Post-adoption Services

Description/Etiology

Adoption is the permanent legal transfer of parental rights and responsibilities from a child’s birth parents (BPs) to adoptive parents (APs). Adoption is also understood to be a lifelong process involving complex, dynamic relationships between children, their birth families, and their adoptive families in the context of their community and culture. Post-adoption services encompass an array of educational, material, and supportive services designed to assist children and families with mental health needs, adjustment, and other adoption-related issues that may arise over the course of childhood. (For more information, please see the series of quick lessons and evidence-based care sheets about adoption.)

Although the majority of adoptions result in successful integration of children into adoptive families, most families experience some normative adoption-related challenges, such as determining when and how to share the child’s birth/adoption story, incorporating children’s dual family relationships, deciding whether to maintain contact with the birth family, and encouraging other children and families to accept differences. APs may experience discordance between their expectations of adoption and the reality, isolation from family and friends who may not understand or support them, struggles to adjust to the demands of parenting, and changes in their lifestyle, household, and marital relationship. Some APs experience post-adoption depression, which is linked with negative parenting behaviors and impact on the developing parent–child relationship. They also may experience stress-related physical symptoms or exacerbation of preexisting medical or mental health problems.

Children who are adopted after infancy may have an array of challenges, including health issues, attachment problems, behavioral issues, and grief regarding loss of their birth families. Establishing parent–child attachment and integrating the child into the nuclear and extended families can be challenging, particularly when adopting older children, who may be ambivalent about adoption as a result of negative experiences with previous caregivers, unresolved grief, and/or conflicting loyalties. Children with a history of deprivation, maltreatment, or multiple changes in caregivers may resist entering into relationships out of fear and self-protection. APs without sufficient training may misinterpret children’s behaviors and attempt to address difficulties through discipline instead of recognizing children’s underlying needs and using a firm yet comforting response; a negative cycle may then develop of escalating child behavior problems and harsh responses from parents. Children may begin exhibiting relationship issues and behavioral problems soon after placement, with issues often intensifying during adolescence. Aggression, which may have been present since early childhood, becomes more difficult to physically manage during adolescence, and there may be occurrences of child-to-parent violence as well as violence toward siblings and pets.

Post-adoption services are a vital support for families who adopt children with complex needs so that adoption “not only creates families but also enables them to be successful” (Smith, 2014a, p. 6). Post-adoption services may include information about and referral to community resources, information about the child’s background and needs, trainings/conferences, guidance regarding adoption issues, financial assistance, medical care, special education, mental health services for children and/or parents, respite, special events, support groups, mentoring, advocacy, assistance mediating contact with birth families, direct support to youth, case management, and/or crisis intervention. In the United States the majority of families adopting a child from foster care receive a financial subsidy...
and continued public health insurance for the child based on a determination of “special needs” (i.e., factors defined by the state that are associated with being harder to place, such as the child’s ethnic or racial background, age, disability, or placement as part of a sibling group). Families adopting through private adoption and intercountry adoption (ICA) receive less support than those who adopt from public agencies; for instance, the children usually do not qualify for healthcare coverage and must be enrolled in the parents’ private health insurance, and no adoption subsidies are available. Adoption agencies approved by the Council on Accreditation (COA) are required to provide or refer families for post-placement developmental, educational, and mental health and therapeutic services; respite care; and re-placement if the child’s placement is disrupted.

In some cases, adoptive parents are unwilling to engage in services to support or preserve the adoption. Parents who have struggled with severe issues with their adopted child for an extended time often express feelings of guilt and inadequacy, high levels of anger with the child for not responding to their parenting, ambivalence about the child, and regret about the adoption. Disruption occurs when a family decides against adopting a child placed with them for adoption before the adoption has been finalized. Post-adoption placement, sometimes referred to as displacement, occurs when a child who has been adopted leaves the home prior to adulthood (e.g., mental health treatment, running away, detention) but the APs maintain their legal rights. The child may subsequently return to the home after a period of treatment or may remain in an alternative setting until reaching adulthood. Dissolution occurs when the legal relationship between the child and the adoptive parents is terminated by relinquishment (i.e., the adoptive parents voluntarily give up their parental rights) or court action.

Adoption has been found to be a more stable permanent outcome than long-term foster care or guardianship for children in foster care. Because it forms a lifelong family, adoption supports a greater sense of long-term belonging and security in children. Although children face varying degrees of challenge depending on their age and the adversities they may have experienced prior to adoption, the majority of children who are adopted exhibit improvements in development and functioning in their adoptive homes. Although adopted children have a higher prevalence of disability than non-adopted children, adoptive families are more likely to have more education and higher socioeconomic status and are more likely to access services for their children than biological families do. For those families who face greater challenges, the provision of post-adoption support and adoption-competent services can be instrumental in reducing the risk of displacement or dissolution.

**Facts and Figures**

Over 2 million children, or 2.3% of the total child population in the United States, were identified in the 2010 census as adopted children (Kreider et al., 2014). Of adopted children in the United States (not including stepparent adoptions), 38% were adopted through domestic, private adoptions; 37% from foster care; and 25% from ICA (Vandivere et al., 2009). An estimated 9–15% of children placed for adoption experience disruption prior to finalization of their adoptions (Festinger, 2014); approximately 10% return to foster care at some point following a finalized adoption (Smith, 2014b), and dissolution occurs in 1–10% of finalized adoptions (Bergeron et al., 2013). A significant number of children also leave their adoptive homes at some point other than through child welfare intervention (Smith, 2014b). A recent study in the United Kingdom found that although only 3.2% of adoptions in a 12-year period were disrupted post-finalization, 8–9% of the children had left their homes prematurely (Selwyn et al., 2014). Disruption was most common during adolescence, and in the majority of cases 5 or more years following finalization. In a U.S. survey, parents who adopted from foster care reported that 60% of the children had current emotional/behavioral problems, and almost 10% of the children had been placed out-of-home (ranging from stays with family or friends to residential treatment or detention) at some time after their adoption was finalized (Egbert, 2015).

Children who are adopted utilize mental health services at much higher rates than non-adopted children. Among adopted children 5 years and over, 46% of children adopted from foster care, 35% of those adopted from ICA, and 33% of those adopted in private, domestic adoptions participate in mental health services, compared with 10% of children in the general population (Vandivere et al., 2009). Children who are adopted are 3–4 times more likely to receive outpatient counseling and 5–7 times more likely to be placed in residential treatment than non-adopted children (Smith, 2014a). The majority of parents (77%) report that their children are well integrated into their families, and 80% felt that their children demonstrated improvement in social, emotional, and/or educational functioning (Hartinger-Saunders et al., 2015b). Post-adoption depression has been noted in approximately 25% of APs (Foli et al., 2013). Families are increasingly likely to utilize post-adoption services over time. In one study, the number of families reporting using post-adoption services increased from 31% at 2 years post-adoption to 81% at 8 years post-adoption. Utilization of clinical services (e.g., therapy) increased from 9% to 31% during the same period (Wind et al., 2007). Adoptive parents in a U.S. survey rated support groups for parents, mental health services for children, and financial assistance as the most important post-adoption services (Hartinger-Saunders et al., 2015b). Non-white families, kinship families (i.e., adopted child is a biological relative), and those who adopt through private agencies are less likely to receive needed post-adoption services (Hartinger-Saunders et al., 2015a).
Risk Factors
Children who are adopted often have multiple risk factors, including prenatal substance exposure, low birth weight, trauma, and disruptions in caregiving. Risk factors linked with serious difficulty or disruption in adoption include adoption at older ages, history of child maltreatment, severe externalizing behaviors, and strong attachment to birth mother; APs who are inexperienced, have no prior relationship with the child, have unrealistic expectations, have more defined preferences (e.g. race, gender, background), have a tendency to pathologize the child, have insufficient information about the child prior to adoption, and have insufficient preparation, training, and support; couples who are not equally invested in the adoption; and placement by less experienced social workers.

Risk factors for post-adoption depression in adoptive parents are similar to those associated with postnatal depression; e.g., history of depression or anxiety, idealization of parenthood, lack of support systems, history of relationship difficulties, difficulties with child (i.e., medical, developmental, and/or behavioral issues), and multiple simultaneous adoptions as well as discrepancies between the expectations parents had of themselves and the bond they would have with the child and the realities of the parenting experience.

Signs and Symptoms/Clinical Presentation
Signs/symptoms in children associated with difficulties in adoption include attachment issues, grief, depression, anxiety, anger/rage, physical and/or verbal aggression (including assaultive behavior toward mother, siblings, pets), severe tantrums, defiance, antisocial behavior, manipulation, lying, stealing, self-harm, hyperactivity, inattention, school difficulties, inappropriate sexual behaviors, soiling, sleep difficulties, night terrors, hoarding food, substance abuse, and running away. Signs of physical conditions such as cleft lip and palate, heart disease, orthopedic issues, malnutrition, and infections often are present in children adopted through ICA.

Social Work Assessment

› Client History
  • Complete a comprehensive biopsychosocial-spiritual assessment to include information on physical, mental, environmental, social, and financial factors as they relate to the child and family
    – Ask about child’s history of trauma and trauma-related symptoms, attachment difficulties, family history, prior caregiving, circumstances that led to child’s being placed for adoption, adjustment to placement, psychiatric symptoms or issues that might pose risk to self or others (e.g., suicidality, self-harm, substance abuse, aggression, fire setting, running away, harming animals, sexual perpetration, child-to-parent violence), history of mental health treatment and psychotropic medication, child’s involvement in other systems (e.g., school, corrections), and family and community supports
    – Ask about household members, siblings and/or other children in the home; parental functioning and risk factors (including unresolved issues that may affect parenting capacity); symptoms of depression; perceptions and feelings about child; parenting practices regarding discipline, supervision, and nurturing; awareness of child’s needs; efficacy in parenting role; family and community supports; ability to meet child’s basic needs; and involvement with other systems

› Relevant Diagnostic Assessments and Screening Tools
  • Instruments used to screen/assess children’s behaviors/symptoms include Child Behavior Checklist (CBCL); Child and Adolescent Needs and Strengths, Mental Health (CANS-MH); Strengths and Difficulties Questionnaire (SDQ)
  • Instruments used to screen/assessment include Adult Attachment Interview (AAI), Working Model of the Child Interview (WMCI), Parent Development Interview, Circle of Security Interview
  • Instruments used to screen/assess trauma exposure and related symptoms include Adolescent-Dissociative Experiences Scale (A-DES), Child Dissociative Checklist (CDC), Child Sexual Behavior Inventory (CSBI), Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA), Diagnostic Interview for Children and Adolescents Acute Stress Disorder Module (DICA-ASD), NCTSN CANS Comprehensive – Trauma Version (CANS Trauma), Trauma Symptom Checklist for Children (TSCC), UCLA PTSD Reaction Index – DSM5 Version
  • Neuropsychological testing may be helpful in assessing cognitive ability, problem-solving, planning, abstract thinking, attention, concentration, memory, language, learning, visual and spatial perception, and motor and sensory skills
  • Conduct occupational therapy evaluation to assess for sensory processing disorder
  • Tools used to assess family/systems relationships include genograms, ecomaps

› Laboratory and Diagnostic Tests of Interest to the Social Worker
  • No laboratory tests are associated with post-adoption services
Social Work Treatment Summary

Social workers should be aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions, and values of their clients. Social workers should adopt treatment methodologies that reflect their knowledge of the cultural diversity of the communities in which they practice.

Social workers should apply an ecological perspective that encompasses complex interactions of individual, social, and transpersonal factors that affect children and their families in order to develop appropriate family-centered services and supports. A complete assessment of each family member is helpful to understand the extent and nature of the effect that adoption has had on the family and its impact on other life areas. This is essential to ensure that children’s individual needs are addressed and that APs have adequate training and support.

Ideally, the family should be introduced to post-adoption services prior to finalization as part of preparing parents for adoption. It is important to review with parents the child’s history, highlighting issues that are likely to emerge over time, and to discuss utilization of support and services.

The needs of all family members should be considered in order to disentangle various contributors to any difficulties the family experiences, rather than focusing solely on the severity of the child’s behaviors or the parents’ current state of mind.

- Interventions designed to strengthen or correct problems in the parent–child relationship and build a sense of trust and safety for the child should be prioritized.
- Social support, particularly from individuals who are knowledgeable about adoption-related issues, is highly valued by APs. Referrals for peer mentoring and support groups are particularly beneficial. APs may also need assistance with childcare and respite, particularly if the child has significant behavioral problems or requires specialized care.
- Adoption-competent therapy is critical to address issues such as complex trauma, attachment, ambiguous loss, and identity formation. Intervention should occur as early as possible, and APs should be included.
- APs also indicate a need for support with tutoring and educational advocacy.

A range of promising evidence-based interventions may be relevant to the adopted child and his or her family.

- Trauma-focused cognitive behavioral therapy (TF-CBT), the most recognized treatment for child trauma, is used with children ages 3–18 years who have PTSD or other emotional problems related to trauma. TF-CBT integrates cognitive and behavioral interventions such as psychoeducation about trauma and common reactions, parenting skills to manage emotional and behavioral reactions, individualized stress management techniques and coping skills, and development of a trauma narrative.
- Theraplay integrates play, family therapy, and psychoeducation to provide children with reparative emotional experiences and build attachment. A variation, whole-family theraplay, has been used to also address family communication and adult relational skills.
- Child–parent relationship therapy (CPRT) is a structured model that has been used successfully to address attachment and relationship problems in children ages 3–10 years who have been adopted out of foster care by training the adoptive parents to carry out interventions designed to increase safety, acceptance, and connectedness.
- Video-feedback intervention to promote positive parenting (VIPP) uses a brief series of home-based video-feedback sessions to increase parents’ sensitivity and responsiveness.
- Parent–child interaction therapy (PCIT) is an intervention used with children ages 2–12 years who have serious behavior issues. During sessions, the therapist coaches the parent in practice interactions with the child from an observation room using a wireless earpiece. Initial sessions are child-directed and focused on relationship enhancement, whereas later sessions are parent-directed and focused on behavior management skills.
- Attachment and biobehavioral catch-up (ABC) is a home-based intervention designed for infants and toddlers (0–2 years) who show signs of attachment difficulties related to maltreatment or disruptions in care. Treatment focuses on assisting parents to interpret the child’s signals in a way that elicits a nurturing response and to provide a sensitive and responsive environment.
- Trust-based relational intervention (TBRI) is an attachment-based program that incorporates principles of empowering (addressing both external and internal physical needs [e.g., sensory needs, nutrition and hydration]), connecting (addressing attachment needs, parent self-awareness, attunement, and playful engagement), and correcting (addressing behavioral needs such as boundaries, self-regulation) to increase the child’s ability to feel safe and develop secure attachment.
- Dialectical behavior therapy (DBT) is a modification of cognitive behavioral therapy that may be used with adolescents. Treatment occurs through a combination of group, family, and individual sessions focused on increasing skills in interpersonal relations, distress tolerance, emotional regulation, and mindfulness.
- Early intervention consists of an individualized package of developmental therapies and services provided to children from birth to age 3 years who have delays in cognitive, physical, communication, social-emotional, and/or adaptive skills or a condition such as Down syndrome, cerebral palsy, or autism spectrum disorder.
• The Triple P Positive Parenting Program is a social-learning-based intervention that focuses on increasing parent knowledge of child development, positive behavior management and parenting skills, and reducing coercive or punitive parental behaviors.

• Incredible Years (IY) is a training program with child, parent, and teacher components. Children are taught social interaction, emotional regulation, and problem-solving skills in group settings in which practice is available with peers and therapists, while caregivers learn positive strategies and the use of calm, nurturing attention.

• Pharmacological treatment may be used to help stabilize and/or alleviate symptoms of thought disorders, mood disorders, and attention disorders and/or to regulate hyperarousal (e.g., sleep problems, anxiety).

• More intensive treatment such as intensive adoption preservation services or residential treatment may be needed.

• Support groups and/or mentoring are found to be particularly helpful for APs; counseling for post-adoption depression, preexisting issues that may be contributing to parenting difficulties, and marital issues may also be indicated.

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<tr>
<th>Problem</th>
<th>Goal</th>
<th>Intervention</th>
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<tr>
<td>Child exhibits signs of insecure attachment, atypical attachment behaviors</td>
<td>Support development of secure attachment</td>
<td>Refer for evidence-based treatment to enhance caregiver and environmental qualities that contribute to attachment (e.g., CPP, ABC), provide psychoeducation and interaction guidance</td>
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<td>Child is exhibiting maladaptive and/or disruptive behaviors, lacks prosocial skills and behaviors</td>
<td>Reduce problem behaviors, teach and reinforce prosocial skills and behaviors</td>
<td>Individualized behavioral strategies focused on reinforcing positive behaviors, close supervision, limiting negative peer associations, and strengthening adult–child relationships; individual and group skills coaching for parents and children; mentoring</td>
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<td>Child experiences trauma-related symptoms</td>
<td>Reduce distress, support resolution of symptoms related to exposure to trauma</td>
<td>Assess for emotional/behavioral issues related to trauma, address maladaptive beliefs about maltreatment, help child feel safe; refer to therapist appropriately trained to address trauma-related issues; teach parents about the effects of trauma and how to respond to trauma-related behaviors; ensure that parent is adequately informed of child’s history so he or she can recognize symptoms and provide support</td>
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Child has mental health condition

Support resolution of mental health symptoms, enhance effective coping

Refer for services as indicated, including evidence-based mental health treatment, substance abuse treatment, psychotropic medication

APs experience high level of distress

Parent will have realistic expectations of child, sense of competence in responding to child’s behaviors, enhanced coping skills, and reduction in stress

Provide education regarding child’s emotional/behavioral issues and strategies for reducing stress, assist parent/caregiver to identify supports and coping strategies, offer respite services, refer to parent support groups, mental health services if indicated (e.g. post-adoption depression, unresolved loss/trauma)

Applicable Laws and Regulations

› Each country has its own standards for cultural competency and diversity in social work practice. Social workers must be aware of the standards of practice set forth by their governing body (e.g., National Association of Social Workers in the United States, British Association of Social Workers in the UK) and practice accordingly
› The United Nations Convention on the Rights of the Child (CRC) is an international human rights treaty that recognizes that every child is entitled to certain basic rights, including that the child’s best interests be the primary concern in decisions that affect him or her
› Guide for Alternative Care of Children is an international policy and practice guide that is focused on the well-being and protection of children who are at risk and/or deprived of parental care
› The Hague Convention on Intercountry Adoption (HCIA) of 1993 is an international agreement that establishes procedural safeguards for ICA. The United States ratified HCIA in 2008

Available Services and Resources

› Adoption UK, http://www.adoptionuk.org/
› Center for Adoption Support and Education (C.A.S.E.), http://adoptionsupport.org
› Centre for Excellence and Outcomes in Children and Young People’s Services (C4EO), http://www.c4eo.org.uk
› CoramBAAF Adoption and Fostering Academy, http://www.corambaaf.org.uk/
› Council on Foster Care, Adoption, and Kinship Care, http://www2.aap.org/sections/adoption/index.html
› National Council for Adoption, http://www.adoptioncouncil.org/

Food for Thought

› Child welfare law and policy developed to prevent children from remaining in foster care for prolonged periods have inadvertently resulted in adoptions’ sometimes moving too quickly and being finalized before the children and/or parents have had the time to make a successful adjustment
Parents may initially be anxious to end agency involvement and be a “normal” family, and often are not receptive to other services until they experience a period of adversity.

Adoption-competent mental health services are important to ensuring that children, BPs, and APs receive adequate preparation and post-adoption support, but the majority of professionals report not receiving adequate training regarding adoption-related issues and often are not knowledgeable of the complex issues affecting these families. Families often report difficulties finding mental health providers who are adoption competent.

Adoptive parents may experience strain in their marriage that is associated with adoption-related issues (e.g., difficulty maintaining a united front when dealing with challenging relationship dynamics or behaviors, being ostracized from support systems when child’s behaviors are severe); marriage enrichment programs specifically for adoptive parents can help strengthen the parents’ marriage and the overall stability of the family (Hill et al., 2015).

Researchers in one study found that 17% of adoptive parents reported the dissolution of an adoption; dissolution was particularly linked with educational deficits and having a child with substance abuse issues (Hartinger-Saunders et al., 2015c).

Red Flags

APs who feel overwhelmed and unable to continue caring for their adopted children may resort to potentially dangerous alternatives such as independently “rehoming” the children with new families who have not had background checks or home studies and who may abuse or exploit them.

Parents may not disclose child-to-parent violence because of stigma and shame, but such violence is a leading cause of adoption disruption and should be routinely screened for when families seek post-adoption services.

To treat attachment issues, some practitioners have used coercive techniques such as “holding therapy,” which involves confrontation and physical restraint of the child in order to break through his or her defenses and provide a “corrective experience”; these practitioners have also advocated for parents to use strict, sometimes harsh, parenting practices to maintain control over the child. Such techniques are not supported by evidence, are considered harmful, and have led to several deaths.

Discharge Planning

When possible, maintain ongoing contact with adoptive families post-finalization through avenues such as newsletters, special events, and continuing education.

Provide linkage to community services, such as referrals for medical, counseling, and educational services as appropriate; connect with other adoptive families and support groups.


References


