics of Adoption-Competent practitioners is adapted from the work of Howard, J. and Livingston-Smith, S. (1997). Strengthening Adoptive Families: A Synthesis of Post-legal Adoption Opportunities Grants. Illinois State University.

"PROMISING PRACTICES IN ADOPTION-COMPETENT MENTAL HEALTH SERVICES"

Through conversations with adopted families and a variety of 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. State child welfare agencies – in partnership with their counterparts in Mental Health and Medicaid – can engage in planning and implementing an array of adoption-competent mental health services, supports and educational opportunities for adoptive families and professionals alike.

The identified promising practices are highlighted below through a series of ***Can Do! Recommendations*** that child welfare managers can implement now – alone and in partnership with their counterparts in the Mental Health and Medicaid Departments.

Every Child Welfare Agency can support low cost family education, support and networking groups.

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.[53] The range of prevention-oriented 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 parents, support groups serve to normalize children's behavior or to provide positive comparisons (at least my child doesn't do that!). They provide parents a safe place to express their feelings with others who share their concerns, to gain a sense of being understood and supported, and to 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 finalization helps families become involved as early as possible in this key preventive services strategy – efforts which can help keep adoptive families together.

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

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

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 state funds and resources from the North American Council on Adoptable Children (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 the adoptive families that needed the 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 Ms. Prybil, it did not take long: *"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 and they 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. "*Its 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."*[54]

Supports for Children and Parents – Illinois Adoption Preservation Services Support Groups

In the state of Illinois, communities spent several years struggling to develop their support group programs for adopted children and their parents as part of their overall adoption preservation programs. According to Jeanne Howard and Susan Smith 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 to 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).[55] 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.

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*

[54] Personal Communication with Julie Prybil, parent liaison with Minnesota Adoption Support and Preservation Program. (December 2001).

[55] 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.

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 of the families expressed that it was difficult to get 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 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 be uncomfortable expressing within their adopted families.

Surveys of adoptive parents related to 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%

Every Child Welfare Agency can develop internet technology opportunities that link families with information and support.

Web-site Options: Together as Adoptive Parents – Pennsylvania

Phyllis Stevens of Harleysville, Pennsylvania is the Director of Together as Adoptive Parents, an organization that uniquely helps adoptive families to find adoption competent-community mental health practitioners. Funded by the state of Pennsylvania, Together As Adoptive Parents has created an interactive web-site that provides data on therapists from around the state. Prospective adoption therapists were sent a survey developed by adoptive families that includes the following questions:

- How many adoptive families do you work with on a regular basis?
- Where did you get your training?
- Have they 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 web-site 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 Ms. 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.

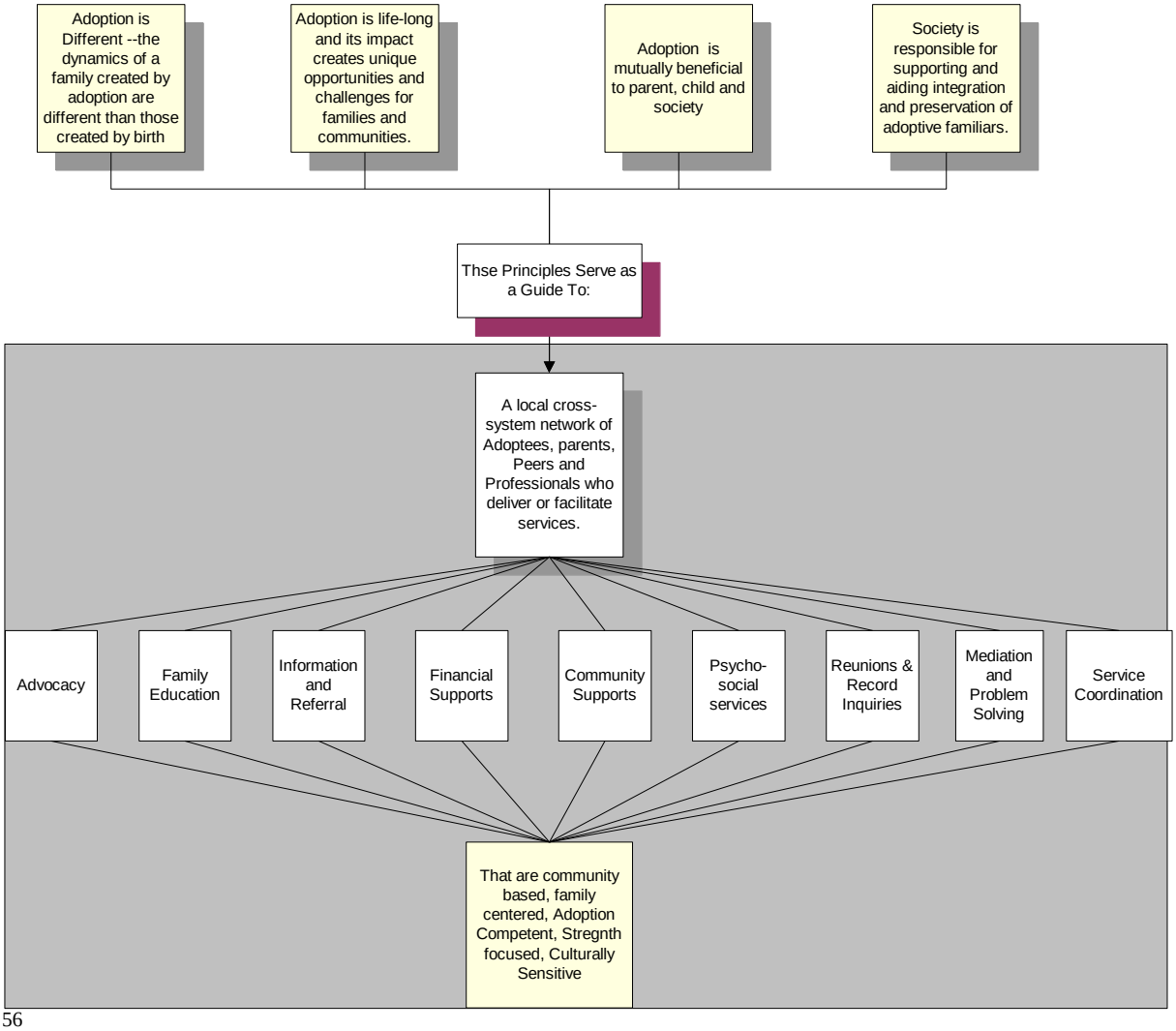
Also included in the website are an array of service options and funding information for families including:

- 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
- 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 education to families*" states Ms. 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."*

Every Child Welfare Agency Can Support Comprehensive Approaches to Adoption-Competent Support, Education and Mental Health Services

The comprehensive services approach to post-adoption services is best described through the work of Jean Howard and Susan Smith of the Center for Adoption Studies at Illinois State University. 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 represents the mix of components of this comprehensive approach which included 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.



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It is extremely challenging for any single agency to develop this kind of a comprehensive array of post-adoption services primarily due to funding limitations. However, states are increasingly using a mix of federal funds (i.e. Title IV-B, Parts 1 & 2; Title IV-E, Maintenance, Training and Administration, Medicaid, TANF, and Discretionary funds), as well as their own resources and staff development time to achieve this comprehensive post-adoption service system. Agencies appear somewhere along this continuum in their development of the component parts of this comprehensive array. Several are highlighted here, including Casey Family Services' post-adoption service approaches.

[56] Livingston-Smith, S. and Howard, J. (1997) Strengthening Adoptive Families. A synthesis of post-legal adoption opportunity grants; Illinois State University.

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 non-profit 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 Ms. 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 also work through their own struggles of lost dreams and feelings of shame and guilt. Children and families are also involved in group activities that seek to normalize their experiences. Strong treatment plans with clear treatment objectives are key to the work at CASE. 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 Connecticut, California 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 (IEP) 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 specifically designed for the school environment – targeting 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 not only understand children's behaviors in the context of adoption, but to also 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, the hope is that practitioners in a variety of settings will better understand the issues faced by adopted children and their families and will develop more adoption-competent therapeutic models and mental health service arrays.

Casey Family Services – Comprehensive Post-Adoption Services Programs

For over 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 – families who had come together through the efforts of the Department of Children and Families, and families who had also adopted children through other domestic or inter-country means. Regardless of the circumstance of their adoption, families reported that they needed specialized education, supports, service referrals and sometimes more intensive therapy to better understand and cope with the ongoing process of adjustment associated with their adoption.

Casey Family Services now provides an array of comprehensive post-adoption programs within six of its eight divisions. Over time, staff have learned from the experiences of seasoned adoption professionals, therapists and families themselves that adoption is a life-long 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 understand and sustain their family relationships over time. Casey Post-Adoption Programs in Bridgeport, Hartford, Vermont, Rhode Island, New Hampshire and Maine include comprehensive post-adoption services programs which 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 our own foster care programs as well.

Each of Casey Division 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, inter-agency, and systems
- Adoption-competent professional training
- Community adoption-awareness education
- An array of support groups for parents and children, and workshops for parents
- Community activities for children and families

For example, the Vermont Division offers an array of supports and services organized through a "levels of service" approach (see appendix). Families can participate in groups and individual family-centered services of varying levels of intensity, and can 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.

In the Bridgeport Division, the Post-Adopt 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 (through an Adoption Opportunities grant received by the State of Connecticut). As well, Bridgeport post-adoption staff provide many opportunities for the general community to understand adoption through public speaking engagements 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, 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 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 Post-Adopt 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-Adopt Program staff work with mental health clinicians across the state to increase their competency in providing therapy with adoptive families, and provide access to respite services (MORE INFO NEEDED).

Hartford and Rhode Island Post-Adopt Programs have developed relationships with their respective state child welfare departments to accept referrals of foster families transitioning to adoption – helping to prepare children and families for what to expect and to provide the comprehensive post-adoption services they will need once their adoptions are finalized. Our 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 are also engaged as consultants with The Casey Center for Effective Child Welfare Practice to provide an array of post-adoption services technical assistance with public and private agencies. The Casey Center provides strategic planning, policy analysis, and adoption-competence 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.

Every Child Welfare Agency Can Implement Adoption-Competent In-Home Therapeutic Intervention

There are several examples of adoption-competent mental health assistance provided through intensive in-home adoption preservation programs – services that offer hands-on crisis intervention and long-term support with pre-adoptive and adoptive families through challenging times. Below two unique examples are highlighted, 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 behavior concerns before they deteriorate. In Illinois, the state wide in-home adoption preservation program, which grew out of the family preservation movement, is available to families voluntarily seeking services when the stability of the adoptive placement 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 five 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.*".[57]

A nurse from the Community Infant Program was assigned to work with Sarah when she was placed with Deborah. A nurse was also 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 one year old, she had been assessed by speech and occupational therapists, and the family was involved in family therapy to learn how to adjust to Sarah's needs – a service which was funded by Medicaid. The case team involved Sarah' father, Deborah, the Boulder County child welfare social worker, the CASA worker, the nurse, and the Speech and Occupational Therapist. While it was decided 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 up, this team of professionals played 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. Deborah shared "*this was one of the biggest gifts that this program gave to our family…early and effective diagnosis and intervention."*[58]

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 lynchpin 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 six years old and free to be adopted by our family, she was a stable and healthy six year old…"* [59]

[57] Personal Communication with Deborah, an adoptive parent. (November 2001).
[58] Personal Communication with Deborah, and adoptive parent. (November 2001).
[59] Personal Communication with Deborah, and adoptive parent. (November 2001).

State-wide 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.[60]

Research about the Adoption Preservation Program by the Center for Adoption Studies at Illinois State University indicates that families served have complex problems that 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 have experienced an array of factors that put them at risk of adoption placement disruption or dissolution, including:

- Multiple types of 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 being the one most commonly reported
- Older age at placement.

One-quarter of the children served have been placed outside their adoptive families since the adoption, with psychiatric hospitalization the most common type of placement. And, 13% of the children served were not living with their adoptive families at the end of services (2/3 of those children were in residential and foster family care, and the remaining 1/3 were 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.[61] The Intensive

[60] 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.
[61] 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.

services include in-home family counseling, in-home 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 insure that old information is accurate. Twenty-four hour availability is part of each adoption preservation program.

The overarching strategy 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; helping parents gain behavior management skills, break ineffective cycles of parenting, and gain access to community resources that can help them help their child.[62] 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 (trauma and loss). 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.[63]

Every Child Welfare Agency can partner with schools of social work or private agencies to develop innovative Adoption-Competent Professional Educational Models for Child Welfare Practitioners, Community-Based Providers and Mental Health Professionals

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 professional to increase community capacity to meet the complex mental health needs of the increasing numbers of adopted children and their families.

[62] 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.
[63] 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.

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 – sustainability being a critical component of the grant.

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 funded with grant dollars, while the second program year funded through a blend of the federal funds and tuition payments. The program includes nine months of one-day classes that address theory and research as well as therapeutic skills courses. Each one-day course earns participants 5 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 (see appendix for full description) 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 Institutional 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, Washing 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 from 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 designing 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 working with families transitioning to and choosing adoption. The program was launched in October, 2001. Classes of 20 practitioners meet once a month for 10 hours over a Friday and Saturday. Instructors are national and local experts in the field of foster care and adoption therapy.

The nine month 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 to include in their list of qualifications and to meet 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 the 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…"* [64]

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.
    - 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.

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

- Required involvement or shadowing with staff members during home visits to better understand the adoption practice orientation.

- Required participation in groups where children share their experiences.

- Required exposure to the language and concepts of post-adoption services.

According to Ms. Fleischman, it is the thoroughness of screening and preparation during the hiring process that 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 (CEUs) 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 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 as students, new graduate social workers will have a deeper understanding of the complexities of adoptive families and mental health concerns involved. (See curriculum in the appendix).

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

The State of Maine has developed a Title IV-E waiver 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. 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.

Maine is using its Title IV-E waiver to provide post-adoption services, 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 and the University of Southern Maine. 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; and

2. If children do have to be removed from their adoptive families, the provision of flexible services and supports will help these adopted children return to their adoptive families earlier and more successfully.

The IV-E waiver has 3 components:

1. Flexible dollars 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; and

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 the 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 state-wide. 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 Medicaid Targeted Case Management program, the use of Medicaid to support behavioral health services for adopted children becomes a viable option to serve adoptive families in Maine – an option that can 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.

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 who 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!"*[65]

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*."[66]

Every Child Welfare, Mental Health and Medicaid Agency can partner to include mental health services for adopted children within the state Medicaid and Managed Care Plans, and to require that all mental health providers be certified as adoption-competent.

Discussions with adoptive parents and professionals across the country have revealed many opportunities for creating adoption-competence within existing mental health systems – without re-inventing 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 and psychiatric conditions so that children can remain safely within their families and communities with the added trauma of out-of-home placement. Two examples hold great promise.

Adoption-Competence in Mental Health 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.

[65] Personal communication with Diane Kindler, Team Leader Casey Family Services. April 2002.
[66] Personal communication with Diane Kindler. Team Leader, Casey Family Services. April 2002.

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 compliment 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 structure consists of eight Mental Health Assessment and Services Agencies (MHASAs) covering the sixty-four 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 understanding attachment, loss and grief that children in the child welfare system experience. Staff from the Child Protection Intake programs were also trained concurrently in the same training events, 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 Opportunity 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 – thus 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.

The experiences of the Adoption Clinic have substantiated that many children who are adopted from the foster care system of California 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 between the Orange County Social Services Agency, Health Care, 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. This public/private partnership provides funding, quality assurance oversight and outcomes measurements.[67]

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, progress in healing trauma resulting from prior neglect, abandonment and abuse. The majority of children are treated without medication.[68]

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 multi-disciplinary staff for the project includes case managers, child assessment specialists, a psychologist, a parent educator, a pediatrician, and an occupational therapist.

Where Systems of Care initiatives exist in states, every state child welfare agency can initiate conversations with the System of Care implementation team to include a focus on adoption-competent mental health services for children and families.

Comprehensive Community Mental Health Services for Children and Their Families Systems of Care Initiative

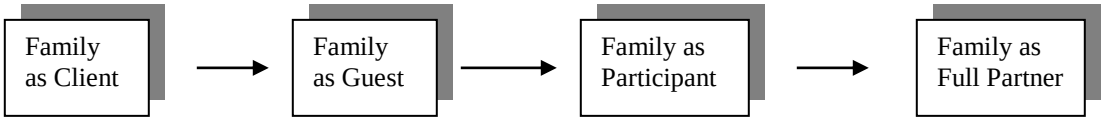
The Comprehensive Community Mental Health Services for Children and Their Families Systems of Care Initiative, funded by the Child, Adolescent and Family Branch of the Substance Abuse and Mental Health Services Administration (SAMSHA), offers an exciting opportunity within an existing structure of mental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

This multi-million dollar federal grant program supports "Systems of Care" initiatives in forty one states, Guam, Puerto Rico and the District of Columbia. (See Appendix). We have elected to highlight several of the fundamental principles and practices of Systems of Care because we believe this program approach, with sites throughout the nation, might serve as an excellent vehicle to house the responsibility for building and sustaining adoption-competent mental health services within states, counties and communities.

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

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 well as advocates within systems of community mental health services.[69]

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



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 wrap-around services to support children and their families within their communities – an approach to service delivery that seems to mirror the vision of adoptive families as they describe efforts to find comprehensive services for their children. The definition of wrap-around 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[70].

For example, an adoptive family may be provided with an array of services, supports, education and even respite in an attempt to keep their eleven-year old emotionally disturbed and suicidal daughter from re-entering in-patient psychiatric care. Wrap-around services could include targeted case management, in-home family therapy, medication management through a local psychiatrist, educational support/classroom aid, and an after-

[69] Systems of Care: Promising Practices in Children's Mental Health: New Roles for Families. (1998). SAMSHA.
[70] Systems Of Care: Promising Practices in Children's Mental Health: Promising Practices in Wraparound for Children with Serious Emotional Disturbances and their Families. (1998). SAMSHA. Volume IV.

school program in a local church. This mix of services wraps support around the family and alleviates stressors during particularly vulnerable times.

Jan McCarthy, Director of the National Technical Assistance Resource 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 policy makers to build the full range and type of services needed."*[71]

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 we did not find a specific link between the Systems of Care Initiatives and adoption-competent training for these mental health providers, we believe 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 – certainly presenting an 'opportunity waiting to happen'!

Every Child Welfare Agency Can Improve the Family-centeredness and Adoption-Competency of its Residential Care Providers.

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, we cannot the ignore the reality 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 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 alike. 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 how, or believing in the importance of working with the child's family.

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

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

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, CEO 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 both their Family Preservation and Residential Care Programs. Mr. Villiotti writes in his paper "Embracing the Chaos: Moving from a Child-Centered to Family-Centered Treatment Model in Residential Care" that there were three structural culture changes that the agency made in incorporating family-centered practice into all phases of their work. These shifts emerged during the mid-1990's 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. These structural shifts include the following practices:

- 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;

- 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.

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."* [72] Staff are trained on how loss and grief affects child behavior, and adoptive parents' reactions. Staff ask adoption-related

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

questions at intake to learn whether a child has been adopted, how long ago, and how/whether people feel the adoption is impacting the current situation. And staff 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 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 continue to strive to find new ways to address the families' issues of betrayal by the state system and seek 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. is a large not-for-profit organization located in Davenport Iowa. The agency provides a comprehensive array of children's services. The organization underwent a significant practice shift over the past three years as they struggled to become a more integrated organization. According to Tom Wilson, President and CEO, *The goal of this massive cultural shift was to ensure that 1) regardless of the 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*.[73] 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 treatment. Residential care, foster care, adoption, and day treatment became one treatment team. These teams are absolutely critical in helping program staff see the "big picture" as they struggle to implement services for children and their families.

When these teams were first developed, the different ways that programs viewed children was 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 their 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 do birth family issues. The

[73] Personal Communication with Tom Wilson, CEO of Family Resources, Inc. (April 2002).

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."*[74]

The post-adoption program of Family Resources is funded predominantly by United Way. According to Gradert "*there is just not enough investment in post adoption services in 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."*[75]

[74] Personal Communication with Christine Gradert, Vice President of Professional Services for Family Resources, Inc. (April 2002).

[75] Personal Communication with Christine Gradert, Vice President of Professional Services for Family Resources, Inc. (April 2002).

SUMMARY AND CAN DO! RECOMMENDATIONS

"We helped to create these families and as such we have a moral obligation to support them as they struggle to stay together.**"**

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

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

For the past decade, Casey Family Services has engaged in providing and learning about the comprehensive array of post-adoption services and supports with families who have come together through adoption. We have learned that adoption is a lifelong process which begins when children are placed with prospective adoptive families and continues beyond legal finalization. From our literature reviews, our own program research and our ongoing experiences with adopted children and their families, we have learned that adoptive families episodically have a need for an array of education, support and therapeutic community services – as Joyce Pavao from the Center for Family Connections in Cambridge, Massachusetts describes – brief long-term therapy. The key is that this mix of services be provided with an adoption-competent knowledge base and approach, by service providers and therapists who can see strengths within complex diagnoses. Families who have come together through adoption need to be understood, encouraged and supported as they provide the nurturing, education, structure and love that adopted children need on an ongoing basis – regardless of the circumstances of adoption.

This paper has offered the opportunity to find promising practices in adoption-competent mental health services – collaborations that have maximized existing resources, developed new strategies and made an incredible difference in the lives of adoptive families. We have learned that these are strategies that state Child Welfare, Mental Health and Medicaid programs CAN DO! And thus, we make our best CAN DO! Recommendations that states can implement over time. These are strategies that we at Casey Family Services and The Annie E. Casey Foundation are committed to helping states implement through our ongoing research, policy, technical assistance, and training.

We hope you find these recommendations relevant to your states' needs and doable even within increasing state budget constraints. Please let us know what you think and what help you would like!

Can Do! Recommendations

1. ***Every Child Welfare Agency can support low cost family education, support and networking groups.***

2. ***Every Child Welfare Agency can support internet opportunities that link families with information and support.***

3. ***Every Child Welfare Agency can support comprehensive approaches to adoption-competent support, education and mental health services***

4. ***Every Child Welfare Agency can implement adoption-competent in-home therapeutic intervention***

5. ***Every Child Welfare Agency can partner with schools of social work or private agencies to develop innovative Adoption-Competent Professional Educational Models for Child Welfare Practitioners, Community-Based Providers and Mental Health Professionals***

6. ***Every Child Welfare, Mental Health and Medicaid Agency can partner to include mental health services for adopted children within the state Medicaid and Managed Care Plans, and to require that all mental health providers be certified as adoption-competent.***

7. ***Where Systems of Care initiatives exist in states, every State Child Welfare Agency can initiate conversations with the System of Care implementation team to include a focus on adoption-competent mental health services for children and families.***

8. ***Every Child Welfare Agency can improve the family-centeredness and adoption-competency of its residential care providers.***

9. ***Every State Child Welfare agency can monitor the efficacy of its private community-based providers in the area of adoption competence.***

10. ***Every State Child Welfare Agency can promote legislative reform to ensure that families do not have to relinquish custody to secure needed services for their children.***

APPENDIX

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We want to thank the following individuals for their willingness to spend their valuable time contributing to the content of this paper.

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Casey Family Services – Vermont Division
Post-Adoption Services Continuum – Levels of Service

Level One Services are low-intensity, community-based supports available as needed to families experiencing the normative crisis points of adoptive family life.

Examples:

- Information and referral services, monthly newsletter, post-adoption library
- Adoptive family events, such as picnics, workshops and activity groups, children's activities
- Parent support/discussion and education groups
- Brief therapy and psycho-educational counseling

Level Two Services include educational and clinical supports relating to specific experiences, challenges, and populations of adoptive families.

Examples:

- Workshops and support groups aimed at increasing the capacity of adoptive families of children of color to develop strong, enduring relationships with their children's ethnic and cultural community and to nurture a strong positive racial identity in the adopted child and the family.
- Training and support, both prior to and following adoption finalization, for parents of special needs children, particularly those with a history of early abuse, neglect and attachment disruption. The focus is on building attachment, responding to behavioral issues, and helping their children and the entire family make sense of their complex history.
- Support/advocacy groups for and by parents of challenging children who are dealing with the sequelae of their children's early experiences of trauma, loss and disrupted attachment relationships.
- Support groups for adopted children and their parents to help them address issues and concerns that arise at particular developmental stages and in the face of predictable life events.
- Strength-based family counseling facilitated by adoption-competent Casey social workers.
- Advocacy and participation on treatment teams.

Level Three Services: are intensive, coordinated therapeutic and case management services in times of crisis and/or with families who have adopted a child with a severe emotional/behavioral disturbance that preceded the placement.

Examples:

- Crisis intervention.
- On-going intensive case management/ service coordination.
- Wrap-around services including intensive in-home therapeutic services and respite.
- Participation in treatment teams to advocate for funding for out - of - home placement where necessary and appropriate.

Adoption Certification Program For Mental Health Professionals
2002-2003 Curriculum Outline
(45 Hours of Continuing Education Regarding Adoption)
Co-Sponsored by the New Jersey Department of Youth and Family Services and the Rutgers University School of Social Work, Continuing Education Program

1) The Psychology of Adoption
   This course sets the stage for the overall program by focusing on:
   - Contemporary Trends in Adoption
   - Psychological Benefits and Risks Associated with Adoption
   - Stress and Coping Models in Adoption
   - Family Life Cycle Tasks in Adoption
   - Implications for Post-Adoption Services

2) Life Cycle Experience of Adoption: Infant Adoptions
   This course explores issues commonly faced by children adopted in infancy:
   - Core Issues of Adoption at Various Ages and Stages
   - Differences Between Families formed by Birth and by Adoption
   - Role of Early Influences on Brain Development
   - Pre-natal and Post-natal Factors that Influence Brain
   - Impact of Sub-Optimal Care
   - Knowing When to Seek a Medical Evaluation

3) Life Cycle Experience of Adoption for Older Children
   This course introduces the special challenges related to parenting children who spent significant time in temporary care systems prior to adoption:
   - Life in the Child Welfare System/ Common Survival Behaviors
   - Adoption as the Permanency Plan
   - Developmental Tasks of Middle Childhood
   - Interplay between Adoption and Child Development
   - Characteristics of Successful Adoptive Families

Core Clinical Workshops

4) Attachment-Focused Therapy for Adoptive Families
   This is a therapeutic course focused on clinical interventions that promote parent-child attachment in adoption:
   - Recognizing the Symptoms of Impaired Attachment
   - Understanding the Impact of Impaired Attachment on the Adoptive Family
   - Facilitating Family Attachment
   - Assessment/Treatment/Clinical Strategies/Stages of Healing

5) Family-Focused Therapy for Post Institutionalized Children
   Young children adopted internationally – and older children adopted domestically -have often spent significant time in institutional care; this course discusses assessment and treatment strategies related to this experience:
   - Behavioral Symptoms Common to Post-Institutionalized Children
   - Impact on the Adoptive Family
   - The Adoptive Family as the Primary Source of Care and Healing

- Assessment/Treatment/Clinical Strategies/Stages of Healing

6) Individual Therapy with Adopted Children
   This course is meant to increase clinical skill related to individual and group interventions:
   - Assessment and Treatment Approaches
   - Identity Development
   - Separation Problems
   - Strategies and Techniques for Various Ages
   - Normalizing the Adoption Experience

7) Behavior Management and Discipline with Traumatized Children
   Effectively managing discipline and behavioral difficulties is often a significant challenge for families adopting special needs children; this course helps increase knowledge related to:
   - Discipline as Protection and Care
   - Supervision as a Form of Discipline
   - Testing, Limit-Setting, Rewards, Consequences, Incentives, Punishment
   - Crisis Intervention
   - Skill-Building for Adoptive Parents

Elective Workshops (choose two)

- Trans-Racial Issues in Adoption
- Birth Family Issues in Adoption
- Therapeutic Group Services in Adoption
- Clinical Services to Birth Families
- Diversity in Adoption: Not Just Moms and Dads

Children's Mental Health Services Project Sites

FY	State/Place	Project Title
1997	Alabama, (Birmingham/ Jefferson County)	Jefferson County Community Partnership
2002	Alaska (Fairbanks Native Association)	Ch'eghutsen' A System of Care
1999	Alaska, (Yukon-Kuskowim, Bethel)	Yuut Calilrüt Ikaiyuquulluteng: People Working Together
1999	Arizona, (Pima County)	Project MATCH (Multi-Agency Team for Children)
2002	California (Glenn County)	County of Glenn
2002	California (Sacremento County)	Sacramento Model
2002	California (San Francisco)	San Francisco System of Care (SFSOC)
2000	California, (Humboldt & Del Norte Counties)	AK-O-NES- Wraparound System of Care
1999	California, (Martinez)	Spirit of Caring Project
1997	California, (San Diego County)	Children's Mental Health Services Initiative

FY	State/Place	Project Title
2002	Colorado,	Project Bloom
1999	Colorado, (Denver)	Colorado Cornerstone System of Care Initiative
2002	Connecticut (State)	Partnership for Kids Project
2002	DC, Washington	The D.C. Children Inspired Now Gain Strength
1999	Delaware, (New Castle County)	Delaware Families and Communities Together (FACT) Project
2002	Florida (Broward County)	One Community
1999	Florida, (Palm Beach County)	Family Hope (Helping Organize Partnerships for Empowerment)
1998	Florida, (Tampa/ Hillsborough County)	Tampa-Hillsborough Integrated Network for Kids (THINK)
2000	Georgia, (Rockdale and Gwinnett Counties)	The PeachState Wraparound Initiative
2002	Guam (Territory)	I'Famagu'onta (our children)
2002	Idaho	Building on Each Other's Strengths
2002	Illinois	System of Care-Chicago

FY	State/Place	Project Title
1999	Indiana, (Lake County)	Circle Around Families
1999	Indiana, (Marion County)	Dawn Project
1998	Kentucky, (Eastern)	Kentucky Bridges Project
1997	Maine, (Indian Township, Passamaquoddy Tribe)	Kmihqitahasultipon (We Remember) Project
1999	Maryland, (Montgomery County - 7 Communities)	Community Kids Project
1999	Massassachusetts, (Suffolk County)	Worcester Communities of Care
1997	Michigan, (Detroit/ Wayne County)	Southwest Community Partnership
1998	Michigan, (Sault Ste Marie (Chippewa))	Mno Bmaadzid Endaad (Be in good health at his house)
1999	Minnesota, (Wilmar)	PACT (Putting All Communities Together) 4 Families Collaborative
1999	Mississippi, (Jackson)	COMPASS Project
2002	Missouri	Show-Me Kids Project
1998	Missouri, (St. Charles County)	Partnership with Families: Initiative for Youth

FY	State/Place	Project Title
1997	Nebraska, (Kearney)	Nebraska Family Central
1998	Nebraska, (Lincoln, Lancaster County)	Families First and Foremost
1998	Nevada, (Las Vegas,Clark County)	Neighborhood Care Centers
1999	New Hampshire, (Concord)	CARE NH: Community Alliance Reform Effort
1999	New Jersey, (Burlington County)	Burlington Partnership
2002	New York (City)	Keeping Families Together
1999	New York, (Westchester County)	Westchester Community Network
1997	North Carolina, (4 regions)	NC FACES (Families and Communities Equals Success)
1999	North Carolina, (Raleigh (1999))	North Carolina System of Care Project
1997	North Dakota	The Sacred Child Project
2002	Oklahoma	Choctaw Nation of Oklahoma

FY	State/Place	Project Title
2002	Oklahoma (State)	Oklahoma State Dept. of Human Svcs.
1998	Oregon, (Clackamas County (Portland))	Clackamas Partnership
1998	Pennsylvania, (Pittsburgh, Allegheny County)	Community Connections for Families
2002	Puerto Rico (Territory)	Puerto Rico Mental Health Initiative for Children (PR/MHIC)
1998	Rhode Island	Project HOPE
1999	South Carolina, (Greenwood)	Gateways to Success
1999	South Dakota, (Pine Ridge)	Nagi Kicopi - 'Calling the Spirit Back'
1999	Tennessee, (Nashville)	Nashville Connection
2002	Texas (Fort Worth)	Community Solutions
1998	Texas, (Austin,Travis County)	The Children's Partnership
2002	Texas, (El Paso County)	The Border Children's Mental Health Initiative

FY	State/Place	Project Title
1998	Utah, (Rural Frontier)	Utah Frontiers Project
1997	Vermont	Children's Upstream Services (CUPS)
1998	Washington, (Clark County (Vancouver))	Clark County Children's Mental Health Initiative
1998	Washington, (King County (Seattle))	Children & Families in Common
1999	West Virginia, (Charleston)	Mountain State Family Alliance
1997	Wisconsin, (Rural Wisconsin)	Northwoods Alliance for Children's Mental Health
1998	Wyoming, (Northern Arapaho Tribe)	With Eagle's Wings