KEEPING THE PROMISE

THE CASE FOR ADOPTION SUPPORT AND PRESERVATION

FUNDED BY THE FREDDIE MAC FOUNDATION

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THE DONALDSON ADOPTION INSTITUTE

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EXECUTIVE SUMMARY

For over three decades, the U.S. government has focused considerable effort and funding on promoting adoptions from the child welfare system. The Adoption and Safe Families Act of 1997 (ASFA) is the most concerted policy in any nation to promote such adoptions, which have increased from an estimated 211,000 in the 10 years leading up to ASFA's enactment (1988-1997) to 524,496 in the most recent 10 years, FY2003-2012 (Maza, 1999; USDHHS, 2013).

This emphasis on permanency through adoption is based on a considerable body of research underscoring the reality that adoption is better for children than are institutions or long-term foster care. Most children being adopted in the U.S. today, however, come to their new families with early life experiences that pose higher risks for developmental challenges as they grow up – experiences such as prenatal hazards, poor nurturance, maltreatment, multiple placements and other traumas. The challenges that emerge must be adequately addressed in order for adoptions to be truly optimal for these children. When adopted children and their families are not able to effectively address these challenges, they face greater prospects for chronic, severe stress; compromised functioning throughout the family; and instability of the adoption itself.

While adoption from foster care has become a federal mandate and a national priority, less attention has been paid to serving these children and families after adoption to ensure that they can remain in their new homes and that their parents can successfully raise them to adulthood. Language in federal funding statutes includes services to strengthen families after adoption as a designated purpose of the funds, but there is no federal mandate to provide such services.

The reality is that far too little is known about the long-term outcomes of children adopted from foster care in the U.S. Several longitudinal studies have been published that have followed children adopted internationally through adolescence, but there is no comparable research on domestic foster care adoptions. Likewise, there is a sizeable body of research on the incidence and causes of disruptions that occur in adoptive placements prior to finalization, but almost none that examines post-adoption instability. The findings of the LONGSCAN study presented in this report are the only available research following children who were adopted from U.S. foster care to adulthood.

Post-adoption instability occurs in many different ways – some children re-enter foster care, and a minority of these experience legal dissolution of their adoptions. Some are in treatment centers or other institutions funded through a range of sources, and others leave their homes more informally, such as going to live with friends or running away. The LONGSCAN study was the first to track post-adoption instability (combining all types) until the youth reached adulthood. It found that at age 16, 87 percent of child welfare adoptees in the study were living with their adoptive families, but 28 percent had lived away from their families at some point after adoption (Proctor & Litrownik, 2013).

This new study by the Donaldson Adoption Institute breaks new ground in investigating the long-term stability of domestic adoptions from foster care through the collection of data from eight states that have some information on post-adoption stability, and through a new analysis of national AFCARS data.

The Institute's study focuses primarily on one type of post-adoption instability: re-entry by youth into the child welfare system. It also integrates existing cross-sectional research on the needs of children and families after adoption and previously unpublished findings from the LONGSCAN study mentioned above, to outline the continuum of needs in these families. Collectively, these findings provide evidence for The Case for Adoption Support and Preservation (ASAP) Services.

Putting the Findings of this Study in Context

It is important to recognize that the majority of adopted youth are functioning within the normal range, including those who came from adverse situations, and over 90 percent of parents in every type of adoption are satisfied with their adoptions (Howard, Smith & Ryan, 2004; Vandivere, Malm, & Radel, 2009). Many adopted youth will heal from previous traumas and flourish, complete their educations and become caring, competent adults. Given the traumatic life experiences that most children in foster care have endured, however, a substantial proportion of them will continue to have ongoing adjustment issues that may intensify as they age. Many children adopted from other countries have had comparable adverse experiences.

Research indicates that adoptive families are three to four times more likely to seek counseling for their children, and five to seven times more likely to seek residential treatment, than are birth families (Price & Coen, 2012; Vandivere, et al., 2009; Howard, et al., 2004; Landers, Forsythe, & Nickman, 1996). While some of this difference may be due to a greater willingness to seek help, it also is indicative of a higher level of challenges. There are many barriers, however, to these families getting the type of help that they need. A primary one is that few mental health professionals are "adoption-competent" – that is, trained in both adoption-related issues, such as attachment and identity, and in the types of conditions confronted by many of these children who have experienced complex trauma (Brodzinsky, 2013).

Specialized adoption support and preservation (ASAP) services began to spring up in the late 1980s and 1990s. Funding constraints, however, have led many of them to be cut back, and many states have never developed them at all. Meanwhile, scientists have learned considerably more about the impact of trauma on the brain and child development than about effective treatments to address these problems, so effective services to address the needs of families facing serious challenges are scarce.

Primary Findings of This Study

- Some families face only a few challenges, but at least 40-45 percent of those adopting from foster care will likely require therapeutic counseling services to understand and effectively address their children's emotional and behavioral needs. It is vital to develop supports and services that address the range of needs that families encounter. Many will require only lower-level training and assistance. Those whose children have the greatest level of need will require more intensive help, such as specialized adoption preservation services.
- Adolescence is the period of greatest need; adoptive parents of teens previously adopted from foster care reported that 57 percent received mental health services (Vandivere et al., 2009). The LONGSCAN study on the consequences of child maltreatment found that when girls and boys adopted from foster care were compared to those reunified or remaining in care, they had superior outcomes as young children (home environment, stability, behavior) but more behavioral and emotional problems as teens (Litrownik, 2012).

- For reasons discussed in this report, it is not yet possible to determine a valid rate of foster care re-entry. The new research presented in this DAI study, derived from a "survival analysis" of close to 35,000 adoptions in Ohio, offers the best approximation to date; it finds a re-entry rate of 9.5 percent and an adoption dissolution rate of 2.2 percent.
- Very few adoptees return to the child welfare system before age 10 (about 15% of those re-entering care); rather, most adopted youth who return do so as pre-teens or teenagers, at least six or more years after their adoptions.
- When comparing adopted children who re-enter the system to all other children in care, the adopted youth are 3½ times more likely to be placed in non-family settings than are other foster children (largely because they are older); they are also almost 3½ times more likely to "age out."
- For adopted children who re-entered and then exited care, 36 percent were reunified with their adoptive families (as compared to 52% of other foster children), and 34 percent experienced adoption dissolutions. Of those in the latter group, 61 percent were adopted again.
- In addition to the numbers of adopted children who re-enter foster care, there are others who leave their adoptive families either temporarily or permanently, and still others who continue to reside with their families but face severe challenges. A synthesis of this study's overall findings related to the entire range of post-adoption instability supports the following conclusions:
    - Approximately 10 percent of youth adopted from foster care re-enter care at some point, and for a minority of them (1/4 to 1/3 of the 10%) their adoptions are legally dissolved. (This number is likely to be lower when there is access to residential care without relinquishing parental custody.)
    - An additional 10 percent or so are estimated to leave their homes after adoption for either short- or long-term periods other than through the child welfare system. (This preliminary conclusion is based primarily on the LONGSCAN study and requires further empirical exploration.)
    - An additional 20-30 percent of youth adopted from care, and their families, face significant challenges that would almost certainly benefit from specialized adoption-competent and trauma-based therapeutic counseling.
- Governmental costs of adoption instability are extremely high. The Congressional Budget Office's estimated 2013 costs for Title IV-E spending for foster care administrative costs and maintenance payments, along with adoption assistance administrative costs and supports, were used to compute average federal expenditures for each. The federal government spends an average of $27,236 annually for each child in foster care covered by federal funding, compared to $5,043 for a child receiving adoption assistance covered by federal funding (Congressional Budget Office, 2013).
- The human toll is immeasurable for families who continue to struggle mightily or experience the breakdown of their adoptions. Adopted youth who re-enter foster care are at very high risk of aging out. Those whose adoptions are legally dissolved or become alienated from their families are likely to suffer severe repercussions from this experience. One young man quoted at greater length later in this report wrote:

    I am a foster/adopted black male who lived through a failed placement and have suffered great consequences because of it. … I felt cut off from the world and like I had no help. … Adoption has

truly rocked my life and entire world. We need increased post-adoption services. My struggles post-adoption were so visible. … It angers me now to realize what was going on and how no one stopped the madness.

Recommendations

In order to support adoptive families in achieving positive adjustments and successfully parenting their children into adulthood, the Donaldson Adoption Institute's recommendations include:

- **Enhance funding for adoption support and preservation services by creating a federal funding stream dedicated to post-adoption services and by developing partnerships among organizations across a range of auspices at the federal, state and community levels. The federal government also needs to provide clear written guidance to states that these services are integral to the adoption process and should work to support their development.**
- **Create an array of specialized adoption support and preservation services and make them accessible to families.**
- **Identify high-risk children and families, and provide them with early intervention and seamless supports both before and after finalization to prevent the compounding of problems in all facets of their lives.**
- **Track post-adoption outcomes of children adopted from foster care in order to assess the extent and nature of post-adoption instability, and to develop strategies for improving outcomes.**
- **Provide intensive adoption-competency training to community mental health professionals who want to serve adoptive families, as well as to clinicians working in post-adoption programs and residential treatment centers.**
- **Provide funding for research and for the development of evidence-based practices to effectively meet the needs of this population, particularly of adopted teens.**
- **Educate pre-adoptive and adoptive parents on the needs of their children and on effective strategies for providing a healing environment, as well as on the benefits of adoption support and preservation services.**
- **Maximize ASAP services available to all types of adoptive families.**

The title phrase **"Keeping the Promise"** reflects the covenant that is made between parents and children when adoptions take place – to be a permanent family. But the commitment is also by agencies and state or federal governments to the adoptive families they help create. When these families struggle to address the developmental consequences of children's early adversity, they should be able to receive the types of services that meet their needs and sustain them. In other words, the covenant should not be solely to create families, but also to enable them to succeed.

Adoptive parents, professionals, state and federal governments – and we as a society – share an obligation to provide the necessary supports and services to truly achieve permanency, safety and well-being for children removed from their original homes with the implicit promise of better lives. If federal and state governments support adoption as the optimal solution for these children, then it is imperative that they and their new families receive the assistance they need to succeed. Support and preservation services must become an integral component of the adoption process rather than remaining an optional "add on" and that means they must be unequivocally mandated and routinely provided.

INTRODUCTION

The value of permanency for children who cannot safely live in their original families is rooted in the belief that all children need consistent, nurturing families to promote optimal development and emotional security, not only during childhood but throughout their lives. This concept is a central tenet of child welfare reforms beginning in the 1970s, as research underscored the harmful effects to children of "drifting" in care and the reality that many were spending most of their childhoods in the foster care system (Fanshel, 1976, 1978).

For over three decades, the federal government has recognized that adoption provides a lifetime of benefits for children who cannot be safely reunified with their families of origin, and it has focused considerable effort on promoting adoption. The Adoption Assistance and Child Welfare Act (AACWA) of 1980 provided federal funds to support the adoption of children with special needs. The Adoption and Safe Families Act of 1997 (ASFA) enhanced the child welfare priority for achieving permanency by establishing shorter timelines for reunification and requiring permanency plans for children within 12 months of entering care – plans that could no longer include long-term foster care. This represents the broadest and most ambitious policy in any nation to promote adoption for children who cannot safely grow up in their original families.

The permanency focus of ASFA accelerated the pace of adoptions from temporary care. In the 10 years before its enactment (1988-1997), approximately 211,000 children were adopted (Maza, 1999). During the most recent 10 years (FY2003-2012), the number of children adopted increased roughly by 2½ times to 524,496 (USDHHS, 2013). In addition, an increasing number of children found permanence through guardianship, increasing from 9,043 in FY 2000 to 16,418 in FY2012.

The U.S. is one of only a few developed countries where drifting in impermanent, out-of-home care is viewed as contrary to the best interest of children, and where the government will terminate parents' rights without their consent to allow children to achieve permanency through adoption or guardianship. A comparative study of child welfare systems in 10 developed countries found that over the previous 10-15 years, the U.S. was the only country where the rate of children in out-of-home care did not increase, largely due to its emphasis on adoption (Gilbert, 2012).

This emphasis on permanency through adoption is based on a considerable body of research underscoring the reality that adoption is better for children than institutional or long-term foster care. Specifically, adoption:

- Offers greater stability.
- Offers children optimal potential for resiliency, particularly if it begins when they are younger.
- Best promotes children's emotional security, sense of belonging and general well-being.
- Offers children support to assist them in the transition to adulthood and a lifelong family.

An overview of this research and that on post-adoption services is contained in two reports published by the Donaldson Adoption Institute – "A Family for Life" and "Keeping the Promise" (Smith, 2013, 2010).

In the past 15 years, approximately three-quarters of a million children have been adopted from foster care in this country, and a little over one-quarter of a million more have been adopted into U.S. families from abroad. Almost all of these children come from backgrounds that pose some risks for their ongoing positive development. Children can be amazingly resilient, and they typically make progress in development after adoption, but the legacy of deprivation, trauma and loss can pose ongoing challenges for them and their adoptive families (Harwood, Feng, & Yu, 2013).

Several decades ago, adoption was envisioned as a "happily ever after" ending for children who had come from difficult beginnings, based on the belief that love would be enough to enable them to thrive. Years of experience in adoptions of children with special needs, along with ongoing research on the impact of early deprivation and trauma on the brain and child development, have driven home the reality that legal permanence does not in itself ensure well-being. Rather, it entails considerable healing often requiring specialized interventions to address the consequences of children's early life experiences, and their adoptive families often require assistance to understand and address the challenges their children need to surmount in order to succeed.

It is important to recognize that the majority of adopted youth are functioning within the normal range, including those who came from adverse situations, and over 90 percent of parents in every type of adoption are satisfied with their adoptions. Given the traumatic life experiences that most children in foster care have endured, however, a substantial proportion of them will continue to have ongoing adjustment issues that may intensify as they age. Based on available research, we know that a sizeable minority (around 40-45%) of children adopted from foster care will have ongoing behavioral and emotional problems (Rosenthal & Groze, 1994; Berry, Barth, & Needell, 1996; Howard & Smith, 2003; Vandivere, Malm, & Radel, 2009; Harwood, Feng, & Yu, 2013); therefore, many of these families need support and specialized services after adoption to effectively address the needs of their children.

The Development of Post-Adoption Services

Research indicates that adoptive families are three to four times more likely to seek counseling for their children, and five to seven times more likely to seek residential treatment, than are birth families (Vandivere, Malm, & Radel, 2009; Howard, Smith, & Ryan, 2004;; Landers, Forsythe, & Nickman, 1996; McRoy, Grotevant, & Zurcher, 1988;). The inability of adoptive families to find adoption-competent services led to the development of specialized post-adoption services, beginning primarily in the late 1980s and 1990s. Many exemplary services were developed, primarily through federally funded demonstration projects and state-supported initiatives, but funding constraints have led some to be terminated, others to be scaled back, and yet others to be offered on very limited bases. These services include information and referral, education and training, support groups and mentoring, respite care, advocacy, crisis intervention, search/reunion services, and therapeutic counseling.

The government does provide important support for many adoptive families through subsidies and through Medicaid coverage for most children adopted from foster care. Such support has made it possible for many parents to adopt; however, it does not provide the range of specialized services needed to sustain families, particularly those facing significant challenges. **A continuum of ongoing *adoption support and preservation* (ASAP) services needs to be developed to bolster families adopting**

children from complicated beginnings and to enable them to succeed – services that include preventive and early-intervention services, as well as clinical interventions for very challenging situations. Some are more formal and offered by professionals, while others are informal and provided through adoptive parent-sponsored programs or via the internet. Prospective adoptive parents need to be educated to understand that their roles can be different in significant ways from raising birth children, and that accessing informal or formal supports or services is a sign of strength – not one of parental inadequacy, as some believe. Not all adoptive families will require or desire ASAP services – and most will need only educational or supportive services that are not costly; however, a minority of them will struggle and would benefit from specialized ASAP therapeutic services.

Adoptive parents facing serious, ongoing challenges with their children need special knowledge, skills and support to address challenges as they arise; while this process can begin in the preparation phase, much of it extends over the course of the child's development (Brodzinsky, 2008). Some strengths and abilities that are particularly important for parents are:

- Understanding their children in light of their history
- Understanding that loss, trauma, adoption and identity issues will resurface in different ways over the course of their children's development and knowing how to support their children to promote resilience
- Having realistic expectations for their children
- Knowing where and when to seek help
- Being able to empathize with their children's feelings and to appreciate their strengths
- Taking care of themselves and managing their' own reactions in interactions with their children
- Mastering the art of therapeutic parenting.

These typically are not abilities that are intrinsic to parents but, rather, are acquired through training, support groups and other therapeutic services.

Preparing and supporting adoptive and guardianship families not only helps to preserve and stabilize at-risk families, but also offers children and families the best opportunity for success. A continuum of ASAP services is needed to address the information, support and therapeutic needs of children and their families. The overall body of adoption research generally has linked receiving post-adoption services with more positive outcomes, while unmet service needs are associated with poorer outcomes (Barth & Berry, 1988; Groze, 1996; Leung & Erich, 2002; Reilly & Platz, 2004).

Creating effective post-adoption services and making them accessible to families are the primary challenges to assuring permanency for children who cannot live with their families of origin and to helping them develop to their fullest potential. Those adopted from foster care were removed from their original families by child welfare authorities, which cared for them for a period of years (sometimes compounding the harm they experienced), and ultimately selected the families who adopted them with an agreement to provide necessary supports over the course of childhood. Federal, state and local partnerships are needed to provide an effective continuum of adoption support and preservation services for these families, so that we can truly fulfill the three-fold mission of child welfare: promoting the safety, permanency and well-being of these children.

This report presents "The Case for Adoption Support and Preservation (ASAP) Services" in five parts:

- Federal Policy and Funding: Increasing Emphasis on Adoption and Post-Adoption Support
- Children's Adjustment after Adoption
- Research Related to Post-Adoption Instability
- Adoption Support and Preservation: Why Is It Imperative?
- Conclusions and Recommendations

PART I: FEDERAL POLICY AND FUNDING

Increasing Emphasis on Adoption and Post-Adoption Support

By John Sciamanna and Jeanne Howard, Ph.D.

For over three decades, the federal government has recognized that adoption provides a lifetime of benefits for children who cannot be safely reunified with their original families, and it has focused considerable effort on promoting adoption – particularly through federal support for adoption assistance and Medicaid coverage, the adoption incentives program, and ASFA's imposition of a timeline for the termination of parental rights. While the federal government at several points in time has signaled the need for services to children after adoption in order to keep families stable and strong, it has paid far more attention to achieving adoptions than to helping them succeed. Nevertheless there are many opportunities in law and policy for federal funds to be used to support and strengthen families after adoption – opportunities that have not been realized.

The government cost savings for the 50,000 children adopted annually from foster care ranges from $1 billion to $6 billion (Barth et al., 2006).

Federal Policy Promoting Adoptions from Care

Since the first significant federal funding for adoption in 1978, designated federal spending to support adoption has increased from just $5 million to a projected $2.6 billion in 2014.[1] Such expenditures, coupled with policy reforms, have had the demonstrable effect of increasing adoptions of children from foster care: In FY 1998, 125,000 children were waiting to be adopted and 37,000 left care through adoption; in FY2012, fewer than 102,000 children were waiting and over 52,000 exited care through adoption. This shift has resulted in significant savings for the child welfare system;

[1] The 1978 figure was the authorized funding level for Adoption Opportunities grants, and the projected 2014 funding is from the President's FY2014 budget, including $2.5 billion for Adoption Assistance, approximately $67 million in PSSF funding for adoption support and preservation, $39 million for Adoption Opportunities, and $39 million for Adoption Incentives. See http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf

one study estimated that the government cost savings for the 50,000 children adopted annually from foster care ranges from $1 billion to $6 billion (Barth, Lee, Wildfire & Guo, 2006).

The 1960's and 1970's

Until the early 1960s, child welfare services were primarily a state responsibility. In 1962, through an amendment to the Social Security Act, the federal government first began providing funds for foster care. Federal funding has since evolved, with expanding expenditures for adoption beginning in the late 1970s and increasing to the present. In the late 1960s and early 1970s, studies on child maltreatment and media attention to the issue led to a national conversation on the government's role in protecting children. A U.S. Children's Bureau conference on child abuse was followed by legislation in state after state making reports of child abuse mandatory. The 1974 Child Abuse Prevention and Treatment Act (CAPTA) provided federal assistance to states to develop programs to address child abuse and neglect.

A range of societal changes, in concert with national attention on child maltreatment, led to growing numbers of children being removed from parental care. Although record-keeping was not systematic prior to the passage of federal legislation requiring states to maintain statistics, over 500,000 children were estimated to be in foster care during the mid-1970s, compared to just 272,000 in 1962 (Tatara, 1993). Research on the negative impact of temporary care on children and the risk of their never returning to their families of origin or achieving permanency through adoption fuelled discussion of ways to better serve children removed from their original homes. At the same time, growing state expenditures led to calls for rethinking child welfare intervention. Foster care was meant to be a transitory response to children's needs, but for large and growing numbers of children, it was not.

> *The longer children stayed in care the harder it was to place them [for adoption]…*
>
> **Committee on Ways and Means, 1992**

Accordingly, states began to consider ways to move children into permanent homes. Some states funded subsidy programs as a way to encourage adoptions from care, recognizing that the loss of foster care payments and the resulting financial hardship were disincentives to foster parents adopting. In 1975, the U.S. Children's Bureau underwrote the Child Welfare League of America's development of the Model State Subsidized Adoption Act. By the mid-1970s, California, New York and Illinois subsidized significant numbers of adoptions from foster care without federal support (Price, 2005) and, by 1977, 42 local or state jurisdictions had enacted adoption assistance programs (Hansen, 2006). Large numbers of children, however, remained ineligible for adoption subsidies.

In 1978, concern in Congress about the number of children in care prompted the inclusion in CAPTA's reauthorization of the Adoption Opportunities Act (PL 95-266), providing for demonstration projects and other activities to remove barriers to the adoption of children with special needs. Child welfare advocates, however, still expressed concern that too little was being done to address children's permanency needs, and scholars emphasized the costs to children who were not adopted, experienced multiple moves and aged out of foster care without permanent families – a phenomenon labeled "foster care drift." A Congressional committee found, "[T]he longer children stayed in care the harder it was to place them [for adoption] … the families adopting children from foster care were poor themselves and

Subsidies "have a positive and statistically significant effect on adoption rates".

Hansen & Hansen, 2006

Subsidies "increase permanent placement of foster care children, leading to both improved child well-being and reduced federal and state spending".

Expect More, 2005

there was no support and if the child had medical expenses, these same families may not have access to needed health care" (Committee on Ways and Means, 1992).

1980: The Adoption Assistance and Child Welfare Act

In 1980, the federal government claimed a major role in child welfare policy through passage of the Adoption Assistance and Child Welfare Act (AACWA) (P.L. 96-272), also known as Title IV-E.[2] AACWA sought to remove financial barriers to adoption by requiring states to provide subsidies to adoptive parents and by creating a federal–state partnership to subsidize adoption. The adoption assistance program provides federal matching funds to states for subsidies for eligible children. Eligibility was based on whether the child, 1) at the time of removal from their biological families, would have been eligible for AFDC (Aid for Families with Dependent Children, the then-federal/state public assistance program) or SSI (Social Security Insurance, the federal public-assistance program for the disabled) and 2) qualified as having "special needs."[3] Eligible children also received Medicaid coverage.

AACWA enabled foster parents, relatives and others who typically have relatively low incomes to be able to adopt children from care. These subsidies, at a median of just $485 a month in FY2010,[4] help families meet the basic needs of their children, and some may include amounts to help pay for critical services to address their children's physical, mental, cognitive and developmental challenges. Research indicates that lowering the ongoing cost of adoption increases adoptions overall, especially for foster parents and relative caregivers – the two groups who, cumulatively, adopt 85 percent of children from foster care in the U.S. Their adoption decisions have significant economic consequences: forfeiting foster payments and supports, while assuming legal responsibility for the ongoing costs of services, education and other expenses (Buckles, 2013; Argys & Duncan, 2008).

The latter study found that reducing the disparity between monthly foster care and adoption payments (more so than the actual levels of either payment) best predicts foster parents' adoption decisions, particularly among those caring for children who are older or have behavior problems. A recent U.S. study found, however, that for children adopted from foster care whose parents had previously fostered

[2] "Title IV-E" refers to the amendment to the Social Security Act.

[3] Individual states set their own definitions of what qualified the child for "special needs" designation, which refers to characteristics of children that make them harder to place for adoption, but generally it applies to older age, certain racial/ethnic groups, sibling group status, or known medical, emotional and/or behavioral challenges. These criteria do not necessarily equate to a developmental delay or problem in the child, and definitions vary widely from one state to another. Overall 90% of children adopted from public care in FY2011 officially met these criteria and qualified their adoptive families to receive Adoption Assistance (USDHHS, 2012).

[4] Interview with Mary Eschelbach Hansen (July 2, 2012) (observation of subsidy = $0 or $1 omitted). Data extracted from the AFCARS Adoption File for FY2010, version 1. AFCARS data were made available by the National Data Archive on Child Abuse and Neglect, Cornell University, Ithaca, NY, and have been used with permission. Data were originally collected by the Children's Bureau with funding by the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services.

them, nearly one-third (30%) received an adoption subsidy lower than their previous foster care payment (Malm, Vandivere, & McKlindon, 2011). Such discrepancies provide a financial disincentive to adoption from the very pool of parents who are most likely to adopt.

Federal expenditures for adoption subsidies have risen over time, as have the numbers and percentages of children receiving them, from less than $400,000 in 1981 to an estimated $2.2 billion in 2012 (Congressional Budget Office, 2013). Yet the cost of maintaining these children in care would be much higher; the estimated governmental cost savings for the 50,000 children adopted annually from foster care ranges from $1 billion to $6 billion (Barth, Lee, Wildfire & Guo, 2006). Monthly adoption assistance payments are at least $100-$150 lower than those for foster care (Buckles, 2013; Dalberth, Gibbs, & Berkman, 2005; Hansen, 2012), and federally funded administrative costs per child receiving adoption assistance is a tiny fraction of administrative costs per foster child – approximately 5.6 percent (Congressional Budget Office, 2013).

Based on the Congressional Budget Office's estimated 2013 costs for Title IV-E spending for foster care administrative costs and maintenance payments and adoption assistance administrative costs and support, **the federal government spends an average of $27,236 annually for each child in foster care covered by federal funding, compared to $5,043 for a child receiving adoption assistance covered by federal funding**. There are additional state savings for moving children from foster care to adoption.

According to an economic analysis (Hansen & Hansen, 2006), subsidies "have a positive and statistically significant effect on adoption rates" and "subsidy policy is the most important determinant of adoptions from foster care that is under the direct control of policymakers." A federal program assessment determined that subsidies "increase permanent placement of foster care children, leading to both improved child well-being and reduced federal and state spending" (Expect More, 2005).

The 1990's: The Adoption and Safe Families Act and Adoption Incentives

Despite federal support for adoption and a strong economy, the number of children in foster care continued to rise during the 1990s, the result of myriad factors: an increased birth rate, higher rates of incarceration of mothers, and the impact of both increasing prenatal substance abuse and parental drug use (Chipungu & Bent-Goodley, 2004). The number of children in foster care rose from around 400,000 in 1990 to over 516,000 in 1997. Congress responded to the challenge with the 1997 Adoption and Safe Families Act (ASFA-PL 105-89), which elevated the importance of permanency in federal policy.

While ASFA did not include large funding increases, it sharpened the focus on permanency through adoption. The law required states to make reasonable efforts to place children in a timely manner, have permanency plans of adoption or another alternative to family reunification so they could achieve permanency as soon as possible if they could not return home, and to document these efforts. ASFA changed the name of dispositional hearings to "permanency" hearings, required them to occur within 12 months (rather than 18 months) of a child's placement in foster care, revised permanency goals by eliminating specific reference to long-term foster care, and established a time limit for states to initiate proceedings to terminate parental rights for children in foster care for 15 of the most recent 22 months.

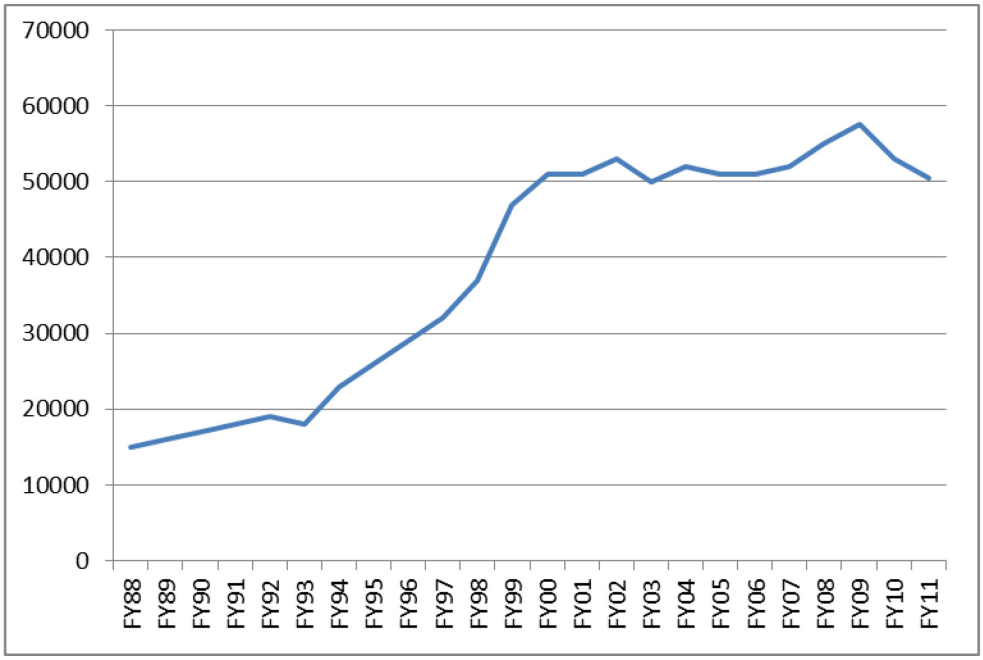
Adoption Incentive Funds

When Congress passed ASFA, as part of a larger legislative effort to encourage and expedite appropriate placement of children from foster care into adoptive families, it created an Adoption Incentive Fund under Title IV-E. If states increased the number of children adopted from foster care over a previous year's baseline, they were awarded an incentive of $2,000 to $4,000 per adoption. As Congress continued to reauthorize the funding, it reset the "baseline" for states.

In the last two reauthorizations,[5] Congress provided an increased bonus of $8,000 for the placement of an "older" child,[6] a $4,000 incentive per child for an increase in the number of special needs adoptions and $2,000 per child for an overall increase in adoptions. In 2008, Congress also provided a $1,000 incentive per child if a state increased its adoption rate (regardless of actual numbers of placements). In 2010, just under $35 million was awarded to 38 states. Not all states receive a share of the funding each year, but since the creation of the incentive funds, all states have received some of them in at least one year. Reauthorization is due this year. Given that the bonus program focuses on moving children to adoption rather than on maintaining the adoption, and given the recent emphasis on adoptive placement for older children, it is likely that bonuses will result in an even greater need for post-adoption support for families. However, while states are required to use the funds for child welfare services, there is no requirement to use them for ASAP.

The impact of ASFA, coupled with financial incentives to states and the establishment of AdoptUSKids, has been a rapid and sustained increase in adoptions, as depicted in the graph below (Maza, 1999; USDHHS, 2013). Since 1998, over 750,000 children have been adopted from the child welfare system.

Number of Adoptions with Public Agency Involvement



[5] The latest being in 2008 as part of the Fostering Connections Act.
[6] Defined as 9 years or older.

Federal Policy Sustaining Adoptions from Care

As noted above, in 1980, the federal government recognized that families who adopt children with special needs likely need support after adoption and provided that support with subsidies, one-time adoption placement costs and Medicaid coverage. During the November 1997 debate on ASFA, lawmakers on both sides of the aisle, however, agreed that the subsidy was insufficient. In floor statements, Senators Rockefeller (D-WV), Craig (R-ID) and Jeffords (R-VT) were among the legislators who highlighted the importance of expanded health care and support services to make it possible for families to adopt children with special needs and for those families to remain stable. Likewise, President Clinton recognized the need for post-adoption services in noting that not only would ASFA "provide States with financial incentives to increase the number of children adopted each year, [i]t will ensure that adopted children with special needs never lose their health coverage—a big issue. It will reauthorize Federal funding for timely services to alleviate crises before they become serious, that aid the reunification of families [and] that help to meet post-adoption needs" (Clinton, 1997).

While AACWA emphasized adoption as a response to child impermanence, concerns emerged about better meeting the needs of biological families with children in care to enable reunification. In 1993, Congress created a new Title IV-B part 2, Family Preservation and Family Support.[7] While the primary intent of the program was to increase services to prevent or reduce child placement, families who had adopted a child from foster care also were included. **Although the federal government did not designate what portion of funds were to go to post-adoption support, it established the expectation that federal funds be used to strengthen families after adoption.** This legislation was significant because it went beyond the broad flexibility in spending under the existing Child Welfare Services Title IV-B, part 1, by specifying that the designated funding of $60 million to $255 million per year be directed to preserving and strengthening families, including adoptive families, in an effort to prevent the placement of children.

Despite growing awareness of the needs of families after adoption, and recognition in federal law and policy that federal funds should be used to support them, federal policy has not provided specific guidelines for providing this support. There is no dedicated funding stream for post-adoption services, even though these services clearly can play a vital role in maintaining adoptive families. Funding categories that address post-adoption services involve broad funding streams that compete with other compelling child welfare services and needs. They must also compete with programs that promote adoption and recruit new families. While federal policy clearly allows the use of funds to maintain and strengthen adoptive families, it does not mandate this use of funds. Without such a mandate to fund post-adoption services at a given level, many families' needs inevitably will remain unmet.

Currently, the two *potentially* biggest sources of funding for post-adoption services are under Title IV-B of the Social Security Act – Title IV-B, part 1, Child Welfare Services (CWS) and Title IV-B part 2, Promoting Safe and Stable Families (PSSF). These two block grants were reduced in the 2013 budget agreement to approximately $268 million (CWS) and $318 million (PSSF). There is a great deal of competition for these two funding sources, especially after reductions in funding levels over the past

[7] Part of the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66).

five years, because a range of child welfare and adoption services are paid for out of each part. Nevertheless, these are important possible sources of funding to meet post-adoption needs.

Promoting Safe and Stable Families (Title IV-B, Part 2)

The funding stream that is most clearly tied to adoption support and preservation is "Adoption Promotion and Support," one of four purposes or service categories of Promoting Safe and Stable Families (PSSF).[8] The program's other three purposes are supporting families in the community, preserving at-risk families and reunifying families in a timely manner. PSSF acknowledged that some adoptive families will need ongoing support, stating that one of its goals is to "support adoptive families by providing support services as necessary so that they can make a lifetime commitment to their children." PSSF defines *Adoption Promotion and Support Services* as services and activities **"**designed to encourage more adoptions out of the foster care system, when adoptions promote the best interests of children, including such activities as pre- and post-adoptive services and activities designed to expedite the adoption process and support adoptive families." **The law mandates that states spend significant portions of their new dollars on each of these service categories and HHS guidance specifies that 20 percent of PSSF funding be expended on the category "Adoption Promotion and Support."[9]**

Despite the possible funding streams that could be used for ASAP – and despite the benefits such services can provide – a National Conference of State Legislatures analysis reported that only 1 percent of total child welfare spending from federal and state sources went to "adoption promotion and support," and most of this was spent on promoting adoptions rather than supporting adoptive families (Christian, 2002). The most commonly specified activities reported by states for this category were adoptive parent recruitment and training, home studies, and worker training. The report noted that primarily **state** funds have been used for post-adoption services, but with recent budget shortfalls, states will likely rely more on federal financing.

PSSF funding grew from its original 1994 authorization of $60 million to its peak of $405 million in 2003 for the four service categories with $100 million of that coming from discretionary funding; however, in more recent years, it has started to shrink.[10] In FY 2012, PSSF was funded at $358 million for the four service categories with $62 million coming from discretionary funding.[11] According to the HHS FY 2012 annual report, states planned to spend approximately 21 percent, or $73 million, on adoption promotion and support.[12] There were, however, eight states that indicated that they did not plan to spend the required 20 percent of their funds on these services for 2012[13] (U.S. Children's Bureau, 2013).

[8] In 1997, ASFA renamed federal funds for a range of permanency services (Title IV-B, part 2), which were first authorized in 1993, the Promoting Safe and Stable Families Program (PSSF).

[9] Regulations direct states to spend at least 20 percent of their allocation on each of the four services.

[10] The funding includes both mandatory and appropriated funds. Mandatory funding is written into law for a period of years (usually five) while the additional discretionary funding is dependent on the annual appropriations (the same as CWS).

[11] In combined mandatory and discretionary funding

[12] States also spent 26 percent on prevention, 24 percent on family preservation and 23 percent on reunification services.

[13] The states that planned to spend less than the regulation-required 20 percent were: Alaska (6%), Arkansas (2%), Georgia (19%), Massachusetts (16%), Minnesota (0), Missouri (0), North Dakota (7%), and Oregon (10%).

Although only one of the PSSF primary service categories is specific to adoption and families who adopt, some of the other service category descriptions reference "adoptive families" and *could be used to provide post-adoption services*.

- *Family Support (Prevention and Support Services)* defined as**,** "Community-based services which promote the safety and well-being of children and families and are designed to increase the strength and stability of families (*including adoptive*, foster, and extended families), to increase parents' confidence and competence in their parenting abilities, to afford children a safe, stable, and supportive family environment, and to enhance child development. These services may include respite care for parents and other caregivers; early developmental screening of children to assess the needs of these children and assistance in obtaining specific services to meet their needs; mentoring, tutoring, and health education for youth; a range of center-based activities (informal interactions in drop-in centers, parent support groups); services designed to increase parenting skills; and counseling and home visiting activities."

- *Family Preservation (Crisis Intervention)* is defined as **"**Services for children and families designed to help families (*including adoptive* and extended families) at risk or in crisis. The types of services within this category include: Pre-Placement Prevention: Services to prevent family disruption and unnecessary removal of children from their homes (as appropriate). These services may include intensive family preservation, *post-adoptive support services*, case management, counseling, day care, respite services, homemaker services, services designed to increase parenting skills, family budgeting, coping with stress, health, and nutrition."

Child Welfare Services (Title IV-B, Part 1)

Title IV-B of the Social Security Act[14] generally is the most flexible child welfare funding stream. Congress has authorized up to $325 million annually, but it has never appropriated this maximum funding level. The highest amount appropriated was $295 million in 1994, and it is reduced in the latest budget to $268 million. Funds may be spent on a wide variety of child welfare-related services, allowing states a great deal of flexibility, and states spread these funds across a wide range of services.[15]

For 2012, HHS reports that states planned[16] to allocate their spending as follows: protective services (32%), family preservation services (18%), preventive and support services (13%), time-limited reunification services (11%), foster care maintenance payments (10%) and administrative costs (5%). While funding from some of these categories could serve adoptive families, states are not required to use the money in this way; only 13 states and Puerto Rico indicated they would spend CWS funds on adoption services, with $7,678,000 for adoption promotion and support and less than 2 percent for adoption assistance. Only two states accounted for more than half of the $7.7 million: Florida indicated

[14] Established as part of the original Social Security Act when it was created in 1935.

[15] Some states are allowed to spend a limited amount on adoption assistance and foster care maintenance payments based on a grandfather provision dating back to when Title IV-E did not cover adoption assistance.

[16] The HHS report does not include data on final actual spending.

that it would spend $1.6 million, while Michigan planned to spend 2.8 million. The remaining 11 states[17] that projected they would use any of these funds on adoption promotion and support each planned to spend $500,000 or less on these services (U.S. Children's Bureau, 2013).

Adoption Opportunities Act

The Adoption Opportunities program was established in 1978 (P.L. 95-266) and was most recently reauthorized in 2010 (P.L.108-36, with CAPTA). The original law preceded the enactment of the adoption assistance program and was one of the first federal attempts to both promote adoptions and address barriers to them. The purpose of the competitive grants is to establish and promote adoption standards, to establish and maintain an internet adoption exchange, and to expedite and promote adoptions. In 2013, Adoption Opportunities was funded at $39 million, with funding administered by the Department of Health and Human Services and distributed through competitive grants and contracts.

Competitive, time-limited grants are intended to provide for an "adoption exchange" organization and the 10 activities that HHS is to carry out either directly or through grants. These activities include promoting the adoption of children in three categories: those of color, those who are older and those who have special needs. A subsection of the law directs HHS to promote a range of post-legal adoption services (including individual, family and group counseling, day treatment and respite care services) as well as providing adoption training to agency staff, mental health professionals and other support personnel. Many early adoption support and preservation programs were initiated through "post-legal" Adoption Opportunities grants; in fact, approximately 65 grants were awarded in this category from 1989 through 1994 (Howard & Smith, 1997). Most of the spending to date, however, has been on training and specialized recruitment, and Adoption Opportunities grants for "post-legal adoption services" were last awarded in 2002.

Fostering Connections to Success and Promoting Adoptions Act

In 2008, Congress enacted the Fostering Connections to Success and Promoting Adoptions Act (PL 110-351), which will gradually eliminate (over nine years, to 2018) current 1996 AFDC income eligibility restrictions to federal funding for adoption assistance (known as "delinking"), thus extending adoption assistance to children who were ineligible and covered solely by state and local funding. The Fostering Connections Act requires states to calculate their savings as a result of increased federal investment and to re-invest these savings into child welfare services. In 2011, Congress clarified that reinvestment can include post-adoption services. To date, there has been limited effort by HHS or the states to implement these provisions, but they hold great potential to increase support for child welfare services – notably **including post-adoption services**. When the law was enacted, the CBO projected savings to the states (and thus the amount of funds that could be reinvested) at $505 million in 2008 alone.

[17] Arkansas, Connecticut, Maine, Nevada, New Hampshire, New Mexico, Oklahoma, Pennsylvania, Rhode Island, South Carolina, and Utah.

Social Services Block Grant

Another possible funding source is the federal Social Services Block Grant (SSBG), which is considered an entitlement to the states; its funding is not dependent on the annual appropriations process but is written into law, with each state entitled to a share. SSBG funds can be spent in more than 29 categories that range from elderly services such as home-delivered meals, to children's services such as child protection or child care. States determine eligibility standards and can move dollars from year to year among their most pressing needs. Funded at $1.7 billion in 2011, SSBG is generally the biggest federal source of financing for child welfare services. Funding has varied considerably in recent years, however; for example, $810 million was spent in 2000 compared to just $660 million in 2004. It is likely to absorb an automatic cut of approximately $120 million left in the 2013 "sequester" budget agreement.

Nationally surveys indicate that 12 percent of total federal funding for child welfare services comes from SSBG (DeVooght, Fletcher, Vaughn, & Cooper, 2012). Child protective services is one of the primary child welfare services funded and almost all states spend some portion of SSBG for this purpose, as well as for protective services, foster care and adoption and other child welfare services. Based on the latest available SSBG Annual Report (2009), 22 states spent $45 million of these funds on adoption services.[18]

Summary and Recommendations to Enhance Policy and Funding

The federal government sees adoption as a critically important answer to the impermanence of foster care. Since it first directed funds to promote the adoption of children from care, hundreds of thousands of girls and boys have been adopted. Nationwide, the average monthly caseload of all foster children is approximately 161,000, while the monthly caseload of children on adoption assistance is 442,000 – a huge change from the early to mid-1990s (CBO, 2013).

Most federal funding has gone to adoption assistance, which enables foster families to adopt children in their care without losing the full monthly benefit they had been receiving. **A far smaller amount has been spent on ASAP services for families after adoption, although federal encouragement exists for such spending.**

Ongoing research into how children fare after adoption makes clear that a) adoption is beneficial, and b) many children will continue to struggle with the legacy of maltreatment and instability from their pre-adoptive lives. While the federal government – through law, policy and spending – has emphasized the first of these conclusions, federal leadership is now needed to address the second. A growing body of research consistently validates the need for adoption support and preservation services to help these children and families, yet they find it very difficult to find services that effectively address their needs (Smith, 2010).

Through a number of laws, the federal government has aggressively supported adoptions from foster care, even providing financial incentives to states to increase their adoptions. Federal, state and local governments and child welfare-related systems need to act just as forcefully to sustain these adoptive

[18] This $45 million total included $23 million transferred from the TANF block grant with states allowed to transfer up to 10 percent of their TANF block grant into the SSBG.

families. Only with partnerships at all systems' levels can we truly fulfill the three-fold mission of child welfare: promoting the safety, permanency and well-being of children.

Recommendations to Enhance Federal Policy and Funding for ASAP Services

Based on this analysis of the progression of federal legislative efforts to promote and support adoptions from foster care and the need for a federal funding stream dedicated to post-adoption services to meet the requirements of the hundreds of thousands of families who have adopted children from foster care, the following short-term funding proposal recommendations are offered:

- Strengthen the current Title IV-B, part 1, Child Welfare Services (CWS):
  - Direct states to indicate in their annual reporting what percentage of CWS funding is used for post-adoption services.
  - Require states to spend CWS funds for post-adoption services. States have been able to "grandfather" in CWS spending for foster care and adoption assistance, because it was a key source of funding for adoption assistance before 1980. Now that federal funding for adoption assistance is expanding as a result of the 2008 Fostering Connections Act, states should be prohibited from spending these funds on adoption assistance and be encouraged or required to reallocate them for ASAP services.
- Strengthen the current Title IV-B, part 2 Promoting Safe and Stable Families (PSSF):
  - Direct HHS to assure that each state is spending at least 20 percent of funding on adoption services, as required by regulation.
  - With the expanded coverage for adoption administration under Title IV-E adoption assistance as a result of the 2008 Foster Connections to Success Act, eliminate the 5 percent spending on administration under PSSF and reallocate the funds to Adoption Promotion and Support Services spending under PSSF.
  - With the combined 20 percent of PSSF spent on Adoption Promotion and Support Services, plus the 5 percent for administration, Congress should further divide this allocation by designating at least 15 percent for ASAP services.
- Strengthen and clarify the Adoption Opportunities Act:
  - Congress needs to strengthen and increase its oversight of the Adoption Opportunities Act so that grants are not diverted away from the legislation's mission of promoting adoptions of children who are of color, who have special needs and who are older, as well as its service requirements to promote and facilitate post-adoption services.
  - Once the mission and oversight of Adoption Opportunities funding is strengthened, the $39 million appropriation should be increased, with funding designated for greater provision of ASAP services.
- At least 25 percent of states' savings from the "de-link" should be designated for ASAP services. Congress needs to follow up its earlier efforts on expanding federal funding for adoption assistance, thereby enabling states to save money (2008 Fostering Connections to Success Act) by enacting legislative language to direct states to reinvest their savings back into their child welfare systems. By 2018, all special needs adoptions will be covered by federal funding. Even if the calculation of the federal costs (and thus the state savings) on the Fostering Connections Act

2008 overestimates the savings to the states, in 2018 states will still receive several hundred million more a year in federal child welfare funds under adoption assistance. That federal investment should not be diverted to other state needs, but should be mandated to remain for child welfare. This would also allow states to provide greater resources for ASAP services.

- Congress and the Administration should determine if states are meeting their obligations within the Medicaid program under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. Under Medicaid, EPSDT requires states to screen and identify the physical and mental health needs of Medicaid-covered children and youth under age 21 – and to ensure that those who need treatment and services receive them. Since children with special needs are covered by Medicaid, this could provide critical funding for ASAP services.
- Congress needs to provide federal reimbursements for all federal adoption subsidies until a child turns 21 – not only when a state determines that the child has a "handicapping condition" that "warrants" such support. This will extend Medicaid coverage to age 21, which is critical not only for medical expenses but also for mental and behavioral health services.

These changes would result in critically needed funding to support and strengthen families after adoption.

PART II: CHILDREN'S ADJUSTMENT AFTER ADOPTION

The largest category of adoptions in the U.S. (other than by step-parents) is of children from the public child welfare system – about 52,000 a year. Far fewer children are adopted annually from other countries (less than 9,000) or domestically as infants (about 13,000 to 14,000) (USDHHS, 2013; U.S. Department of State, 2013; Smith, 2010). The vast majority of all these children, particularly those adopted from foster care or orphanages, come to their adoptive families with early life experiences that pose challenges for their physical, emotional and cognitive development.

Experiences that Pose Risks for Ongoing Development

Most adopted children, before entering their new families, have had a range of negative experiences, including one or more of the following:

- Adverse prenatal conditions (malnutrition, low birth weight, exposure to toxic substances such as alcohol and drugs, inadequate health care)
- Early deprivation and neglect
- Physical, sexual and/or emotional abuse
- Exposure to violence toward others
- Multiple placements, interrupted attachments and traumatic grief

While risk factors are associated with a greater level of challenges, they do not necessarily predict problems for everyone who experiences them. Rather, the presence of a risk factor increases the *probability* of a certain outcome; however, there is a broad range of outcomes among children experiencing the same risk factor. Although children can be amazingly resilient, many with early adverse experiences have challenges that continue to negatively impact their development in negative ways, and they may require specialized treatment to facilitate healing and developing to their fullest potentials (Smith, 2010). A recent study by Harwood, Feng and Yu (2013) highlights the role of parent-child relationship quality in ameliorating or minimizing the impact of pre-adoption adversities on children's mental health and school outcomes. Using data from the 2007 National Survey of Adoptive Parents, the researchers found that across all three types of adoptions studied (i.e., foster, international, private domestic), the link between early risk such as older age at placement and later mental health and school problems were partially mediated by quality of parent-child relationship. These findings reinforce the importance of supporting positive relationships among children and their families from the very beginning of placement and continuing the support in the post-adoption years.

Research demonstrates a significant relationship between cumulative adverse experiences in childhood and a range of negative child and adult outcomes, including both mental and physical health problems, substance abuse and other risky behaviors, aggression and even poor work performance (Felitti et al., 1998; Anda et al., 2006). The Adverse Childhood Experiences Study (ACES), a classic study of more than 17,000 adults, assessed the prevalence and impact of 10 specific adverse childhood experiences,[19] finding that 13 percent of these adults experienced four or more of these experiences during childhood (Felitti et al., 1998). Those with this extent of adverse childhood experiences had 12 times the odds of having serious negative health outcomes in adulthood than did other adults.

A recent study assessed the prevalence of these 10 experiences among children involved with the child welfare system, finding that more than half had experienced four or more of them as did two-thirds of child welfare youth ages 11-17. (These assessments were considered to underestimate the extent of children's adverse experiences, since many were still young, and all were likely to have had experiences that were not known to their current caregivers.) Also, children in the child welfare system often had additional adverse experiences that were not on the list assessed, including poverty, being removed from their homes, multiple caregivers and separation from siblings (Stambaugh et al., 2013).

The compounding of traumatic experiences increases the likelihood of a child having behavior and emotional problems; in fact a new study of over 11,000 children who had experienced at least one trauma found that the odds of a child's scoring in the clinical range (the level of children receiving mental health treatment) on the Child Behavior Checklist scales went up for each additional traumatic event they had experienced. For example, each additional traumatic event experienced (from a list of 20) increased the odds of scoring in the clinical range for rule-breaking by 16 percent and by 11 percent for aggressive behavior (Greeson et al., 2014).

[19] The 10 experiences included: physical neglect, emotional neglect, physical abuse, sexual abuse, emotional abuse, mother treated violently, household substance abuse, household mental illness, parental separation or divorce, and incarcerated household member.

The Impact of Complex Trauma and Traumatic Grief

It is estimated that at least 90 percent of children in foster care have experienced trauma (Stein et al., 2001), but the extent of their maltreatment and other traumas is not completely known. Often children are removed from their original families due to a single indicated allegation (neglect in the majority of cases), but later other types of maltreatment come to light. Many of the behavioral symptoms of adopted children who are seen in mental health settings stem from the effects of trauma, and a high percentage of children who have externalizing behavior disorders (attention deficit hyperactivity disorder, oppositional defiant disorder or conduct disorder) have trauma histories (Ford et al., 2000). Externalizing behavior problems have been found to be more prevalent among children adopted from foster care, and a maltreatment history has been identified in a number of studies as being associated with these behaviors (Berry & Barth, 1989; Smith & Howard, 1991; Rosenthal & Groze, 1994; Simmel, Brooks, Barth, & Hinshaw, 2001; Howard & Smith, 2003; Harwood, Feng, & Yu, 2013). Sexual abuse is even more strongly associated with a high level of acting out behavior problems and adoption instability than is physical abuse (Rosenthal & Groze, 1992; Smith & Howard, 1991, 1994; Howard & Smith, 2003; Simmel, 2007). Maltreatment also puts children at increased risk for depression and can affect their adjustment into adulthood, especially when maltreatment is severe (Ji, Barth, Brooks, & Kim, 2010).

The impact of abuse on children is both psychological and physiological. The **psychological impact** can include pervasive fearfulness, depression, low self-esteem, difficulties in self-regulation of feelings and behaviors, and PTSD-related symptoms such as re-experiencing trauma-related reactions linked with certain triggers. Trauma experts coined the term “complex trauma” to describe the cumulative effects of prolonged exposure to traumatic experiences in a relationship with a caregiver. These children have organized their views of the world and have shaped their personality in ways that help them to cope and survive. Chronic experiences of maltreatment are often linked with a world view involving mistrust of others, festering anger, aggression and a strong need to control others to defend against feelings of powerlessness (Finkelhor & Browne, 1986; Ford et al., 2000; Smith & Howard, 1999; Briere et al., 2001). Overall, trauma experts have identified seven domains of impairment in children exposed to complex trauma: attachment, biology (physiological maturation and functioning), affect regulation, dissociation, behavioral control, cognition and self-concept (Cook et al., 2005).

Another aspect of the long-term impact of abuse and neglect on children is how these experiences can alter the **neurochemistry and physiology of the brain** and result in neurodevelopmental damage (Perry, 1998). One deficit in brain functioning linked with trauma relates to “executive functioning” or abilities located in the part of the brain associated with aspects of self-control, working memory, learning, attending, decision-making, and problem-solving. A British study of foster and adopted children referred for a trauma assessment found that all of them had significant deficits in executive functioning and concluded that children’s oppositional responses to adult instructions often result from the brain’s difficulties in processing information. In other words, the researchers recognized that non-compliant behavior is frequently related to the fact that the child *can’t do* rather than *won’t do* tasks, stating that “unless these difficulties are identified and addressed, these children get ‘left behind’ and a growing gulf develops between them and their peers” (Lansdown, Burnell, & Allen, 2007, p. 49).

Traumatic grief, defined as "a condition in which trauma symptoms impinge on children's ability to negotiate the normal grieving process" (Cohen & Mannario, 2004, p. 819) is another type of trauma often experienced by children adopted from foster care. Studies examining foster youths' perspectives on the meaning of permanency found that many of them had experienced emotional pain as a result of repeatedly losing relationships that mattered to them (Samuels, 2008 & 2009). The emotional trauma that children experience at separation from their parents is often compounded by separation from siblings, grandparents and others as well as the subsequent loss of foster parents, foster siblings, friends and even teachers, caseworkers or mentors. Children also are typically not helped to grieve these ambiguous losses, which can result in internal barriers and resistance to investing in other permanent relationships (Brodzinsky, 2011; Howard & Berzin, 2011; Unrau, Seita, & Putney, 2008). It often takes significant therapeutic intervention and therapeutic parenting to counteract these defensive patterns and to promote resiliency. Children need therapeutic assistance both before and after adoption to address trauma and loss issues, and adoptive parents need to be helped to understand and support their children's ongoing challenges related to trauma, loss and identity.

Mental Health Needs of Children Adopted from Foster Care

After physical safety needs of children in the child welfare system have been addressed, mental health problems are one of the most serious threats to their well-being (Levitt, 2009). Children who have experienced ongoing trauma and loss are extremely vulnerable and at very high risk for mental health and/or substance abuse problems. The impact of these experiences can alter all aspects of their development and keep them from developing the skills and capacities they need to be successful in the classroom, in their communities and in interpersonal relationships (Cook et al., 2005).

A substantial proportion of children adopted from foster care continue to have ongoing adjustment issues that may intensify as they age. There are very few longitudinal studies of children adopted from foster care, but those that have been done indicate that the percentage of children with behavioral and emotional problems in the "clinical range" (at the level of children receiving mental health treatment) increases over time (Rosenthal & Groze, 1994; Simmel et al., 2007).

While fewer than 10 percent of children in the general population receive mental health services (National Survey of Children's Health, 2007), the National Survey of Adoptive Parents reported that 46 percent of children adopted from foster care, 35 percent adopted internationally and 33 percent adopted as infants had received mental health services (Vandivere et al., 2009). For those adopted from foster care in the U.S., the rate of mental health services usage is higher for boys than girls (52% vs. 36%) and for those who were older at placement and older at assessment. Parents rated mental health services as very helpful for only about half (50.7%) of children adopted from care (Tan & Marn, 2013).

The body of research on post-adoption services indicates that **adolescence is the period of greatest need** and the most common time that adoptive families seek help (Smith, 2010). The National Survey of Adoptive Parents reported that for those adopted from foster care who were now teens, 57 percent received mental health services (Vandivere et al., 2009). Adolescence is universally filled with a range of challenges – complex identity work, a heightened need for peer approval, puberty and hormonal shifts, deeper reflection on life events due to cognitive advances; and the push toward independence and separation from family. For children who have experienced profound loss and trauma, there is often a resurgence of issues in early adolescence; for example, a study of youth served through an adoption preservation program found that post-traumatic stress disorder symptoms were most prevalent among pre-teens – 59 percent of the 12-year-old children were identified as having PTSD symptoms, compared to 35 percent of all other children in the program (Smith, Howard, & Monroe, 2000). Depression is high among teens generally, but it is particularly high among youth adopted when they are older. A recent study found that teens adopted at age 4 or older had higher rates of depression than non-adopted youth or those adopted before age 4. Also, 23 percent of the later-adopted youth reported suicidal thoughts during adolescence (Festinger & Jaccard, 2012).

> Adolescence is a particularly vulnerable period for youth who have experienced profound loss and trauma. Problems typically are at their highest level during these years.

LONGSCAN Underscores the Vulnerability of Maltreated Youth Long After Adoption

A remarkable longitudinal study that was mandated by Congress and begun in 1991 focused on the antecedents and consequences of child abuse and neglect, following children from early childhood into adulthood. The Longitudinal Studies of Child Abuse and Neglect, LONGSCAN, involved five study sites, each with a different type of sample, ranging from those at-risk for maltreatment to others having maltreatment reports, and a fifth site, San Diego County, that followed children who entered foster care prior to 3.5 years of age due to substantiated maltreatment. Data collection from caregivers, case records, and later teachers and the youth themselves occurred at ages 4, 6, 8, 10, 12, 14, 16, and 18. Of the 330 children in the San Diego sample, 126 were adopted at some point. Many of the findings comparing the long-term outcomes of adolescents who were adopted, reunified, and remained in foster care are not yet published but are available from conference presentations and research reports.

Early data in the first six years of the San Diego study found that adopted children were likely to grow up in families with more resources, be exposed to less violence and be more likely to have a stable home. At ages 4 and 6, adopted children had lower scores on the Child Behavior Checklist than reunified children or those remaining in foster care (Litrownik et al., 2003). The researchers later observed: "By the age of 8, and continuing at 10, this advantage was no longer observed. And, by age 14, the adopted youth were now being rated as having significantly more internalizing and externalizing problems" (Litrownik, 2012, p. 65; Litrownik, 2011).

Three groups of youth were compared, using their raw scores on the Child Behavior Checklist: 1) 74 adopted by age 12, 2) 71 reunified by age 12, and 3) 71 who were not adopted or reunified by age 12. The mean scores were relatively equivalent at age 4 (externalizing—13 versus 13.6 and 15; internalizing—5.9 versus 5.7 and 5.1); however, adopted youth evidenced more problems during early adolescence (externalizing—16.2 for adopted versus 12.7 for reunified and 9.4 for long-term foster youth; internalizing—10.4 versus 7.9 and 7.4) (Litrownik, 2012). Findings from the Diagnostic Interview Schedule for Children confirmed that adopted youth also had more disruptive behavior disorder diagnoses – attention/hyperactivity, oppositional defiant and conduct disorders – than the other two groups. The researchers wrote (Litrownik, 2012, p. 66):

> *Following these analyses we went back and re-read a number of life event narratives for adopted youth. The narratives were consistent with the quantitative data, and one surprising observation was a number of the youth had spent some time in a residential treatment program during their early adolescence. These unique and unexpected findings suggest adoption from foster care may not prevent children from being exposed to subsequent challenges, nor protect them from developing disorders. We have not identified the specific challenges that they faced, but hypothesize that they are likely to include preprogrammed vulnerabilities (i.e., genetic, constitutional, early adversities or exposures—drugs), and dealing with the normal challenges of adolescent identity (i.e., demands of parents, peer group identification, and interest in their biological parents and implications for their development).*

The researchers analyzed the factors associated with long-term positive behavioral adjustment or resilience of youth in the study across all types of permanencies, finding that early child cognitive ability and social competence, long-term caregiver stability, and low frequency of physical abuse from ages 6 through 14 were primary predictors of resilience (Proctor, Skriner, Roesch, & Litrownik, 2010).

The San Diego LONGSCAN study is the only one of its kind that has followed youth adopted from foster care through their teens. We do not know the extent to which its findings on this sub-sample of adopted youth can be generalized to all child welfare adoptions. It does, however, underscore that a substantial proportion of youth adopted from foster care will continue to have adjustment challenges and experience instability or impermanency.

More longitudinal research examining both child and family functioning is needed in order to discern the critical factors contributing to ongoing challenges, as well as the interventions and supports that minimize negative adjustment trajectories and instability. It is evident that adolescence is a vulnerable period for youth adopted after experiencing adversity. Studies focused primarily on early-placed adoptees show that differences generally are not manifested until children are school age; they intensify during adolescence; and they level off in young adulthood (Feigelman, 1997; Simmel, Barth, & Brooks, 2007). It also is possible that some of the youth adopted from foster care who have a tumultuous adolescence will achieve a more positive adjustment in early adulthood.

Assessment and Treatment of Mental Health Needs

Research finds that children in the child welfare system have mental health needs that are not being adequately identified or treated, so it is likely that those children who go on to be adopted have unmet mental health needs. There is a significant gap between the number of children who need services and those who actually receive them; yet, in spite of the dramatic underutilization of mental health services among children in foster care, they still use mental health services at a much higher rate than other children and incur heavy expenditures for this service usage (Burns et al., 2004; Stahmer et al., 2005; Halfon, Berkowitz, & Klee, 1993).

Perhaps what is even more troubling is that the **available evidence indicates that children in care who receive mental health services may not benefit from them**. A study using data from the National Survey of Child and Adolescent Well-Being found that the use of outpatient mental health services had no statistically significant impact on either externalizing or internalizing behavior problems as measured by the Child Behavior Checklist (Bellamy, Gopalan & Traube, 2010). The authors of another study with similar findings concluded: "It is unwise to depend on community providers for the mental health needs of children and families entering the foster care system; **child welfare needs to develop resources grounded in evidence-based practices**" (Love, Koob, & Hill, 2008). The U.S. Children's Bureau is now funding a series of five-year demonstration projects to improve screening, assessment and services related to the trauma-based and mental health needs of children in care.

Very **few practice interventions address the nature of complex trauma** or attachment and identity issues among adopted children who also may have other coexisting developmental challenges. For example, trauma-focused cognitive behavior therapy (TF-CBT) was developed for children whose primary presenting problems are related to a single traumatic event and who display symptoms of posttraumatic stress disorder (PTSD). The PTSD diagnosis does not capture the developmental effects of complex trauma exposure or the complex layering of adaptations to trauma and loss with other enduring emotional, behavioral, and developmental issues (Cook et al., 2005; Briere, Kaltman, & Green, 2008).

The pervasive and complex symptoms of some children adopted from care require specialized treatment that addresses the broad range of domains involved, particularly in developing core capacities for self-regulation and interpersonal relationships (Tarren-Sweeney & Vetere, 2013). Adoptive parents need to be partners in this treatment and to learn how to most effectively interrupt dysfunctional patterns of interaction and facilitate developmental catch-up. Research indicates that early intervention with children having high levels of externalizing behavioral problems is linked with a more rapid decline of these problems when compared to youth not receiving mental health services (Thompson, 2009). Therefore, effective treatment for these children beginning at the earliest possible point serves as prevention against compounding of their problems in all facets of their lives and throughout their development. Intervention, however, needs to be provided by therapists who are adoption-competent. Too often, adoptive parents seeking mental health services for their children and families find that clinical providers do not understand the unique complexities associated with their life experiences and/or often intervene in ways that are unhelpful and that sometimes even compounds their problems (Brodzinsky, 2013).

Based on the findings of this body of research, it is evident that a significant portion (up to half) of adopted children who have experienced trauma and loss will continue to face developmental challenges over the course of their childhood, particularly in adolescence. The majority of children in foster care who have significant mental health needs are unlikely to get effective help in addressing these issues prior to their adoptions. Adoptive parents and their children need help, both at the time of their adoptions and ongoing as needed, to be able to effectively address critical issues and to promote resiliency at home, in school and in their communities.

PART III: RESEARCH RELATED TO POST-ADOPTION INSTABILITY

A young man, Russell Pretz (2013), who completed a foster youth internship program with the Congressional Coalition on Adoption Institute, wrote in his chapter for the internship program's report, *Our Voice Their Future*, about his and his siblings' own experience of a failed adoption and his own recommendations for improving post-placement supports.

> *My sister, my two brothers and I experienced a failed adoption….After being in care for four years, all four of us were adopted together. Unfortunately, our adoptive parents were not made fully aware of the significance of our past emotional trauma, and more importantly, did not receive the support they needed to effectively parent four children with learning disabilities and emotional and mental health issues. As a result, they were not able to effectively parent us, and now my siblings and I no longer have contact with them. Instead of providing us with a home and a forever family, the failed adoption resulted in our spending the remainder of our childhood in group homes, psychiatric wards, hospitals and other institutions* (p. 62).

Russell reported that some children adopted from foster care are not realizing the goal of permanency because adoptive parents do not receive sufficient post-placement support, especially mental health services. He recognized that there are adoptions that fail, both officially and unofficially, but because the federal government does not currently collect data on the number of children experiencing post-adoption instability we do not know how common these are.

This report by the Donaldson Adoption Institute seeks to fill this vacuum to the extent possible by providing three types of information on post-adoption instability: 1) a review of scholarly research, 2) a presentation of state-based research on post-adoption placements and adoption dissolution that was collected directly from state child welfare departments for this report and 3) two in-depth analyses commissioned for this report, one from California and the other using AFCARS data. The primary conclusions that can be drawn from all of these data are summarized at the end of this section.

Ongoing Challenges and Adoption Instability

Children's early adverse experiences create challenges to securing permanency at many levels – in finding adoptive placements for them, as well as posing risks for adoption disruptions, ongoing negative adjustments, post-adoption re-entry into foster care, and adoption dissolution. Considerable research has examined the factors linked with the achievement of adoptions for children in care; primary child-related factors linked with finalized adoptions include: younger age, no diagnosed mental health problem and lower levels of behavior problems, no sexual abuse history, early placement stability, and fewer moves in care (Barth, 1997; Akin, 2011). Less is known about risk factors for instability once adoptions have been finalized.

Before embarking on an analysis of the phenomenon of adoption instability, it is important to underscore the reality that the vast majority of adoptions are successful and that permanency promotes children's well-being. As one adoption scholar, Trudy Festinger (in press), writes:

> *The wonder is that in the long run, most of the children placed in adoptive homes are adopted… Adoptive placements of older children and of children with problems oblige agencies to take risks. To do so implies that goals may not be reached. But not to do so also entails risk – the risk of not giving children who are waiting the opportunity to grow up in families they can call their own.*

A complex array of factors influences adjustment after adoption, including risk and protective factors in the child, in the adoptive parents and family, and in community and service systems.[20] When the level of challenge and stressors exceed the child's and parents' ability to cope on a chronic basis, negative outcomes usually result. These include a range of types of adoption instability involving the child leaving the home, either formally or informally, temporarily or permanently, as well as ongoing negative adjustments involving chronic, intense family difficulty or pronounced internal struggle, such as the child not feeling fully accepted or secure within her adoptive family. **Formal types of adoption instability** include adoption **disruption** (removal of child prior to finalization), **post-adoption placement** of the child (re-entry into the state's custody or placement in a residential treatment setting without the state assuming custody) and **adoption dissolution** (legal parent-child relationship is severed after finalization) (Child Welfare Information Gateway, 2012). Youth also may leave their adoptive families on a more informal basis, such as by running away for an extended period, going to live with friends or being sent away by their parents

Research Reported in the Scholarly Literature

Adoption Disruption

There is a much more extensive body of research on adoption disruption than on instability that occurs after adoption. As the number of adoptions of children from foster care increased in the 1970s and 1980s, researchers devoted considerable attention to examining the factors associated with children

[20] For a more extensive review of these factors, see Smith, *Keeping the Promise* (2010).

leaving their adoptive placements prior to finalization. While disruptions in infant adoptions are rare, adoptive placements of older children have higher risks of breakdown, with reported **disruption rates** of large child welfare populations ranging from 9 percent to 15 percent (Urban Systems Research & Engineering, 1985; Festinger, 1986; Barth & Berry, 1988; Goerge, Howard, Yu, & Radomsky, 1997). Most studies of adoption disruption occurred in the 1980s, and very few have analyzed disruption rates since the passage of ASFA in 1997. One exception is an Illinois study of the outcomes of 15,947 adoptive placements occurring in 1995-2000. By the end of data collection in 2003, 9.5 percent of placements had disrupted, and 3.6 percent were still awaiting finalization, so the final disruption rate was probably somewhat higher than 9.5 percent (Smith, Howard, Garnier, & Ryan, 2006). This study also found a decrease in the rate of disruption in the three years after ASFA, as compared to the pre-ASFA period.

In addition to determining disruption rates, research has examined the risk factors associated with disruption, including child, family and agency-related variables. Most often, an accumulation of risk factors rather than a single one is responsible for the breakdown of an adoptive placement.

Attachment difficulties of both children and parents have been identified through research as a primary risk factor; for example, an English study of children placed in middle childhood found 27 percent had not yet developed an attached relationship to at least one parent by one year after placement, and these youth were much more likely to have serious behavior problems (Rushton, Mayes, Dance, & Quinton, 2003). When an adoptive mother perceived a lack of attachment by the child, there was an eightfold increase in adoption disruption; however when the mother felt she was getting something back from the child she was much more likely to develop an attachment herself and to remain committed in the face of challenges. At the six-year follow-up about half of those originally placed for adoption were doing well, but 23 percent of the adoptions had ended and 28 percent were continuing with substantial difficulties (Rushton & Dance, 2006). Other research has found that adoptive mothers with a high degree of maternal sensitivity and secure attachment styles are better able to respond to maltreated children's past loss or trauma issues, and these placements are less likely to disrupt (Steele, Hodges, Kaniuk, Hillman, & Henderson, 2003; Kaniuk, Steele, & Hodges, 2004).

Other risk factors that are most consistently associated with disruption are delineated below; for more extensive reviews of this body of research, see Festinger (in press) and Coakley and Berrick (2007). **Child-related factors** include older age at removal and at adoptive placement; a higher incidence of various types of maltreatment, particularly physical and sexual abuse as well as emotional abuse; challenging emotional and behavioral problems; more previous placements; and unresolved feelings about separation from first/birth parents. **Parent-related factors** include being a matched adopter rather than a relative or foster parent; a large discrepancy between expectations and reality; and the adoptive mother having more education. **Agency-related factors** include inadequate disclosure of information about the child; high personnel turnover or inexperienced staff; and inadequate parental preparation and support (Barth & Berry, 1988, Berry & Barth, 1990; Smith & Howard, 1991, 1994; Groze, 1996; McRoy, 1999; Rushton & Dance, 2006; Smith et al., 2006).

Post-Adoption Placement and Instability

Children may experience placement outside of their adoptive families following the finalization of their adoptions by returning to the foster care system, entering a juvenile justice setting or being placed in a residential treatment program by their adoptive parents without relinquishing custody. As stated earlier, instability also can occur informally when youth leave their homes or are sent to live with someone else.

Due largely to the confidentiality surrounding adoption records and other barriers in data collection, very little research exists on post-adoption instability. For several decades, researchers have reported that children from all types of adoptions are overrepresented in the populations of residential treatment programs (Price & Coen, 2012; Hoksbergen, 1997; Landers, et al., 1996; McRoy, et al., 1988). A Colorado study of more than 1,200 youth in residential treatment centers across the state found that 17.1 percent had been adopted, but parental rights were still intact for only 41 percent of them (Price & Coen, 2012). Another study reported that 10 percent of families had children who had been in a psychiatric hospital since adoption, and 5 percent had been in another type of out-of-home placement (Rosenthal, Groze, & Morgan, 1996).

The Donaldson Adoption Institute currently is conducting a study of adopted youth in residential treatment settings across the nation. Requests for participation have been sent to the 150 member agencies of the National Association of Therapeutic Schools and Programs, and a preliminary analysis of the 48 responses returned to date found that nearly a third (31%) of youth currently enrolled in these programs were adopted, ranging from 5 percent to 93 percent, with a median of 30 percent.

Some adoptive families are able to obtain residential treatment for their children without their entering the child welfare system; in many states, however, children must re-enter state custody in order to obtain funding for this care. According to one post-adoption needs assessment, 72 percent of states have some provisions for covering post-adoption residential treatment (Fuller, Bruhn, Cohen, Lis, Rolock & Sheridan, 2006); but many families have difficulty in securing such care even when it is clearly needed.

LONGSCAN's findings on adoption instability. The San Diego LONGSCAN study found that caregiver stability for adopted children between the ages of 6 and 8 was much greater than for other groups (reunified, long-term foster care/guardianship with relatives or non-relatives): 2.3 percent of adopted children changed caregivers or living arrangements between ages 6 and 8 as compared with 19.2 percent of other children in the study (Proctor, Randazzo et al., 2011). This stability continued through age 12, but then began to decline. While 87 percent of youth were living with their adoptive families at age 16 and 82 percent at age 18, the percentage of youth who had experienced a change in their living arrangement (formally or informally) at some point after adoption finalization was much larger – 28 percent by age 16 and 46 percent by age 18.

Youth across all sub-samples (reunified, adopted, foster) had moved out by age 18, and the authors did not view moves between 16 and 18 as necessarily indicative of instability in the adoption, although it could be. For youth who left their families after adoption, moves were both permanent and temporary. Sometimes these were placements for residential treatment, after which the youth returned home. For others, it was a formal placement back into foster care, a group home or other setting. An analysis of living situations at age 18 revealed that more youth not living with their adoptive families were in

informal arrangements, such as with the family of a significant other or friends and siblings, than in formal placements – primarily child welfare or juvenile justice settings (Proctor & Litrownik, personal communication, December 5, 2013).

Studies of post-adoption re-entry into foster care. There are only a few studies that report on post-adoption re-entry into the child welfare system of children who had been adopted. Festinger (2003) followed up on 516 children adopted from foster care in New York City in 1996 and found that 3.3 percent had re-entered the system within a four-year period; most of these children remained connected to their adoptive families, however, and were expected to return to them.

An Illinois study analyzing the outcomes of 11,798 child welfare adoptions found that 6.6 percent of children adopted between 1976 and 1987 had re-entered the foster care system by 1994 (Goerge, Howard, Yu, & Radomsky, 1997).[21] It found that children adopted prior to age 5 were less likely to return to care than those adopted at older ages, and the risk of re-entry care was lowest for Hispanic youth (80% less than for Whites) and higher for males (22% greater) than females. Those spending two to four years in care before adoption were 50 percent more likely to re-enter than those in care for less than one year. An interesting finding of this study is that the risk factors for adoption disruption are not necessarily the same as those for post-adoption placement into foster care. While spending two to four years in care prior to adoptive placement (as opposed to one year or less) was associated with a lower risk of adoption disruption, it was linked with a higher risk of re-entering foster care after adoption.

Festinger and Maza (2009)[22] used FY 2005 AFCARS data to analyze the experiences of previously adopted children re-entering or exiting the child welfare system that year (for first time since adoption). First, they compared the adopted children who had re-entered care to non-adopted children entering care to identify their similarities and differences. They found some differences between these two groups: 1) a higher percentage of the adopted children (33.6&) were designated Black non-Hispanics as compared to approximately one-fourth (24.6%) of the non-adopted children, and a lower percentage of adopted children were Hispanic (9.4%) than the non-adopted children (18.9%); 2) child behavior problems was more frequently reported as a circumstance present at entry for adopted children (44%) than for non-adopted 14%); adopted youth were entering at older ages than non- adopted youth (median=14.4 vs. 6.5 years); and there was a higher rate of placement in institutional or group care for adoptees (41% vs. 20%). Also, the median length of time in care for those children experiencing a post-adoption placement and exiting care was 21.9 months, compared to a median of 11.9 months for non-adopted children exiting care. A purpose of this article was to explore the use of the term *displacement* to describe care re-entry, and the authors concluded that the term *post-adoption placement* was a more appropriate and neutral term.

[21] To identify cases of adopted children re-entering care, researchers employed a technique known as probabilistic record-matching that compared multiple pieces of information in reopened cases and pre-adoption records.

[22] More current and detailed AFCARS data (FY 2012) on dissolution and other topics related to post-adoption placements are presented in Part III of this report.

Adoption Dissolution

Developing accurate information on adoption dissolution or on post-adoption re-entry into foster care is extremely complex and difficult particularly because of confidentiality laws, name changes, cases being closed after adoption and other data practices. Almost all states give adopted children a new case ID when they re-enter care after adoption, and most do not have the ability to cleanly match the re-entry cases to pre-adoption case data. Also some adoptive families move out of state, and their home state may not know if they re-enter care in another state or if their adoption is legally dissolved. In addition, some parents privately place their adopted children in residential treatment facilities. Furthermore, although AFCARS requires states to indicate if a child entering care was previously adopted, it does not allow for the identification of the state in which the adoption occurred or the type of adoption – foster care, international, private, etc.

There is very limited scholarly research on the rate of adoption dissolution or the factors associated with it. Festinger and Maza (2009) is the rare scholarly article that describes some factors associated with adoption dissolution. Recognizing the limitations described above, the authors reported that of the 3,166 post-adoption re-entries who exited care in FY2005, 1,241 (39%) experienced adoption dissolutions, and 1,925 (60.8%) did not experience dissolutions. Most of those whose adoptions were dissolved (87.5%) were adopted into another family. Overall, 35.6 percent of youth exiting care were reunified with their adoptive families and others aged out of care or left due to other circumstances. These data indicate that for children re-entering foster care after adoption, many eventually return to their adoptive families.

The Consequences of Adoption Breakdown

The Economic Cost

Governmental costs of adoption instability are extremely high; the federal government spends $27,236 a year on the average foster placement, compared to an average of $5,043 a year for a child receiving adoption assistance covered by federal funding (Congressional Budget Office, 2013). Findings later in this report indicate that adopted children who re-enter foster care are more likely to be in congregate care that costs considerably more, and they are likely to remain in care for longer periods than other foster children. Successful adoptions yield other public financial benefits through lower costs for human services and reduced crime, estimated as a total savings of $302,418 per adoption (Hansen, 2007). Collectively, these factors underscore the high price tag to governments and to society of failure to effectively preserve adoptions.

The Human Cost

The emotional toll of adoption breakdowns for both youth and adoptive families is immeasurable. It occurs not only when children re-enter state care, but also when parent-child relationships become so tenuous that their ties are ultimately severed. The Adoption Institute regularly receives e-mails from adopted individuals, often in response to media programs involving Institute staff; several have e-mailed in the past few months about the far-reaching consequences of experiencing failed adoptions. One

young woman's vivid description of her own experience is contained in Appendix I of this report. Ashley did not experience a legal dissolution of her adoption but, rather, a complete emotional severing of the parent-child relationship when she reached the age of majority. She describes the tremendous anguish and emptiness that continue to impact her life, "I have no family but have a huge open heart that is aching for someone to love me… I have not been able to see my dear brother in over 8 years because they would not allow it…. I find it hard to give myself any kind of credit as I was not wanted by not just my birth parents, [but] my adoptive parents as well."

Another young man, in his late 20s, e-mailed the Donaldson Adoption Institute in December 2013 to relate his own failed adoption experience:

> *I am a foster/adopted black male who lived through a failed placement and have suffered great consequences because of it. Although I managed to move to ___ and make a living on my own, life has been frustrating to say the least. For quite some time I felt cut off from the world and like I had no help. Although I only managed to graduate high school, I have gone on to teach, coach, and mentor at-risk youth like myself who fell through the cracks. I hope to start my own company to continue this mission, but I myself am as disadvantaged as the people I want to help and don't know what to do. Adoption has truly rocked my life and entire world. We need increased post-adoption services. My struggles post-adoption were so visible, it's egregious. It angers me now to realize what was going on and how no one stopped the madness. I know there are kids just like me out there who are suffering - I want to be a part of the support system.*

Requiring Custody Relinquishment to Obtain Residential Treatment Compounds Trauma

Another factor that compounds the human cost of post-adoption instability is the harm that comes to adopted youth and their families when parents' attempts to obtain help are addressed within the context of an adversarial stance, through policies and laws that require parents to formally "abandon" their children and be accused of child neglect in order to obtain residential treatment. These policies are harmful on so many levels, creating additional stresses and barriers that are counterproductive to preserving these adoptions, interfering with parents' abilities to see and support their children, traumatizing children unnecessarily and punishing parents who are doing their best to help their children. Residential treatment staff may keep adoptive parents at a distance and only call caseworkers with questions or reports on the children. A vivid account of the impact of such policies is excerpted from on adoptive parents' account in her book *Second Time Foster Child* in Appendix II (Hoy, 2012).[23]

[23] A proposed solution to this policy being considered in Illinois is HB4739 which provides for voluntary, time-limited child welfare placement for child treatment when there is no evidence of abuse or neglect (see http://www.ilga.gov/legislation/BillStatus.asp?DocTypeID=HB&DocNum=4739&GAID=12&SessionID=85&LegID=79406)

State-Based Research on Post-Adoption Instability

In order to synthesize existing research on post-adoption instability, the Donaldson Adoption Institute surveyed state child welfare directors, asking if they had any reports on post-adoption placements or dissolutions in their states, and if so, whether they could share these with DAI. The Institute collected additional information about post-adoption services. To assist in this study, states were each asked to identify two contacts within them – one who was knowledgeable about post-adoption services and another about child welfare data. A follow up e-mail was sent to those not responding to the initial survey, and ultimately 36 directors responded to our queries. We also asked the adoption program managers, who were interviewed by phone for the study of post-adoption services, whether their states were able to track post-adoption placements or dissolutions.

Almost all of the states responded that they did not have reports on post-adoption placements or dissolutions, nor were they able to track these phenomena. Institute staff also contacted researchers at Chapin Hall, University of Chicago, a research center focused on children, which has a child welfare database containing data from 25 states, and found that only one of these states had the ability to match post-adoption and pre-adoption data on children because they did not change the case ID if an adopted child re-entered care. Ultimately, we obtained usable reports on post-adoption instability from eight states. The reports were primarily of two types. The first was based on case reviews of groups of adopted children returning to care and/or experiencing dissolutions over a specific time period. The second type calculated the percentage of adoptions that occurred in specific years in which children had returned to care during a specified period. Reports from two states included more advanced statistical analyses. The following is information derived from these reports.

New Mexico tracked re-entries into state custody following adoption and provided figures for FY2013 – 47 adopted children had re-entered state care; 15 were dissolutions (11 of which were attributed to parental death) and 32 re-entered care and had not experienced dissolutions.

Utah and Kansas tracked the number of children adopted in each fiscal year who had come back into state custody through FY2012 (see Table I). For example, of the 506 finalized adoptions in Utah in FY2001, 7.5 percent had re-entered care by FY2012; and for the 623 finalized adoptions in Kansas in FY2005, 10.9 percent had re-entered care by FY2012.

Table 1:
Child Welfare Adoptions in Utah and Kansas, Percent Re-entering Care through FY2012

State Fiscal Year	Years since Adoption	Utah Adoptions	% Re-entered Care	Kansas Adoptions	% Re-entered Care
FY2010	2	597	1.3%	721	3.3%
FY2009	3	530	1.3%	816	2.5%
FY2008	4	513	2.5%	712	6.2%
FY2007	5	561	4.8%	715	6.2%
FY2006	6	503	2.2%	501	9.4%
FY2005	7	456	4.8%	623	10.9%
FY2004	8	427	4.9%	613	10.0%
FY2003	9	452	6.2%	486	9.7%
FY2002	10	443	11.5%		
FY2001	11	506	7.5%		

Table 1 indicates the shorter the time between the finalized adoptions and FY2012, the smaller the percentage of post-adoption placements. Further, these placements continued for a long time after finalization. Unfortunately this table does not permit the calculation of a true rate of post-adoption placement. To accomplish that, all adoptions, including those of families who moved out of state, would need to be followed until every child reaches the age of majority. These data also do not include adopted children who were placed directly by their parents into residential treatment facilities. However, these data are valuable in showing a snapshot of the proportion of adopted youth in a cohort of adoptions who re-enter state care over time, ranging from 1.3% in a two-year period up to 11.5% over a 10-year period. Kansas reported that the mean length of time to re-entry was 45 months after adoption, and the median length of time to re-entry was 39 months.

Also, Utah shared a 2008 needs assessment in which 804 parents of 975 children adopted from the state's child welfare department reported on their needs and satisfaction with services. Overall, 60 percent reported that their children had current emotional and behavioral concerns and, as a result, 9.8 percent of these children had been placed outside their homes at some point after adoption.

Ohio reported that as of October 1, 2013, there were 391 previously adopted children out of a total of 12,109 children in the state's foster care system. These include some children adopted from abroad and out-of-state, as well as those adopted from Ohio's system. Overall, 150 of these children had experienced adoption dissolutions.

A data analyst at the Ohio Department of Job and Family Services conducted a **survival analysis** based on close to 35,000 adoptions occurring from 1990 to the present in order to determine rates of foster care re-entry and adoption dissolutions (Hubble, 2013). The actual rate of re-entry was 6.79 percent. The analysis estimated the re-entry rate for adopted children 18 years after finalization, even if the time after adoption was less than 18 years. The **estimated foster care re-entry rate based on this analysis was 9.52 percent**. The median time between finalization and foster care re-entry was 5.1 years, with a mean of approximately 5.6 years.

A similar **survival analysis for adoption dissolution yielded a rate of 2.22 percent**. For those experiencing adoption dissolutions, the time between finalization and dissolution was a median of 4.5 years, with a mean of 5.1 years.

The most common **ages at which adopted children re-entered foster care** was 12-15 years old, and this re-entry age did not seem to be associated with the age at which the child was adopted. The distribution of the ages at re-entry for the 2,368 Ohio adopted children is in Table 2 below.

Table 2: Ages of Ohio Adopted Children at Foster Care Re-entry

Age at Re-entry	Number	% of All Adoption Re-entries
Under 5 years	52	2.2%
Ages 5 – 9	285	12.0%
10 and older	2,031	85.8%

Of the 588 children experiencing **adoption dissolutions**, 2.2 percent were under 5 years old, 18.4 percent were between 5 and 9, and 79.4 percent were 10 or older when their adoptions dissolved.

Children who were adopted younger than age 5 had lower rates of foster care re-entry and adoption dissolution. The age at adoption and rates of both re-entry and dissolution are reported below.

Table 3: Ohio Rates of Care Re-entry and Dissolution by Age at Adoption

Age at Adoption	Number	Re-entry Rate	Dissolution Rate
Under 5 years	16,404	3.60%	.98%
Ages 5-9	10, 536	9.55%	2.52%
10 and older	7,937	9.71%	2.05%

In Ohio, the rates of foster care re-entry and dissolution do not vary greatly by gender, but there are differences by race. For example, the rate of foster care re-entry is 5.41 percent for white children and 8.96 percent for non-white children. The adoption dissolution rate was 1.39 for white children and 2.15 for non-whites. (These rates are based on all children adopted since 1990, not just on those who have reached age 18, as reported in the survival analysis.)

These data are based on former statewide information systems and SACWIS, which does not fully capture international adoptions or post-adoption re-entries and dissolutions over the past 18 years.

Massachusetts conducted an extensive review of adopted children who were in care of the Department of Children and Families (DCF) at any time during FY2007 (Farley & Zalesky, 2009). It found that 819 adopted children spent some time in care that year, and adopted children represented approximately 5 percent of all children in care at the end of FY07. The findings from a review of the 601 open cases at the end of FY07, as well as an examination of entry (n=256) and exit cohorts (n=218) during that year are summarized below.

Age. For the adopted children in care at the end of the year, 89 percent were age 13 or older, and 18 percent were over age 18. There were no significant differences by gender. The peak age at re-entry was age 15 (23%), with another 20 percent entering at age 16. Only 15 percent of the 256 adopted children entering care that year were under age 13.

Time between adoption and re-entry. The length of time between adoption finalization and care re-entry was examined for those adopted children in care at the end of the year. As Table 4 indicates, almost two-thirds (65%) of the children who re-entered care spent at least six years in their homes after adoption finalization and prior to re-entry.[24]

Table 4: Time between Adoption and Care Re-entry in Massachusetts

Years	Percent (valid)
2 or less	12.4%
3-5	22.5%
6-8	29.1%
9-11	19.9%
12 or more	16.1%

Types of adoption. Overall, 87 percent of previously adopted children entering care were child welfare adoptions (82.4% from DCF and 4.3% from other states). Other types of adoptions included intercountry (6.3%), private domestic infant (5.1%), private kinship (1.2%), and the rest other/unknown.

Race/ethnicity. African-American children made up a much larger proportion of adopted children returning to care than might be predicted. They represented 34 percent of the adopted children returning to care, but only 15 percent of the total child welfare population; whereas white children comprised 50 percent of adopted children in care and 56 percent of the total child welfare population. The proportion of adopted children returning to care who were Hispanic/Latino was very close to those in the state's child welfare population.

Reason for care re-entry. Forty percent of the open cases entered care through a request for voluntary services, 29 percent entered due to a Care and Protection order and another 29 percent entered by way of a Child in Need of Services (CHINS) petition. Only five children's cases involved a Voluntary Adoption Surrender at placement or soon thereafter. All of the adopted children age 4 and under who came into DCF's care did so through Care and Protection orders. The number of children entering care via the CHINS petition began to increase at age 9 and continued increasing through the mid-teen years.

Time in care. The DCF analysis concluded that there seemed to be two cohorts of adopted children in care – one group entered and exited care quickly (less than 1 year), and the other remained in care for an extended time period. In looking at the children in care at the end of the year, 1/3 had been in care for less than a year, and 2/3 had been in care a year or longer. Children who entered care at young ages were likely to exit in less than a year; for those age 11 or younger at re-entry, only 6 percent were in

[24] These figures exclude 31 youth who turned 18 during the year, chose to voluntarily re-enter care and did not have a goal of reunification, as well as 5 others who had more than one adoption.

care for more than 1 year. The **length of stay** for the 218 cases that closed in FY2007 were: less than 1 year (43%), 1-2 years (31%), 3-4 years (13%), and 5 or more years (12%).

Type of placement: Slightly over half (53%) of youth were in "high end" placements – residential care (32%) or intensive foster care (21%).

Reunification with adopted family: For the 256 children who entered DCF care in FY07, 60 percent had a goal of returning to their adoptive families. For the 601 youth in care at the end of FY07, 31 percent had a goal of reunification with their adoptive families; however, for children in care longer than one year, 74 percent did not have any type of permanency goal, leading the researchers to conclude that returning home quickly is crucial to a successful permanency outcome. Of the 218 cases that were closed in FY07, 39 percent of the youth were 18 or older. For the remaining 132 youth, most were either reunified with their adoptive families (63.6%, or 38.5% of those exiting care) or achieved permanency with other families (16.7%). Overall, 84 percent of previously adopted youth who exited care in FY07 maintained connections to adoptive, guardianship and/or birth families, and another 4 percent were connected to other families, mainly foster families (Farley & Zalesky, 2009).

Vermont's child welfare system conducted a similar analysis in 2007 of 106 adopted children who had re-entered foster care prior to their 18th birthdays, in order to determine if there were patterns that would help predict which cases might benefit from intensive services after adoption. A majority of these children were males (58%) who had experienced on average 4.5 placements prior to adoption, and the average length of stay in care after adoption was 1.2 years. Their mean ages for specific events included:

Entry into custody	5.8 years
Adoption finalization	9.6 years
Care re-entry	14.4 years

Reviewers examined known child issues present at finalization and found that the most common included: a diagnosis related to mental illness (76%), cognitive disabilities (33%), aggression or violence (20%), ADD/ADHD (19%), prenatal substance exposure (20%), abandoned as an infant (13%), physical disability (11%), and failure to thrive or infant head injury (10%). The most common reasons for removal from original family included (some had more than one reason): neglect (55%), physical abuse (42%), sexual abuse (26%) and domestic violence (16%).

The reviewers concluded that most of these children and youth would have required out-of-home treatment whether they had been adopted or remained in foster care. They reported that most of them did eventually return to their adoptive families, but did not give a specific percentage.

Florida's Governor's Office produces an annual report which, for the past four years, has tracked the number of adopted children who are returned to foster care and their adoptions are dissolved. This reporting began because there were 98 dissolutions in FY2008-09, and the Governor's office set out to reduce this number in future years (Florida Office of the Governor, 2010 -- 2013). Administrators at the Florida Department of Children and Families track the dissolutions occurring in each of the 20 circuit courts and have Community Based Care lead agencies assist in determining the primary reasons that the

dissolutions occurred, as well as assessing the effectiveness of post- adoption services programs. The dissolutions reported do not include those that may have occurred in other states or those due to child or parent deaths. The goal is to track those cases for which improved services might prevent dissolution. The number of dissolutions reported for FY 2010, 2011, and 2012 were 41, 48, 75, and 65, respectively. The primary child- and parent-related reasons assessed as contributing to these 229 dissolutions are reported below. In some cases, more than one reason is given. It is also important to note that due to dissolutions of several large sibling groups, the number of families involved is smaller than the number of children.

Table 5: Primary Child and Parent-Related Reasons Cited for Adoption Dissolutions in Florida

Child-Related Reasons	***Number of Cases (229)***	***Percent***
Behavioral Issues	143	62.4
Mental Health Issues	83	36.2
Safety of Other Children	46	20.1
Juvenile Justice Issues	25	10.9
Parent-Related Reasons		
Abuse or neglect	96	41.9
Unable to care for or provide safety (not a category in 2013)	20 of 164	12.2

In some of the cases involving abuse or neglect charges against adoptive parents, the adoptive parents, they were afraid for their own safety and/or the safety of other children in the home. According to Kathleen Waters, Florida's Adoption Program Manager, if the parent refused to take a child home from a psychiatric hospital or residential treatment setting for these reasons, a protective services allegation of abandonment was filed.

In addition to the data that were voluntarily provided by states for this report, the Donaldson Adoption Institute worked with other researchers to complete two additional in-depth analyses for this study. Through conversations with scholars at the Center for Social Services Research at the University of California at Berkeley, it was agreed that Dr. Joseph Magruder would analyze data from California's child welfare system. The Institute also contracted with Dr. Penelope Maza (an Institute Senior Research Fellow) to complete an analysis of national AFCARS data.

Studies Commissioned for this Report

California: Post-Adoption Re-entries into Care, The Experience of a 5-Year Cohort of California Foster Child Adoptions

By Joseph Magruder, Ph.D., Center for Social Services Research, University of California at Berkeley

Summary

This study followed a cohort of 25,783 children who were adopted from foster care in California during a five-year period between 1997 and 2001 to learn the frequency with which they children re-entered care and the experience of those who did so. The number (1,737) and proportion (between 6.7% and 7.9%) of children identified as having returned to care is probably understated. The median re-entry age of 14, which was generally independent of the child's age at first foster care entry or adoption, suggests that adolescents are at high risk of re-entry. Few re-entering children's parents had their parental rights terminated and most of those children whose parents' rights were terminated were subsequently adopted. However, when parental rights were not terminated, at least half of the re-entering children remained in care and may not have returned to their adoptive homes.

Study Cohort

This report describes the post-adoption re-entry experience of a cohort of 25,783 children whose adoptions from the California foster care system were finalized (legally completed) during a five-year period between January 1, 1997, and December 31, 2001. Most (51%, or 13,170) had first entered care at less than 1 year of age. The January 1, 1997 date coincides with the beginning of the phased roll-out of California's Child Welfare Services Case Management System (CWS/CMS), which allowed linking of child welfare and adoption data for the first time. The cohort beginning date maximizes the number of children in the cohort who would be 18 on the October 1, 2013, data extract date and thus past the age of being able to re-enter out-of-home care as minors.

In California, the two primary ways adopted children may re-enter care are 1) through placements made by adoptive parents but with the concurrence and funding of the Adoption Assistance Program (AAP) or 2) through placements made by the child welfare system, generally following allegations of abuse or neglect. AAP funds may be used to provide time-limited out-of-home care services to adopted children, as described by California Welfare and Institutions Code Section 16121(b), for the "… temporary resolution of mental or emotional problems related to a condition that existed prior to the adoptive placement … as part of a plan for return of the child to the adoptive family, that shall actively participate in the plan" (California Legislative Counsel, 2013). Such a placement is not a re-entry to the formal child welfare system and would not be recorded as a placement in the CWS/CMS. Some, but not all, of these placements are documented to a limited degree in CWS/CMS as part of AAP payment documentation.

An adopted child also may re-enter care through the formal child welfare system, just as any other would enter care. Most such children are court dependents supervised by the county child welfare agency, but children who are in care as a result of juvenile justice system intervention are supervised by

the county probation officer but are placed in child welfare settings funded under child welfare auspices. If adopted children re-enter care through the child welfare system, they receive a new CWS/CMS identifier.

The study site was the California Child Welfare Indicators Project, a collaborative venture between the University of California at Berkeley School of Social Welfare and the California Department of Social Services. In addition to studies such as this, the project provides policymakers, child welfare workers, researchers and the public with direct access to customizable information on California's entire child welfare system. The data archive used by the Indicators Project includes comprehensive demographic, placement and child welfare services data on children in out-of-home placement, as well as on all children who receive child welfare services in their own homes. The primary source of Archive data is data downloaded quarterly from the CWS/CMS, which is the California version of the federally mandated Statewide Automated Child Welfare Information System (SACWIS). This report is based on data downloaded shortly after October 1, 2013 (The "2013 Quarter 3 Extract"). Data are entered into CWS/CMS, which also serves as an automated case management system, by county case carrying social workers and/or clerical staff.

Re-entry Undercount

This study identified 1,737 children who re-entered care from among the cohort of 25,783 children. It is probable that there were other children who re-entered care who were not identified. The four reasons for this undercount, in declining order of probable importance, are 1) not all AAP payments are reported in CWS/CMS, 2) it is not always possible to link a child who re-enters the system after adoption to the child's pre-adoption identity, 3) some of the children in the cohort are still minors and at risk of future re-entry and 4) children may re-enter care in non-AAP, non-child welfare service systems. These reasons are explained in the following paragraphs.

Adoption Assistance Program Re-entry. Some, but not all, AAP-funded out-of-home placements are documented to a limited degree in CWS/CMS as part of AAP payment documentation. General AAP payment data suggest that this undercount may be substantial. As part of the process of developing the state budget, the California Department of Social Services, using county aid payment data, estimated the mean monthly AAP caseload in State Fiscal Year 2012-13 (July 2012 to June 2013) to be 85,580 (California Department of Social Services, 2013, p. 33). The 85,580 includes an unknown number of children receiving AAP payments after adoptive placement, but before the adoption was finalized. The CWS/CMS included current payment data for 48,059 children as of January 1, 2013 – 1,078 of whom were receiving payments prior to finalization of their adoptions. In other words, CWS/CMS only includes AAP payment data on about half (56%) of the 85,560 children receiving AAP grants. If data on AAP-funded out-of-home care is missing in a similar fashion, then substantially more children in the study adoption cohort have received AAP-funded out-of-home care than are identified.

Formal Child Welfare Program Re-entry. Adopted children who re-enter care receive a new CWS/CMS identifier, thus preventing direct linking of pre- and post-adoption CWS/CMS records. To compensate for this problem, records for this study were matched using the child's date of birth and gender at adoption and re-entry; the date of birth and gender of at least one of the adopting parents at adoption and re-

entry; the identification of the parent as an adoptive parent at the time of re-entry; and a re-entry date that occurred after the finalization of the adoption. This methodology does not differentiate between twins of the same gender. Because it is dependent on correct reporting of birthdates and the identification of adoptive parents as such, it probably undercounts the number of re-entries. Because the data are not necessarily unique, it is also possible, but unlikely, that the match is simply one of chance alignment of child and adoptive parents' birthdates and gender. Finally, because the study is limited to California data, it does not identify children who re-entered care in another state or those from another state who re-entered care in California.

Children Who Have Not Turned 18. More than 10,000 of the children in the study cohort have yet to reach age 18 and thus are still at risk of re-entering care, a risk that is not evenly distributed over time but is highest in adolescence.

Other Care System Re-entries. Some children may have been placed in post-adoption out-of-home care by specialized programs such as programs for the developmentally disabled, funded through California's Regional Center system, or skilled nursing placements, funded by California's MediCal (Medicaid) program. Such placements could not be identified using CWS/CMS data.

Re-entry Data

The following discussion assumes that the characteristics of the 1,737 children re-entering care and their re-entry experiences are representative of all children who re-entered care. When all children in the study cohort were considered, 6.7 percent were identified as having re-entered care (Table 6a). However, when the analysis was limited to the 15,480 children for whom we have data through their 18th birthdays, that is to those children who were no longer at risk of re-entering care, **7.9 percent were identified as having re-entered care** (Table 6b).

The effects of other independent variables were tested using logistic regression. The results for the full cohort and the cohort of those who have turned 18 differed slightly. In general, there were no significant differences based on the child's gender or reason for initial entry into care (not shown on table). **Children adopted by relatives were less likely to re-enter care. African-American children were more likely to re-enter care** than were white, Hispanic or Asian children (full cohort) or white children (age 18 cohort). Regarding the effect of age, it is reasonable to conclude that **1) children who first enter foster care before age 1 have a lower re-entry rate than do those who enter somewhat later in childhood and 2) while relatively few children who first enter care after about age 8 exit to adoption, those who do also have a lower re-entry rate.**

Table 6a: California Children Known to have Re-entered Care after Adoption (All Cohort Children)

	In Care Post Adoption				Total	
	No		Yes			
	N	row %	N	row %	N	col %
Age at First Removal						
0 *b*	12,496	94.9	674	5.1	13,170	51.1
1 **	2,835	91.1	276	8.9	3,111	12.1
2 **	2,193	90.5	229	9.5	2,422	9.4
3 **	1,667	91.2	161	8.8	1,828	7.1
4 **	1,266	90.9	126	9.1	1,392	5.4
5 **	975	91.0	96	9.0	1,071	4.2
6 **	751	91.6	69	8.4	820	3.2
7 *	568	92.1	49	7.9	617	2.4
8 *	425	93.0	32	7.0	457	1.8
9	320	97.3	9	2.7	329	1.3
10	189	95.0	10	5.0	199	0.8
11	146	98.6	2	1.4	148	0.6
12	88	97.8	2	2.2	90	0.3
13	76	98.7	1	1.3	77	0.3
14	31	100.0	0	0.0	31	0.1
15	17	94.4	1	5.6	18	0.1
16	3	100.0	0	0.0	3	0.0
Gender						
F *b*	12,233	93.2	891	6.8	13,124	50.9
M	11,810	93.3	846	6.7	12,656	49.1
Missing	3	100.0	0	0.0	3	0.0
Race/ Ethnicity						
Black *b*	5,727	92.2	482	7.8	6,209	24.1
White **	9,072	93.6	616	6.4	9,688	37.6
Hispanic **	8,524	93.4	598	6.6	9,122	35.4
Asian *	451	95.8	20	4.2	471	1.8
Native American	208	94.5	12	5.5	220	0.9
Missing	64	87.7	9	12.3	73	0.3
Relative Adoption						
Yes *	9,803	93.5	685	6.5	10,488	40.7
No *b*	14,243	93.1	1,052	6.9	15,295	59.3
Total	24,046	93.3	1,737	6.7	25,783	100.0

b = baseline; * = <.05 significance level; ** = <.01 significance level

Table 6b: California Children Known to have Re-entered Care After Adoption Children Age 18 or Over on October 1, 2013

	In Care Post Adoption				Total	
	No		Yes			
	N	row %	N	row %	N	col %
Age at First Removal						
0 *b*	4,210	93.7	282	6.3	4,492	29.0
1 **	1,796	90.8	183	9.2	1,979	12.8
2 **	1,817	90.0	203	10.0	2,020	13.0
3 **	1,590	91.1	156	8.9	1,746	11.3
4 **	1,259	91.0	125	9.0	1,384	8.9
5 *	975	91.0	96	9.0	1,071	6.9
6 *	751	91.7	68	8.3	819	5.3
7	568	92.1	49	7.9	617	4.0
8	425	93.0	32	7.0	457	3.0
9 *	320	97.3	9	2.7	329	2.1
10	189	95.0	10	5.0	199	1.3
11 *	146	98.6	2	1.4	148	1.0
12	88	97.8	2	2.2	90	0.6
13	76	98.7	1	1.3	77	0.5
14	31	100.0	0	0.0	31	0.2
15	17	94.4	1	5.6	18	0.1
16	3	100.0	0	0.0	3	0.0
Gender						
F *b*	7,341	92.2	623	7.8	7,964	51.4
M	6,918	92.1	596	7.9	7,514	48.5
Missing	2	100.0	0	0.0	2	0.0
Race/ Ethnicity						
Black *b*	3,427	91.6	314	8.4	3,741	24.2
White *	5,454	92.5	444	7.5	5,898	38.1
Hispanic	5,007	92.0	434	8.0	5,441	35.1
Asian *	231	95.1	12	4.9	243	1.6
Native American	113	92.6	9	7.4	122	0.8
Missing	29	82.9	6	17.1	35	0.2
Relative Adoption						
Yes *	6,584	92.9	507	7.1	7,091	45.8
No *b*	7,677	91.5	712	8.5	8,389	54.2
Total	14,261	92.1	1,219	7.9	15,480	100.0

b = baseline

* = significant at < .05 level

** = significant at <.01 level

The median age at re-entry into foster care was 14 for both the entire cohort and for those children who had turned 18. The modal re-entry age was 15 for the entire cohort and 16 for those who have turned 18 (Table 7). Eighty percent of all re-entering children and **86 percent of those who had turned 18 re-entered after age 10.**

Table 7: Children Re-entering Care by Age at Re-entry

Age at Re-entry	Children Re-entering Care			
	All Re-entering Children		Children Age 18+ on 10/1/13	
	N	col %	N	col %
0	2	0.1		
1	3	0.2		
2	12	0.7		
3	8	0.5	1	0.1
4	26	1.5	4	0.3
5	23	1.3	9	0.7
6	27	1.6	10	0.8
7	49	2.8	26	2.1
8	55	3.2	33	2.7
9	65	3.7	38	3.1
10	73	4.2	44	3.6
11	93	5.4	55	4.5
12	134	7.7	90	7.4
13	202	11.6	137	11.2
14	259	14.9	191	15.7
15	290	16.7	218	17.9
16	267	15.4	227	18.6
17	146	8.4	133	10.9
18	2	0.1	2	0.2
19	1	0.1	1	0.1
Total	1,737	100.0	1,219	100.0

With the exception of children whose adoptions were finalized after about age 11, there was no relationship between the child's age at adoption and the age at re-entry for those who were at least 18 (Table 8). For the entire cohort, there was some relationship between age at finalization and age at re-entry only because the children who had not turned 18 were in the age group (age 14 to 17) at greatest risk of re-entry.

Table 8: Adoptions Completed in 5 Year Period Beginning January 1, 1997
Children Age 18 or Over on October 1, 2013

Age at Finalization	Median Years to Re-entry	Median Age at Re-entry	Total
1	13	14	1
2	10	13	15
3	11	14	58
4	9	13	114
5	9	14	165
6	8	14	190
7	7	14	178
8	6	14	139
9	6	15	123
10	4	14	89
11	4	14	58
12	3	15	47
13	2	15	23
14	2	16	11
15	1	16	6
16	0	16	2
All	7	14	1,219

In sum, these data suggest that **children who first enter foster care at less than 1 year of age are at lower risk of re-entering care after adoption than those who enter as toddlers or latency-age children. More importantly, for those who do re-enter care, the age at re-entry appears to be a function of the child's age – adolescence – and not a function of the age at first removal or the age at adoption.**

Termination of Parental Rights

Re-entry into care and dissolution of the adoption are not the same. **The parental rights of the adoptive parents of only 72 of the 1,737 re-entering children were recorded as having been terminated.** Sixty-three of these were terminated by court action, two by relinquishment and seven by the death of the adoptive parents (Table 9). This is probably an undercount as there were 16 other children whose post-adoption placement episodes were reported as having ended with a finalized adoption. Sixty of the 72 children were subsequently adopted; five were still in care (three with legal guardians), five had aged out of care; one had died and one was reported to have been reunified with a parent. The relatively infrequent termination of parental rights without a subsequent adoption may reflect reluctance on the part of California courts to terminate parental rights unless adoption is highly probable.

Table 9: Termination of Parental Rights (All Cohort Children)

Last Re-entry Placement Episode Ending Status	Parental Rights Termination Type			Total
	WIC 366.26	Relinquishment	Death	
In Care	4		1	5
Adoption Finalized	52	2	6	60
Age of Majority	4			4
Death of Child	1			1
Emancipation	1			1
Reunified	1			1
Total	63	2	7	72

Note: WIC 366.26 is the California Welfare and Institutions Code Section providing for termination of parental rights for children who are court dependents in the child welfare system.

Return Home

Although termination of the parental rights of the adoptive parents was relatively rare and usually accompanied by a subsequent adoption, the data suggest that **many, perhaps more than half, of the children who re-entered care did not return home to the adoptive family**.

Two methods were used to identify the children who returned home at the end of their last known placement. For those children whose most recent post-adoptive placement was a child welfare placement, a most recent placement episode end of "reunified" (court or non-court) or "released home" was interpreted to be a return home. Because placement episode end reason is a required item in CWS/CMS, this data should be complete and relatively accurate. However, for placements funded by AAP, a return home could only be inferred by the presence of a subsequent AAP payment based on the child not being in out-of-home care. Thus, a child who returned home but did not receive a payment, or whose payment was not reported in CWS/CMS, was not counted as having returned to the adoptive home.

There were 1,649 children who were known to have re-entered care but whose parents' parental rights had not been terminated and/or who had not been adopted after their re-entry into care. Of these children, 1,172 had become 18 by October 1, 2013.

Of the 1,649 children, 773 (47%) were identified as having returned to their adoptive parents' home. Of the 1,172 who had turned 18, 549 **(47%) were identified as having returned to the adoptive home** (Table 10). **Children whose placement was AAP-funded were more likely to be identified as having returned home than were children placed by child welfare agencies.** This finding is consistent with the AAP program's expectation of parental intent and involvement. It should be noted that the overall

observed return home rate for children with AAP placements may well be reduced by the apparent underreporting of AAP payment activity in CWS/CMS.

Table 10: Children Returning Home Following Re-entry into Care
At least age 18 on Oct. 1, 2013, with Termination of Parental Rights and Exits to Adoption Excluded

Returned Home	First Re-entry Agency						Total	
	Welfare		Probation		AAP			
	N	%	N	%	N	%	N	%
No	407	59.0	158	64.0	58	24.7	623	53.2
Yes	283	41.0	89	36.0	177	75.3	549	46.8
Total	690	100.0	247	100.0	235	100.0	1,172	100.0

The effects of other independent variables on return home for the cohort of children who had attained age 18 and thus were not able to return to the adoptive home as minors were tested using a logistic regression. Neither the child's gender nor whether the adoptive parents were relatives were statistically significant. In general, **the younger children were when re-entering care, the more likely they were to return home**, but because of the small number of young children re-entering care, these differences were only significant for a few age groups. **African American children were less likely to return home than were white or Hispanic children** (Table 11 on following page). Youth with TPR and subsequent adoptions were excluded from this analysis.

Conclusion

In spite of the uncertainty regarding the identification of children re-entering care following adoption, it is possible to conclude that **children who first enter out-of-home child welfare-supervised care at a very young age are at less risk of re-entry, as are children who first enter care after about age 10**, but probably for very different reasons. For those who do re-enter, **the timing is a function of current age, of adolescence**, not of their age at initial entry, gender or reason for entry. **African American children appear to be at greater risk of re-entry as well as of not returning home** after re-entry.

This work must be taken as preliminary. There is a need to both refine data systems to collect more accurate data about re-entry and to refine the methodology used to identify children who have re-entered.

Table 11: Adopted Children Returning Home by Age at Re-entry (At Least Age 18)

	Evidence of Return Home Post Placement				Total	
	No		Yes			
	N	row %	N	row %	N	col %
Re-entry Age						
3	0	0.0	1	100.0	1	0.1
4	1	25.0	3	75.0	4	0.3
5	1	14.3	6	85.7	7	0.6
6	3	30.0	7	70.0	10	0.9
7 *	6	28.6	15	71.4	21	1.8
8 *	8	26.7	22	73.3	30	2.6
9 **	8	23.5	26	76.5	34	2.9
10 *	14	36.8	24	63.2	38	3.2
11	22	44.9	27	55.1	49	4.2
12	41	47.7	45	52.3	86	7.3
13	70	54.3	59	45.7	129	11.0
14 *b*	103	56.0	81	44.0	184	15.7
15	126	57.8	92	42.2	218	18.6
16	132	58.7	93	41.3	225	19.2
17	88	66.2	45	33.8	133	11.3
18	0	0.0	2	100.0	2	0.2
19	0	0.0	1	100.0	1	0.1
Gender						
F *b*	323	54.3	272	45.7	595	50.8
M	300	52.0	277	48.0	577	49.2
Race/ Ethnicity						
Black *b*	186	61.4	117	38.6	303	25.9
White **	204	47.2	228	52.8	432	36.9
Hispanic *	218	53.0	193	47.0	411	35.1
Asian	7	58.3	5	41.7	12	1.0
Native American	4	50.0	4	50.0	8	0.7
Missing	4	66.7	2	33.3	6	0.5
Relative Adoption						
Yes	278	57.6	205	42.4	483	41.2
No *b*	345	50.1	344	49.9	689	58.8
Total	623	53.2	549	46.8	1,172	100.0

b = baseline; *= <.05 level of significance; **= <.01 level of significance

Post-Adoption Instability: A National Study

By Penelope Maza, Ph.D., Senior Research Fellow, Donaldson Adoption Institute

National Data

Analyses of data from the Adoption and Foster Care Analysis and Reporting System (AFCARS) were conducted for this report[25]. The AFCARS data have strengths and weaknesses for addressing Adoption Support and Preservation (ASAP). The major strengths are that they include data from every state, collect information on whether or not the child was previously adopted, and collect extensive information on the child's foster care experience. On the other hand, the AFCARS data are weak because they provide only general categories of the age at which the adoption occurred, and, as with most other data on this issue, the child's prior experience in foster care cannot be linked to her/his placement experiences being studied.[26]

Study Concepts and Their Operationalization

Some concepts used in this report need to be defined. The "served" population includes those children who experienced at least one day in foster care during the year. It does not include adopted children placed directly by their parents in residential treatment or some other type of facility. The "year" refers to the federal fiscal year, which for the year being studied (FY2012) began on October 1, 2011, and ended on September 30, 2012. A "post-adoption placement" (PAP) refers to adopted children returning to foster care. A "dissolved" adoption applies to adoptions in which a legal relationship between the adoptive parents and the adopted child was severed either voluntarily or involuntarily.[27]

An additional concept that is being used in this report is "anchor" adoption. This is the adoption that occurred prior to the child's re-entry into care that is the subject of this study. This is distinct from an adoption that occurs upon discharge from the foster care experience being studied. This distinction is important when discussing data quality pertaining to identifying PAPs and dissolutions.

During FY 2012, 638,031 children were served in the U.S. public foster care system. Of these children, 17,477 were identified as having been ever adopted (2.7% of the total). Children identified as PAPs total 14,650 (2.3% of the total). The difference between the number of children identified as adopted and the number identified as PAPs is a function of data quality. The major data entry errors occurred when the discharge reason of adoption was seen as the child "ever being adopted" rather than referring to the anchor adoption. A detailed cleaning procedure was used to identify these and other errors, resulting in

[25] The analysis was conducted by Penelope L. Maza, Ph.D. utilizing AFCARS 2012v1 foster care data. The data utilized in this report were made available by the National Data Archive on Child Abuse and Neglect, Cornell University, Ithaca NY; and have been used by permission.
Data from AFCARS were originally collected by the Children's Bureau, U.S. Department of Health and Human Services under the authority of section 479 of title IV-E of the Social Security Act. Neither the collector of the original data, the funder, the Archive, Cornell University, or its agents or employees bear any responsibility for the analyses or interpretations presented here.

[26] For a more detailed description of the AFCARS data and its strengths and weaknesses for the study of ASAP issues, see Festinger & Maza, 2009.

[27] For a more extensive discussion of definitions, see Festinger & Maza, 2009.

the total number of PAPs of 14.650.[28] The number of dissolutions identified is 4,593. PAPs constituted 2 percent (4,931) of the 236,009 children exiting care in FY 2012. PAPs Dissolved were .7 percent (1,691) of the total exits.[29]

Basic Information about PAPs and Not PAPs

More than half of the PAPs, Not PAPs and total number of children who experienced at least one day in care in FY 2012 were male, 52.5 percent, 52.1 percent and 52.1 percent, respectively. Non-Hispanic whites appear most frequently among PAPs, Not PAPs and the total, 45.1 percent, 42.6 percent and 42.6 percent, respectively. Black or African American-non-Hispanics appear more frequently among PAPs (33.8%) than among Not PAPs (25.1%) and the total (25.3%). In contrast, Hispanics appear less frequently among PAPs (12.3%) than Not PAPS (21.1%) and the total (20.9%). Finally, the median length of stay until discharge was six months longer for PAPs than for Not PAPs and the total, 19, 13.2 and 13.3 months respectively (See Table 12).

Table 12: Gender, Race/ Ethnicity, Length of Stay for PAPs and Not PAPS

	PAP	Not PAP	Total
Gender			
Male	52.5%	52.1%	52.1%
Female	47.5%	47.9%	47.9%
N	14,650	623,277	637,927
Race/Ethnicity			
American Indian/Alaskan Native-Non Hispanic	1.4%	2.1%	2.1%
Asian-Non Hispanic	0.6%	0.6%	0.6%
Black or African American-Non Hispanic	33.8%	25.1%	25.3%
Native Hawiian/Other Pacific Islander-Non Hispanic	0.3%	0.2%	0.2%
Hispanic	12.3%	21.1%	20.9%
White-Non Hispanic	45.1%	42.6%	42.6%
Unknown/Unable to Determine	1.7%	2.6%	2.6%
Multiple Racial Heritage	4.8%	5.7%	5.7%
N	14,644	622,196	636,840
Median Length of Stay in Months Until Discharge			
Median LOS	19.0	13.2	13.3
N	14,650	623,381	638,031

The usefulness of AFCARS data is limited for certain purposes because information on specific children cannot be linked from before to after the anchor adoption. Other than some broad categories for age at anchor adoption, nothing is known about the child's earlier experience(s) in care or the adoption population he or she came from. This is referred to as "left handed censoring." This type of data

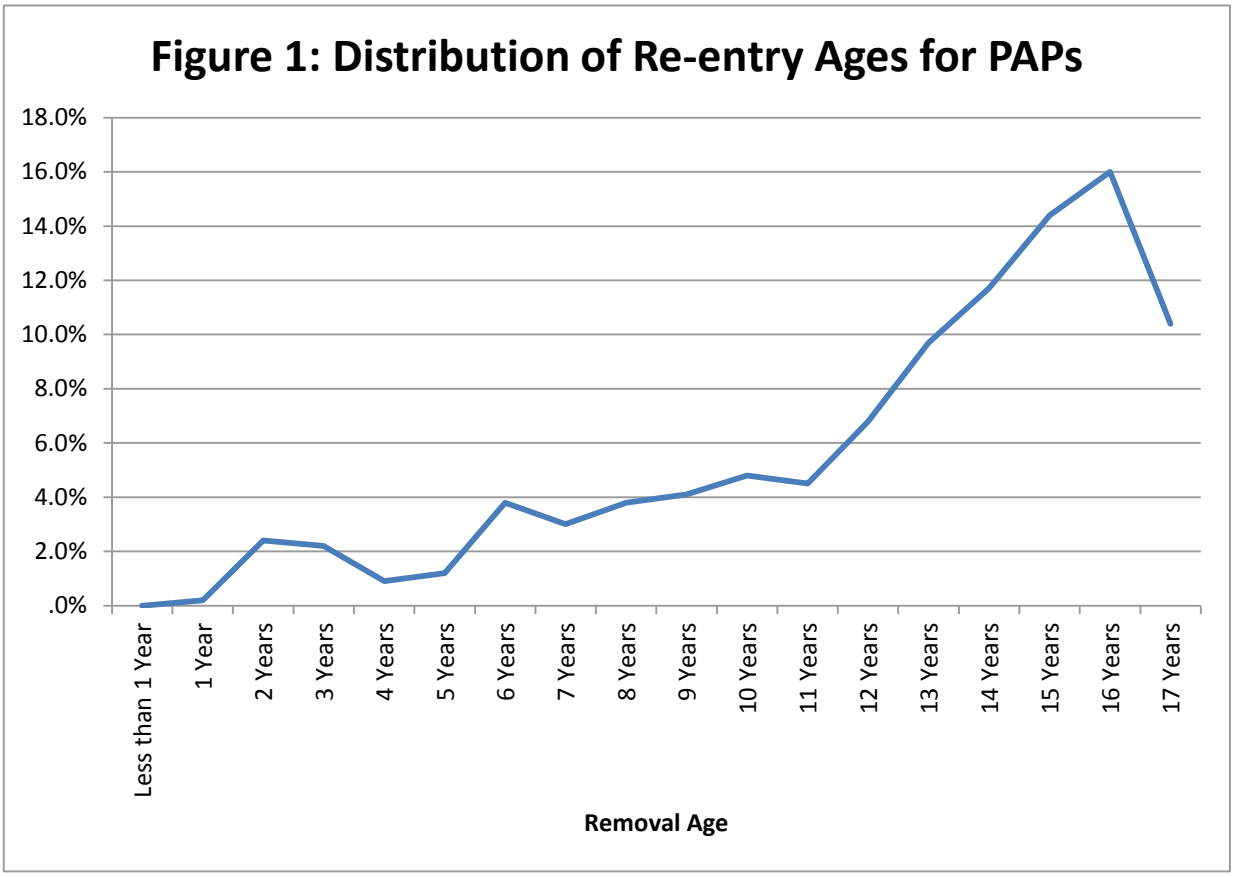
[28] For a detailed description of the data cleaning process, see Festinger & Maza, 2009.
[29] N's may differ somewhat throughout this report due to missing data, or the nature of the sub-population (e.g. re-entries, discharges, first placement setting, etc.) being analyzed.

censoring is particularly problematic when trying to interpret demographic descriptions of PAPs because it is inappropriate to say that one group is "more likely" than another to be a PAP. For example, when examining data in Table 12, it is incorrect to describe African American children as being more likely to be PAPs than Not PAPs, because there is no way to determine what the percentage of children in the adoption cohorts from which they came were African American.

Even if it were appropriate to say this, the information is not available that could explain the over- or under-representation of African American children, or children of any race/ethnicity, among PAPs or Not PAPs. For example, the following information is unknown: the ages at which the children were removed from their homes before the anchor adoption; information on their birth parents or the reasons for entry into care; or if they were adopted by relative(s) or transracially. This and other information might be able to explain either the over- or under-representation of any of the racial/ethnic groups among PAPs and Not PAPs, but it unknown. This type of data description is only appropriate for longitudinal data bases that can identify adoption cohorts and can track children from before to after the anchor adoption.

Re-Entry Age

The median age at which children re-enter care from their adoptive homes differs among three major groups of interest. The median age of children who are Not PAPs is 6.3, vs 14.6 for PAPs (not dissolved) and 11.9 years old for children with dissolved adoptions. The re-entry ages for PAPs (when they were removed from their adoptive homes) are shown in Figure 1, indicating that a substantial increase in the percentage occurs after 11 years old.



However, these age differences are only weakly related to anchor adoption age. As Table 13 indicates, **no matter how old the child is at the anchor adoption, the subsequent entry into care occurs either in the late pre-teen or teen years**. Even for children adopted when they are under 2 years old, their mean and median re-entry ages after the anchor adoption is approximately 10 years old, or substantially after the adoption. As the anchor adoption age increases, the removal age also increases, although the time between the anchor adoption and re-entry decreases. These older re-entry ages have implications for the types of placements and outcomes the youth experience.

Table 13: Mean and Median Re-entry Age by Anchor Adoption Age Categories

	Mean	Median	N
Less than 2 years old	9.7	10.1	798
2-5 years old	11.8	12.7	2,262
6-12 years old	13.6	14.3	3,061
13 years or older	15.3	15.9	478
Unable to Determine	11.2	11.9	6,599
Total			13,198

Placement Settings and Circumstances of Re-Entry

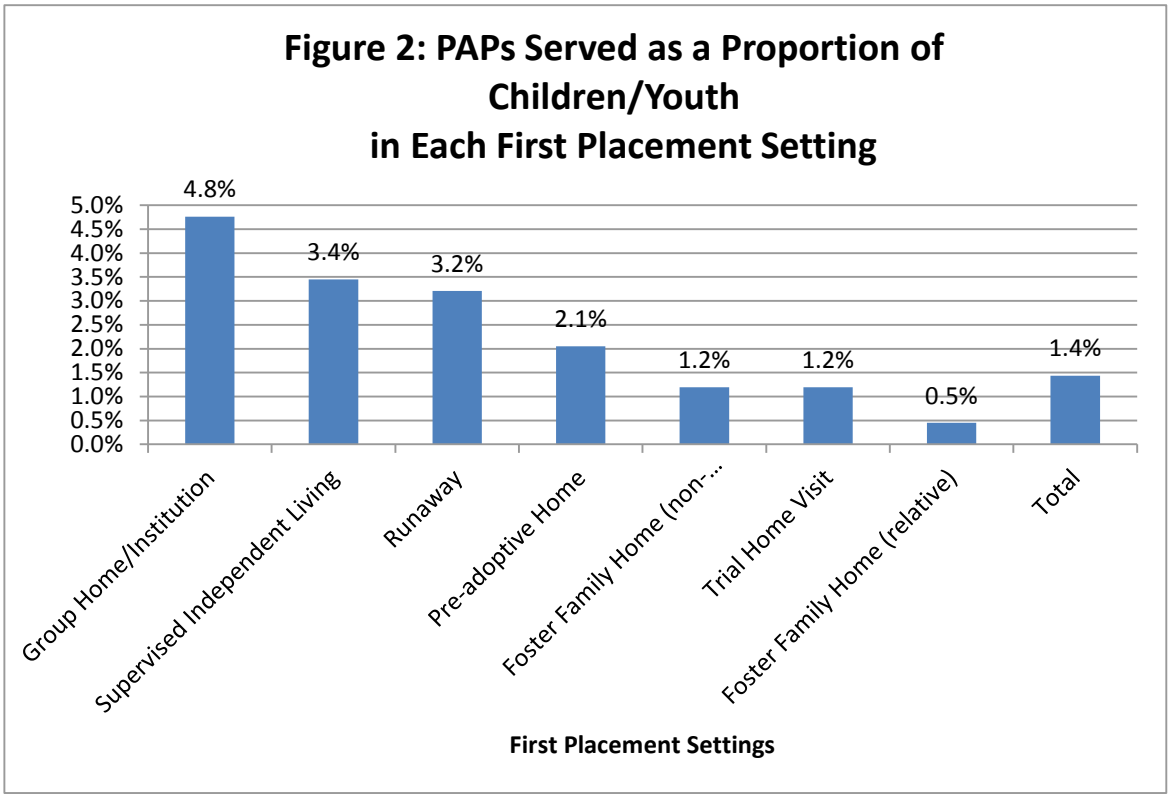
A consequence of the older re-entry ages is the placement setting experienced by PAPs as compared to not PAPs. Table 14[30] shows that PAPs are almost 3 ½ times more likely to have their first placement setting in group/residential care (37.3% vs. 10.9%) and about one-third as likely to be placed in relative foster care (9.9% vs. 31.7%).[31] As shown in Figure 2, PAPs are three times more likely to be placed in group/residential care (4.8%), over twice as likely to be in independent living (3.4%). or in runaway status (3.2%) than their proportion in the population (1.4%).

Table 14: First Placement Setting After Anchor Adoption

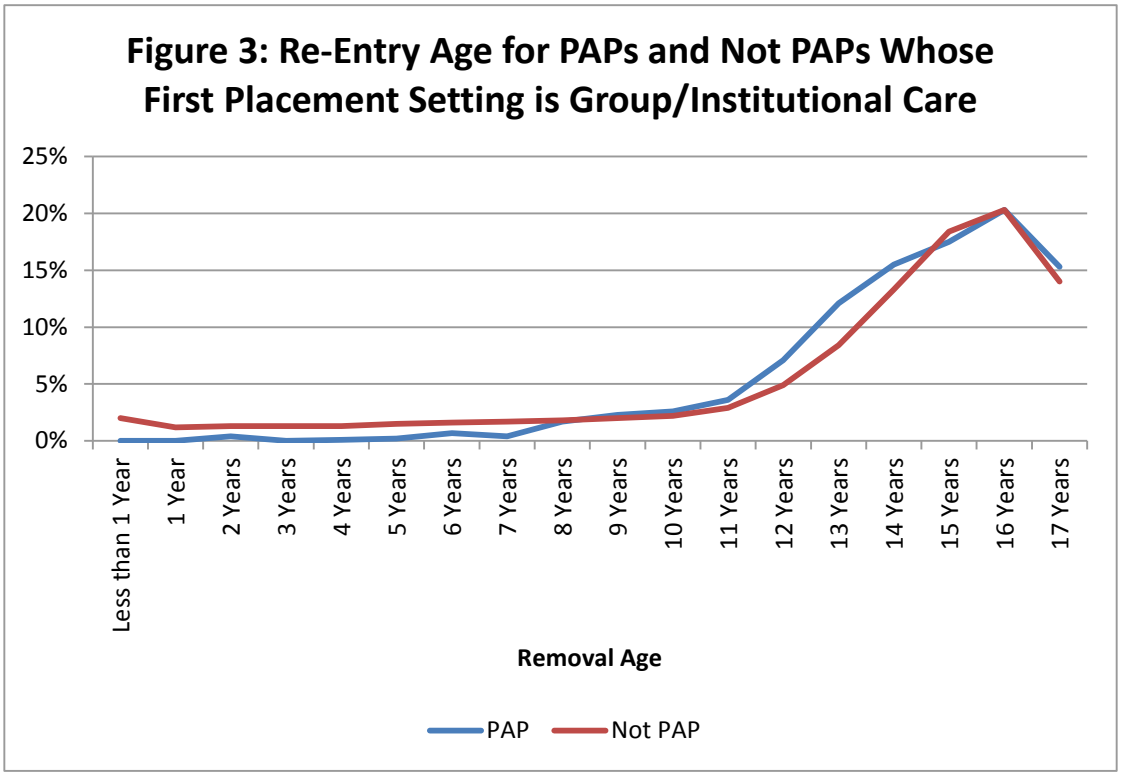
	PAP	Not PAP
Pre-adoptive Home	8.3%	5.8%
Foster Family Home (relative)	9.9%	31.7%
Foster Family Home (non-relative)	32.1%	38.6%
Group Home/Institution	37.3%	10.9%
Supervised Independent Living	0.6%	0.2%
Runaway	2.1%	0.9%
Trial Home Visit	9.9%	11.9%
Total	100.0%	100.0%
N	3,746	257,153

[30] The N's reported in Table 13 are lower than total N's previously reported because they only include first placement settings. Since AFCARS data only records the placement setting the child was in at the end of the year, those children who were not in their first placement setting are not included in this table.

[31] This same set of relationships was also present for second placement settings which are not shown here.

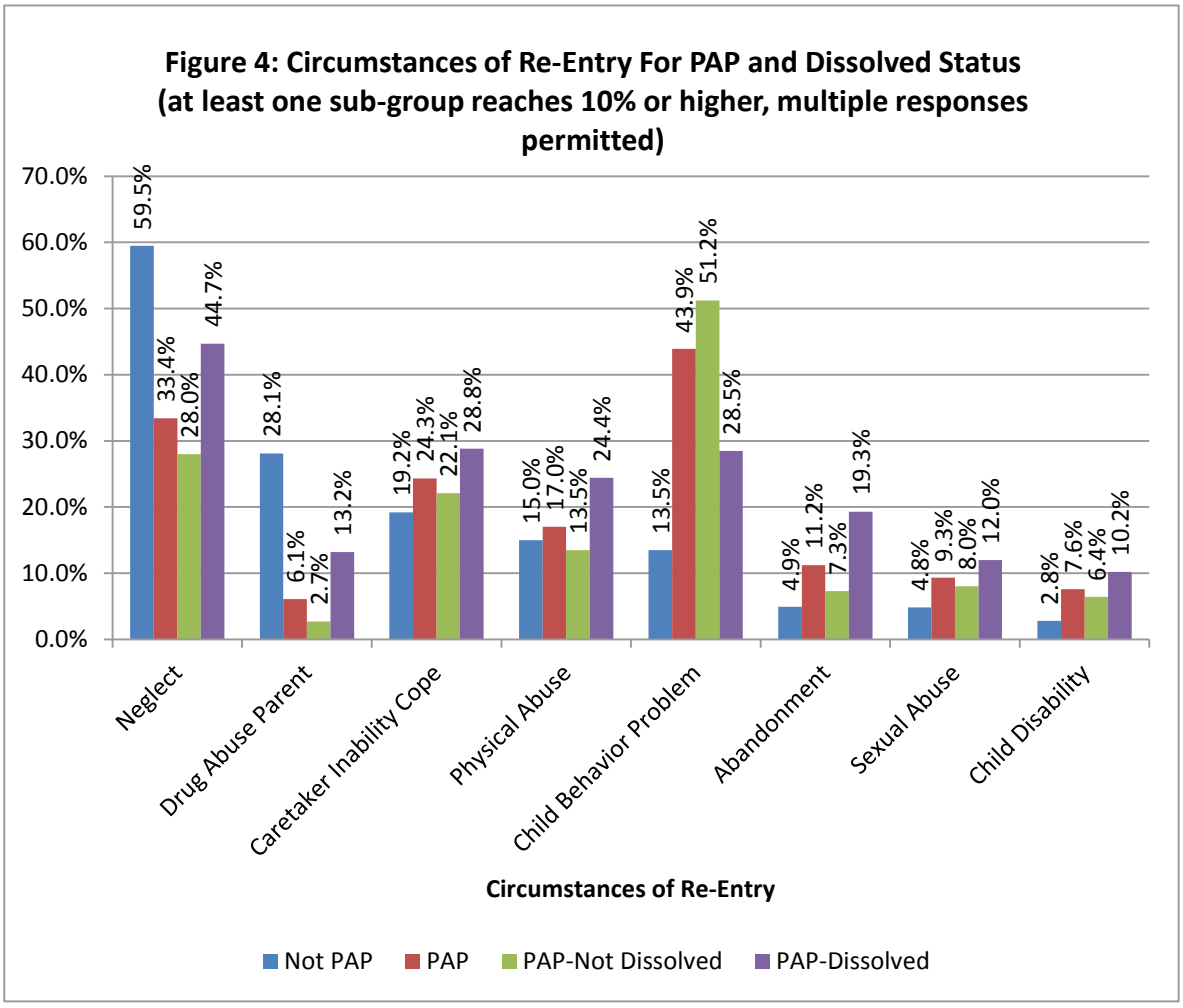


To determine whether these findings are a function of PAP vs. Not PAP age at re-entry or entry, the two groups were compared on their percentage of first placement settings that were in group/residential care for each age at re-entry. As Figure 3 reflects, when examining these two groups by age at re-entry or entry, their first placement percentages in group/residential care are virtually identical.



Another factor in the foster care experience of these groups is the differences in their circumstances of removal.[32] Not PAPs are most likely to have neglect (59.5%) as a circumstance of entry in contrast to PAPs and PAPs-Not Dissolved whose most frequent circumstance is child behavior problem, 43.9 percent and 51.3 percent respectively. PAP-Dissolved are notable in the following categories: neglect (44.7%), caretaker inability to cope (28.8%), physical abuse (24.4%) and abandonment (19.3%) (See Figure 4).

[32] Circumstances in which no group reached 10.percent include: parent incarceration, parent death, alcohol abuse of parent or child, drug abuse of child and relinquishment.



Dissolution Status and Discharge from Care

Whether or not a child's adoption is dissolved has some relationship to race/ethnicity. A larger percentage of Black or African-American non-Hispanics are among those whose adoptions are not dissolved (35.6%) than dissolved (29.8%) in contrast to Hispanics, whose adoptions are more likely to be among those dissolved (15.3%) than not dissolved (10.9%). White non-Hispanics are represented almost equally in each group, 44.7 percent in the not-dissolved group vs. 46.0 percent in the dissolved group (See Table 15).

Table 15: Dissolved Status for PAP Racial/Ethnic Groups	Not Dissolved	Dissolved
American Indian/Alaskan Native-Non Hispanic	1.4%	1.3%
Asian-Non Hispanic	0.7%	0.5%
Black or African American-Non Hispanic	35.6%	29.8%
Native Hawaiian/Other Pacific Islander-Non Hispanic	0.2%	0.4%
Hispanic	10.9%	15.3%
White-Non Hispanic	44.7%	46.0%
Unknown/Unable to Determine	2.0%	1.0%
Multiple Racial Heritage	4.4%	5.6%
Total	100.0%	100.0%
N	10,051	4,593

Of course, the most important issue related to these groups is whether or not they achieve permanency. Table 16 indicates that PAPs are less likely to be reunified with parent, primary caretaker than Not PAPs (35.7% vs. 51.6%), over three times as likely to be emancipated (32.7% vs. 9.4%) and about as likely to be adopted (22.4% vs. 21.3%).

Table 16: Discharge Reasons for PAPs vs. Not PAPs Not-Dissolved	PAP	NOT PAP	Total
Reunified with parent, primary caretaker	35.7%	51.6%	51.3%
Living with other relative(s)	2.8%	8.3%	8.2%
Adoption	22.4%	21.3%	21.3%
Emancipation	32.7%	9.4%	9.9%
Guardianship	2.7%	7.0%	6.9%
Transfer to another agency	2.3%	1.8%	1.8%
Runaway	1.4%	.5%	0.5%
Death of child	0.1%	0.1%	0.1%
Total	100.0%	100.0%	100.0%
N	4,937	236,164	241,101

Comparing those PAPs whose adoptions have been dissolved with those that have not, almost half (49.7%) of those PAPs Not Dissolved compared to less than one in 10 (9.0%) of PAPs Dissolved are reunified with parent or other primary caretakers[33] and more than one-third (36.1%) of the PAPs Not

[33] Although somewhat rare (i.e. 15 children in FY 2012), being reunified does occur after dissolution. Even rarer is the phenomenon of children being reunified with the birth family after adoption.

Dissolved vs. more than one-fourth (26%) of the PAPs Dissolved are emancipated. The overwhelming majority (60.5%) of PAPs Dissolved are adopted again[34] (See Table 17).

Table 17: Discharge Reasons for PAPs Dissolved and PAPs Not Dissolved

	Dissolved	Not Dissolved	Total
Reunified with parent, primary caretaker	9.0%	49.7%	35.7%
Living with other relative(s)	0.6%	3.9%	2.8%
Adoption	60.5%	2.3%	22.4%
Emancipation	26.0%	36.1%	32.7%
Guardianship	2.3%	2.8%	2.7%
Transfer to another agency	0.7%	3.2%	2.3%
Runaway	0.8%	1.8%	1.4%
Death of child	0.1%	0.1%	0.1%
Total	100.0%	100.0%	100.0%
N	1,700	3,237	4,937

Another factor to examine about the experiences of PAPs is their lengths of stay until discharge. Table 18 compares the median lengths of stay for specific discharge reasons for Not PAPs. PAPs Dissolved and PAPs Not Dissolved. The table shows that, for the most part, PAPs compared to not PAPs take longer to exit regardless of the discharge reason. The median months are the closest for adoption, 27.9, 26.6 and 23.5 for Not PAP, PAP Dissolved and PAP Not Dissolved respectively. These data need careful interpretation because, as discussed above, PAPs are removed at older ages than Not PAPs.

Table 18: Median Length of Stay in Months to Discharge By PAP and Dissolved Status

	Not PAP	PAP Dissolved	PAP Not Dissolved
Reunified with parent, primary caretaker	8.6	11.8	11.2
Living with other relative(s)	7.2	18.6	12.5
Adoption	28.0	26.6	23.5
Emancipation	34.8	45.2	36.0
Guardianship	15.1	30.1	22.7
Transfer to another agency	6.1	14.9	18.4
Runaway	11.1	35.5	20.8
Death of child	8.7	93.9	23.5

[34] In Table 16, 2.3.percent of the PAPs Not Dissolved are reported as adopted. These 59 cases are mostly situations of missing termination of parental rights (tpr) dates. Some of these are errors and some are purposeful because some Indian tribes do not require tpr's for a child to be adopted. Because the distinction between the two reasons cannot be made in AFCARS, these cases were included as PAPs but not as PAPs Dissolved in these analyses.

Emphasis on Re-Entry Age

The analyses above demonstrate the importance of children's ages when studying and sharing information on ASAP. For example, in Table 14 PAPs have a 3 ½ times greater percentage in group/residential care than Not PAPs for their first placement setting after re-entry. However, as Figure 3 shows, this difference is a function of older age at re-entry, because when controlling for age, the percentages of PAPs and Not PAPs who are placed in group/residential care are essentially equal. The difference seen in Table 14 is a function of the age distributions of the two groups.

Re-entry age for PAPs also impacts outcomes for children. Because children experiencing a post-adoption placement enter care at older ages, regardless of the age at which they were adopted, they immediately become part of the group of children in care who have the most precarious relationship to permanency. Previous research has shown that children whose removal age is 9 years or older "are particularly disadvantaged in being adopted (Maza, 2007) and that their risk begins as early as an entry age of 7" (Maza, 2009). Children who were emancipated were removed at an average age of 10 compared to children not emancipated, who were removed at an average age of 3 (Maza, 2002). Although the rate of adoption for PAPs and Not PAPs is almost equal (22.4% vs. 21.3%) the rate of emancipation for PAPs is almost three and a half times that of Not PAPs (32.7% vs. 9.4%). A substantial proportion (60.0%) of PAPs Dissolved are re-adopted. Their second largest discharge reason is Emancipation (26.0%) and this outcome is even higher for PAPs Not Dissolved (36.1%). These findings provide support for improved ASAP services to prevent removal after an anchor adoption, to facilitate the return of the child to the adoptive parents, or, when necessary, to expedite the child's re-adoption.

Summary of Overall Findings on Post-Adoption Instability

The new research findings presented in this report provide considerable data to fill in some of the missing holes in our knowledge about post-adoption instability, but they are only pieces of the puzzle. These findings are preliminary and based largely on data that has many limitations. Much more research is needed to fully understand post-adoption outcomes and stability, such as a meta-analysis that combines data from several states where pre- and post-adoption cases can be matched.

There are degrees of instability in adoptions involving post-adoption placements – on one end is a temporary placement that is in the child's best interest during which the adoptive parents are fully engaged with their child who eventually returns home. These placements may happen with or without child welfare agency facilitation or payment. The greatest level of instability would involve the dissolution of the parent-child relationship or the transfer of a child to a new home, possibly an unsafe one, without professional oversight or legal safeguards. Adoption scholars who discuss the distinction between legal permanence and relational permanence would assert that there also are adoptions in which the youth stays at home until reaching the age of majority, but the parent-child relationship is tenuous and subsequently ends. This is the case in the young woman's story in Appendix I of this report.

Findings in previous studies have pointed to the reality that some adopted children leave their homes, either on a temporary or permanent basis, before reaching adulthood. For example, a needs assessment of child welfare adoptive families in four states reported that 15 percent of the children had been in a

psychiatric hospital or other placement since their adoptions. These children were on average 12 years old at the time of the survey, so this percent would be significantly higher by the time they all reached age 18 (Rosenthal, et al., 1996). Also, the LONGSCAN study described earlier reported that adoption stability began to decline after age 12; while 87 percent of adopted youth were living with their adoptive families at age 16 and 82 percent at age 18, the percentage of youth who had experienced a change in their living arrangement (formally or informally) at some point after adoption was much larger – 28 percent by age 16. For majority of older teens not living at home were not in state care.

The state and national research presented in this report addresses post-adoption placement of adopted children with the facilitation and payment of the child welfare system. The data from California include some children who do not re-enter state custody, but the child welfare system pays for placements through the Adoption Assistance Program. All other state and national data reported involved adopted children who were taken into the custody of the child welfare system.

Rate of Re-entry and Dissolution

It is not possible to determine a valid rate of re-entry into foster care after adoption from the available research for many reasons discussed earlier in this report. The closest approximation from the research presented in this report is Ohio's survival analysis, which found a rate of 9.5 percent for child welfare adopted children's re-entry into care and 2.2 percent for adoption dissolution. (Ohio was able to cleanly match re-entering cases to previous adoptions from care, but this analysis could not include children adopted in Ohio who had moved to other states.) California's analysis found that 7.9 percent of child welfare adopted children who had reached age 18 were placed outside their adoptive homes with child welfare agency involvement, but cautioned that this was an undercount due to several issues with the data.

The only state-based data that reported on the proportion of intercountry, private domestic or other types of adoptions among adopted children in care were from Massachusetts. That state's report indicated 87 percent of adopted children in care were child welfare adoptions (approximately 5% from other states) and others included intercountry adoptions (6.3%), private domestic infant adoptions (5.1%) and private kinship adoptions (1%).

Age at Post-Adoption Placement

According to all of the analyses reporting specific ages at re-entry, very few adopted children are placed outside their adoptive homes before age 10 (about 15% of those re-entering care). California and Massachusetts reported that children who do re-enter care at young ages have shorter stays and are more likely to return to their adoptive families than children entering care at older ages. All analyses found that the number of adopted children re-entering care begins to go up at age 11, increasing through age 16. Most adopted children who re-enter care do so six or more years after their adoptions.

Circumstances Related to Post-Adoption Placement

The national analysis found that the most commonly reported circumstances noted when adopted children are placed back into care include: child behavior problem (44%), neglect (33%), caretaker inability to cope (24%), physical abuse (17%) and abandonment (11%).

For those post-adoption placements in which a dissolution occurred, the following circumstances were noted in AFCARS data: neglect (45%), caretaker inability to cope (29%), child behavior problem (28.5%), physical abuse (24%) and abandonment (19%). Case review studies of dissolved adoptions found that child behavioral and mental health issues were factors in almost all cases and the adopted child was a threat to safety of other children in the home in 23 percent of cases. Parental abuse or neglect was a factor in 32 percent of cases involving dissolutions.

Placement Settings

According to the national analysis, adopted children who re-enter care are three and a half times more likely to be placed in a group/residential care setting when compared to children entering care who are not previously adopted. This difference is related to the older age of adopted youth when they re-enter care (if the two groups are examined by age at removal, the percentage in residential care is virtually identical).

Risk Factors for Post-Adoption Placement

California's analysis reported that children adopted by relatives are less likely to re-enter care. Several state analyses and the national analysis found a higher percentage of African Americans among the adopted children who re-entered care than among the general child welfare population. Ohio also found both higher rates of care re-entry and dissolution for African American adopted children than for their white counterparts. California also found that African American adopted children had higher rates of care re-entry and were less likely to return home than white adoptees. Finally, the analysis of national AFCARS data found that a larger percentage of African American adopted children in care are among those whose adoptions are not dissolved than those that dissolved.

While older age of the child at adoptive placement is a big risk factor for adoption disruption, it appears to have a less direct relationship to risk for care re-entry. Ohio found that children adopted at age 4 or younger did have a lower rate of re-entering foster care; however In California's analysis, children who first entered foster care after age 8 and were later adopted had the lowest re-entry rates. The age at which youth re-enter care generally appears to be a function of the child's current age – being a pre-teen or teen – and not a function of the age at which they first came into care or their age at adoption. For example, California found that the median age at re-entry was 13-16 for all adopted children re-entering care, regardless of their age at adoption finalization.

Types of Exits from Care

The national analysis found that adopted children re-entering foster care are less likely to be reunified with their parents (36%) than are other children in care (52%). Of the previously adopted children who

exited care in FY 2012, 34 percent experienced adoption dissolutions, and most of these (61%) were adopted again. Also, adopted children re-entering care stayed longer in care than other foster children; for example those reunified were in care over 11 months as compared to 8.6 months for other foster children. The rate of emancipation of adopted children re-entering care was almost 3 ½ times that of other foster youth (32.7% vs. 9.4%). These national data indicate that if adopted youth are not provided the services needed to remain in or return to their adoptive families, they are at extraordinarily high risk for emancipation.

A Holistic View

A synthesis of this study's overall findings related to the entire range of post-adoption instability supports the following conclusions:

- Approximately 10 percent of youth adopted from foster care re-enter care at some point, and for a minority of them (one-quarter to one-third of the 10%) their adoptions are legally dissolved. (This percentage of children re-entering care is likely to be lower if there is a realistic way to access residential care without being taken back into state custody.)

- An additional 10 percent are estimated to leave their homes after adoption for either short or long-term periods other than through the child welfare system. (This preliminary conclusion is based primarily on the LONGSCAN study and requires further empirical exploration.)

- An additional 20-30 percent of child welfare adopted youth and their families face significant challenges that would likely benefit from specialized adoption-competent and trauma-based therapeutic counseling.

The Consequences of Adoption Breakdown

The costs of adoption breakdowns are extremely high, both for the children and families involved, as well as for society. Because adopted youth are much more likely to be in high-level and therefore costlier placements, the average federal governmental cost figure for an adopted child who re-enters care is considerably higher than the $27,000 annual figure cited earlier. Also, there are considerable costs for state governments. Finally, successful adoptions yield other public financial benefits in reduced costs for human services when youth become adults, which one economist has estimated as over $300,000 per adoption (Hansen, 2007).

PART IV: WHY ADOPTION SUPPORT AND PRESERVATION IS IMPERATIVE

The Continuum of Needs in Child Welfare Adoptive Families

The body of research on the outcomes of child welfare adoptions consistently demonstrates a **high level of parent satisfaction** with their adoptions, despite relatively high levels of behavioral and emotional problems among many of the children (Rosenthal & Groze, 1992, 1994; Smith & Howard, 1991, 1999; Reilly & Platz, 2003; Howard, Smith & Ryan, 2004). For example, in the latter Illinois study of 1,343 adopted children, ages 6 to 18, who were receiving adoption subsidies, 91 percent of parents reported that they were satisfied or very satisfied with their adoptions, although 53 percent of their children had seen a counselor for emotional or behavioral problems. While 89 percent rated their children as having a good or excellent adjustment at home, many more reported problems at school – 54 percent said that teachers had complained that the children's behaviors interfered with their learning; 40 percent were receiving special education services; and 25 percent had been suspended.

> *Perhaps most important, children in this study were in families where they were valued and cared for. Their parents reported feeling close to them and that their adoptions had a positive effect on the family. Parents would choose to adopt their children again, even knowing everything they now know* (Howard & Smith, 2003, p. 38).

The parents' ratings on two variables – the child's level of attachment and overall level of behavior problems – were combined to illustrate a **continuum of needs with three levels**. Parents were asked how well their child was able to give and receive affection compared to other children of the same age, and they completed a checklist of 28 behavior problems comprising the Behavior Problem Index (BPI).[35] BPI scores can vary from 0 to 28; children in the Illinois study had a mean BPI score of 11.9, as compared to a mean of 6.4 for more than 11,500 children sampled in a national survey (Howard & Smith, 2003; Zill, Peterson, & Snyder, 1987). The three categories illustrating these children's range of needs were:

	Rating on ability to give/receive affection	Behavior Problem Index
• **58%**	"Very well"	8.7
• **30%**	"Fairly well"	15.3
• **12%**	"Poorly" or "Not at all"	19

The majority of children (58%) were rated as very able to give and receive affection; and while they had a couple more behavior problems than the average child (2.3 on the BPI), they were functioning within

[35] The Behavior Problem Index (BPI) was developed for a National Longitudinal Study of Youth (Zill, 1990) and has been used in the California Longitudinal Adoption Study. In Zill's analysis, the mean BPI score ranged from 14.0 to 14.8, depending on age group, for youth receiving mental health treatment in the last year.

the normal range. The 30 percent of children in the middle category had a fair ability to give and receive affection and their BPI scores were just above the cutoff score for the "clinical range." However, the top 12 percent of youth had significant attachment problems and a very high BPI score that was several points above the clinical cutoff. In a similar vein, 12 percent of parents responded "very difficult" to the question, "How difficult has your child been to raise?" and these children had a BPI score of 21.3. As one might guess, older youth were more likely to fall into this category, with "very difficult" responses ranging from 7.4% for children 8 or younger to 19 percent for ages 15-17, and 31 percent for 18-year-olds (Howard & Smith, 2003). It is important to remember that this is a cross-section of school-age children adopted from foster care and that as they grow older, additional challenges may be encountered or become more manifest.

Matching Needs and Services

The service needs of children and their families vary significantly across the three categories in the continuum above. While unique challenges may arise in any adoptive family and all may benefit from education and support, those with children who have significant emotional and behavior problems have the greatest service needs after adoption. For example, a needs assessment of 562 families in three states who adopted from foster care found that almost 70 percent of those reporting that their children had emotional and behavior problems, as compared to 35 percent in the full sample, cited a need for respite care (Rosenthal, et al., 1996).

Those children who are in the "clinical range" would also need family-focused therapeutic interventions at the earliest possible point, ideally soon after adoptive placement so that dysfunctional patterns do not become entrenched, as well as later on when additional challenges may emerge. Some may need advocacy or case coordination services, and possibly respite, if their children require intense supervision and care. Finally, the families of the children in the top 12 percent need all of these services in addition to intensive adoption preservation services that provide home-based family therapeutic intervention, on-call crisis intervention and phone support, advocacy, respite care and possibly residential treatment, if necessary. The therapists providing these services need adoption-competency training and evidence-informed trauma treatment skills (Smith & Howard, 1999; Hart & Luckock, 2004; Brodzinsky, 2013).

An innovative British study, using a methodology described as "matching needs and services," conducted a needs assessment on a consecutive sample of 103 children placed for adoption from foster care; the research identified the needs of these children in relation to ongoing parenting and support that were apparent at the time of adoptive placement (Randall, 2009). These were categorized into nine levels of need, ranging from the lowest to the highest level of complexity and difficulty. At the lowest level (*apparently straightforward*) were children placed at very young ages, with no known prenatal or genetic risk factors, and demonstrating normal development. These children were assessed as needing support around lifebook work to address identity issues, transfer of attachment from previous caregivers, and work in addressing contact plans with birth families (when appropriate). The top level (*complex, high risk*) involved children with many previous placements, significant maltreatment histories and challenging behaviors; the list of needs for these boys and girls, beyond normal parenting, included 13 items. Among them were:

- Parents with secure attachment histories who can cope with low levels of rewards
- Therapeutic parenting
- Parents who can understand children's behavior in light of their histories
- Child receives assistance to get in touch with feelings
- Access to mental health services and therapy
- Supportive school environments that understand children in context of their histories

In an ideal world, children with high levels of need could be matched with parents who already have the insights and skills for therapeutic parenting, as well as access to other necessary services; in reality, however, these ongoing needs often are not known or clearly articulated at the time of placement, nor are they linked with ongoing services. Adoptive families with knowledge and experience in parenting challenging children are in scarce supply. Also, for children who are preschoolers at the time of adoption, developmental and emotional consequences related to risk factors in their backgrounds emerge over time, such as when they start school or reach adolescence. It is vitally important that families be able to access services when needs arise across the adoptive family lifespan.

Critical Capacities of Adoptive Families

Adoptive families have been studied to better understand the aspects of family functioning and environment that predict adoption outcomes. The importance of many aspects of family environment in shaping adoptee adjustment has been demonstrated by research. The importance of parents having **realistic expectations** for adoption and their adopted children is a recurring theme in adoption literature and research (Barth & Berry, 1988; Brodzinsky, 2008; Groze, 1995; Pinderhughes, 1996; McRoy, 1999; Reilly & Platz, 2003). According to the latter study of 259 child welfare adoptive families, parental expectations represented the only one of five variables assessed that had a significant influence on all four adoption outcomes evaluated (parental satisfaction, quality of parent-child relationship, and impact of the adoption on the family and the marriage).

Adoptive parents' inability to understand and respond constructively to their children's problems or remain committed to their children in the face of ongoing struggles is also a critical factor in placement stability. Some children will have significant challenges no matter how prepared, knowledgeable, and skillful adoptive parents are. The capacity to persevere in the face of ongoing challenge will only succeed if adoptive parents are able to access and utilize appropriate supports -- from family, friends, neighbors, professionals, and importantly, their peers; those who have faced similar challenges with their adopted children and found satisfactory ways of resolving them. Adoptive parents need to feel hope and empowerment in meeting the challenges of raising their children. They need to recognize that they can make a difference in their children's lives by helping them process trauma and loss, and by providing unconditional love, acceptance, a sense of belonging in the family, and appropriate structure and rules. Successful adoptive parents, rather than seeing their children's negative behavior as a reflection of who the boys and girls are, "reframe" these troublesome episodes in terms of developmental delays and the legacy of previous adversities; in doing so, they are likely to remain more engaged, committed, and hopeful in their ability to support their children's resiliency and developmental recovery.

While parent preparation can help shape their understanding and expectations to some extent, parents also need to receive training and help after adoption in order to learn **therapeutic parenting strategies** that promote the child's ability to self-regulate in a manner that supports attachment (Rushton & Monck, 2009). A study of adoptions from foster care concluded that for parents whose children had externalizing behaviors, the less prepared the family was to parent children with such problems, the less able they were to regulate negative behaviors (Simmel, 2007). This author suggested there was an escalating dynamic found in past research in some families where the child's aggressive behaviors fueled coercive disciplinary practices by the parents, which in turn led to heightened aggressive behaviors in the child (Simmel, 2007; Patterson, Reid, & Dishion, 1992). In other words, the more the child defies parental controls, the greater lengths parents go to in order to exert their authority and curb negative behaviors, including such extreme measures as motion detectors outside the child's room.

A **positive parenting style** (warmth, sensitivity responsiveness, positive disciplinary strategies and active involvement) is important for all parent-child relationships, but these qualities are particularly important when children have experienced past maltreatment and need a healing environment. These qualities also are linked with positive adjustment in adoptive families (Simmel, 2007; Smith-McKeever, 2005; Kaniuk, Steele, & Hodges, 2004). For some parents with particularly challenging parenting demands, maintaining this stance requires training in therapeutic parenting, learning how to manage their own triggers and maintain self-control, and receiving adequate social support to continue this stance.

Social support is particularly critical for families adopting children with multiple challenges. The consequences of caring for a family member with extraordinary health or mental health problems are far-reaching – economic cost, impact on family and other relationships, restrictions on personal and social activities, stigma, and psychological overload or burnout. When parents experience chronic stress with their children, it can lead to shrinking social networks (fewer friends), reduced feelings of competence, and restriction of their interactions outside the family (Armstrong, et al., 2005). For example, a qualitative study of challenges in intercountry adoptive families reported that some experienced a lack of support from friends or relatives that resulted in their feeling disconnected from others who did not understand their situations or made insensitive comments (Reynolds & Medina, 2008).

The **family's capacity to cope with stress** is another key need, particularly in families where a high level of stress is present. The California Long-Range Adoption Study demonstrates that adoptive families' ability to cognitively manage stress and challenges is linked with better psychosocial adjustments in their children (Ji, Brooks, Barth, & Kim, 2010). Having parents who scored low on a standardized measure evaluating the family's cognitive orientation toward managing stress and challenge was a more powerful predictor of adopted children's psychosocial adjustment problems than any of the four pre-adoption risk factors analyzed. The researchers recommended greater attention to family stressors and coping mechanisms, both in adoption research and in post-adoption services.

When Stresses Exceed Coping Capacity

Some adopted children and their families undergo periods of severe difficulty both in the months after the initial placement and periodically thereafter. When there are difficulties early on, parents often

assume that things will get better with time, but if there is no improvement as the years go by or if problems intensify, they may feel growing disenchantment and hopelessness. Adoption practice literature reports a number of dynamics commonly seen in families who have children with a high level of behavior problems that have not improved despite repeated attempts to get help. Severe power struggles between parents and children often lead to parents becoming increasingly extreme in their attempts to control their children. They also may have difficulty truly connecting or empathizing with their child. The conflict frequently results in marital tension and disagreement on how to parent; conflicts throughout the family including between sibs; isolation; and parents' being exhausted, feeling like failures and feeling hopeless. Sometimes families that were very functional at the time of adoption have become dysfunctional, and parents may present as harsh, volatile and unreasonable. In this state, families are very vulnerable to a crisis and a triggering event can result in their being unable to cope (Smith & Howard, 1999).

The Continuum of Post-Adoption Services

Prior to the marked increase in child welfare adoptions beginning in the 1980s, it was assumed that existing community services for all families could meet the therapeutic needs of adoptive families. As adoptive parents were unsuccessful in finding effective help for their children, however, the need for specialized services became apparent. Post-adoption programs began primarily in the late 1980s and 1990s, but their development has not been continuous. Recent funding constraints have led some to be terminated, others to be scaled back and yet others to be offered on very limited bases. Major news stories in the past several years, from the young boy returned to Russia by his adoptive mother to stories of "re-homing" of adopted children and the deaths of some children in troubled adoptive families, have renewed public awareness of the need for post-adoption support and services.

The layers of issues and dynamics present in complex, chronic adjustment difficulties are often not understood by adoptive parents or the professionals they contact. The type of help parents seek most is adoption-competent therapy, but research indicates that most mental health professionals lack relevant training (Reilly & Platz, 2003; Brodzinsky, 2013). Adoptive parents in a Nevada study rated counseling as the service area they most needed (50%) but could not adequately get (Reilly & Platz, 2003). Another study surveyed 485 individuals who were part of the adoption triad (87% adoptive parents) regarding their experiences seeking help (Atkinson, Gonet, Riley, & Freundlich, 2013). Of those who had worked with mental health professionals (81%), slightly less than one-fourth believed the professionals were adoption-competent, and an additional 26 percent reported that some were, but others were not. Some adoptive families have reported experiences with therapists that actually damaged their families – practices such as conveying blame to parents for their children's problems, telling parents to just give their children back, and failing to assess the impact of previous maltreatment (Linville & Lyness, 2007; Smith & Howard, 1999; NACAC, 2002).

It is critically important for service providers to understand the unique aspects of adoption and the developmental impact of inadequate early care and trauma in order to effectively serve these families. A task force on adoption competency training, led by the Center for Adoption Support and Education, developed a definition of adoption competency that specified requisite knowledge, skills and values

competencies in 18 domains (Atkinson, et al., 2013). Accessibility of adoptive families to such services necessitates in-depth adoption competency training of a cadre of mental health professionals in the community, as well as the creation of specialized adoption support and preservation services. For a more in-depth discussion of the need for adoption competence among these professionals, see a recent publication by the Donaldson Adoption Institute: *A Need to Know: Enhancing Adoption Competence among Mental Health Professionals* (Brodzinsky, 2013).

A continuum of ongoing *adoption support and preservation* (ASAP) services needs to be developed to bolster families adopting children from complicated beginnings and to enable them to succeed – services that include preventive and early-intervention services as well as clinical interventions for very challenging situations. The types of post-adoption services that are most common include:

- ***Information/referral/advocacy.*** A range of programs exists to provide brief assessment of needs and referral for adoptive families. Some also offer advocacy to assist families in getting services that are sometimes difficult to obtain.
- ***Education.*** Parents benefit from education about a range of adoption issues, including the particular needs of their adopted children and how to best meet them, whether they arise from transracial adoption, the impact of substance exposure and other traumas, therapeutic parenting needs of a traumatized child, or other concerns. There are many informal resources (magazines, books, internet) and formal services (trainings, webinars, conferences, consultations) to educate adoptive parents, as well as adopted youth.
- ***Support.*** Individuals in the extended family of adoption need social support, which, like education, may be provided informally or through formal services. The many different approaches to providing supportive services include support groups, mentor programs, organized social activities for adoptive parents and/or children, retreats and camps, and others.
- ***Respite.*** Parents of children with significant challenges may need formal respite services, which are often difficult to find or obtain. In addition to those programs developed specifically for adoptive families, there are services through agencies serving special needs populations.
- ***Clinical services.*** These include brief problem-solving counseling, clinical evaluations, and individual and family therapy.
- ***Residential treatment.*** Short or longer-term residential services may be required for children and youth with severe difficulties that cannot be sufficiently addressed in-home.
- ***Search/reunion/mediation services.*** In addition to search and reunion services offered through adoption agencies, there are myriad additional resources to assist adoptive and birth family members in locating each other, in providing support through this process, and in facilitating communication between birth and adoptive family members.

Some are more formal and offered by professionals, while others may be informal and be provided under adoptive parent-sponsored programs or through the internet. Prospective adoptive parents need to be educated to understand that adoptive parenting can be different in significant ways from raising birth children, and that accessing informal or formal supports or services is a sign of strength – not one of parental inadequacy, as some parents believe. Not all adoptive families will need or desire ASAP services, and many will need only educational or supportive services that are not costly.

Some families require only brief therapeutic interventions to get them on the right path; however, a significant minority of families will continue to struggle and would very likely benefit from specialized adoption preservation services. The types of post-adoption services required to help these families goes beyond weekly counseling sessions; they involve:

- Family therapeutic interventions with home-based service availability
- 24-hour phone support for emergencies
- Advocacy for other needed services (educational, diagnostic, etc.)
- Case coordination with other professionals
- Respite care

Therapists providing these services need to be adoption-competent and have specialized training in a range of trauma-informed and evidence-based interventions, as well as the ability to address loss, identity, attachment and other adoption-related issues in families (Smith & Howard, 1999; Atkinson & Gonet, 2007; Atkinson, Gonet, Freundlich, & Riley, 2013; Brodzinsky, 2013).

Research Links ASAP Services with Positive Outcomes

Adoption subsidies facilitate adoptions from foster care. The foundational support for families adopting children from foster care is the availability of subsidies that minimize financial barriers to permanency. Research indicates that **the availability of adoption subsidies increases the likelihood of children being adopted** from foster care (Hansen, 2007; Hansen, 2005; Hansen & Hansen, 2006; Children's Rights, 2006; Barth, Wildfire, Lee, & Gibbs, 2003; Dalberth, Gibbs, & Berkman, 2005). Subsidies are particularly important in order for foster parents and older relatives to adopt (Buckles, 2013; Argys & Duncan, 2008). The latter study found that reducing the disparity between monthly foster care and adoption payments (more so than the levels of either payment) best predicts foster parents' adoption decisions, particularly among those caring for children who are older and/or have behavior problems. Unfortunately, a recent U.S. study found that for children adopted from care whose parents had previously fostered them, nearly one-third (30%) received an adoption subsidy lower than their previous foster care payment (Malm, Vandivere, & McKlindon, 2011); such discrepancies provide a financial disincentive to adopt by the very pool of parents most likely to do so.

Many parents report they could not have afforded to adopt without a subsidy (Malm, et al., 2011). In a multi-state study of adoptive and prospective adoptive parents of children from care, most (81%) indicated that subsidies were important to their decision to adopt, and 65 percent of those who had already adopted reported that they could not have done so without a subsidy (Children's Rights, 2006). In another study of success factors associated with families' adoption of children from care, two-thirds (66%) of adoptive parents said they needed the subsidy to be able to adopt (McRoy, 2007). Two of the top three barriers to foster care adoption by African American families are lack of financial resources to support children and to complete adoption; these are also among the top reasons cited by professionals (Ledesma, et al., 2011). Hence, many families could not adopt without subsidies.

Availability of post-adoption services promotes adoption and parent satisfaction. The availability of post-adoption services also has been linked with parents' greater ability and willingness to adopt

children from foster care. The lack of such services was identified by both agency staff and adoptive parents as a barrier to adoption from foster care in McRoy's study (2007), with 43 percent of parents responding to a survey reporting that this represented a major barrier for them. Receiving post-adoption services also has been linked with more positive outcomes, such as greater parenting satisfaction; the converse is also true – that is, having needs that are unmet is associated with poorer adoption outcomes (Gibbs, Barth, & Houts, 2005; Reilly & Platz, 2004). For example, the latter study of 249 parents of 373 adopted children with special needs found that those receiving post-adoption services reported higher parental satisfaction and those with unmet counseling needs (as well as several other types of service needs) reported lower perceived parent-child relationship quality and more negative impact of their adoptions on their family and marital relationships.

Formal and informal support promotes permanency and positive adjustment. Research on child welfare adoptive families indicates that the amount and quality of support they receive contributes to family permanency and positive adjustment (Barth & Berry, 1988, Groze, 1996; Leung & Erich, 2002; Houston & Kramer, 2008). A longitudinal study on the contribution of agency and non-agency supportive resources to the well-being of special needs adoptive families found that those who received more services prior to finalization were more stable and experienced less conflict three years later (Houston & Kramer, 2008).

Utilization of support groups is associated with greater parenting satisfaction (Reilly & Platz, 2003; Gibbs, Barth, & Houts, 2005). These groups can be a powerful source of information, social support and validation for parents and children who may not be connected to other adoptive families. Similarly, support groups or social activities in which adopted children can interact with each other can be invaluable for them and can help to decrease their sense of difference. In one evaluation of their participation in a support group, children were most likely to report that they fit in with this group more than others, and they liked spending time with other adoptees. When asked to describe what they liked best about being in the group, one child wrote: "Now that I know more kids that are my age that are adopted, I feel much better about being adopted and having the same feelings as I do" (Smith & Howard, 1999, p. 223).

Specialized ASAP programs are highly rated by parents but lack rigorous evaluations. Evaluations have been conducted on some post-adoption programs that are useful in describing the needs and characteristics of families seeking services and their perceptions of outcomes; however, our knowledge is very limited as to the efficacy of these services. Only one evaluation (Maine's) used an experimental research design. We do not yet have an evidence-based model of post-adoption services, and more research on therapeutic interventions with these families is critically needed.

Several models of intervention focused on the types of challenges common among youth adopted from care have begun to build a research base, although none rise to the level of established evidence-based practices. These are described in a report on post-adoption services published by the Donaldson Adoption Institute (Smith, 2010). Below are examples of some of the relevant post-adoption program evaluations and studies of interventive models:

- Maine Adoption Guided Services model (MAGS) used a randomized experimental design in its evaluation. Beginning in 2000, families finalizing adoptions were randomly assigned to the Guided Services or Standard Services groups. Those in MAGS had access to an Adoption Guide, that is, an adoption-competent social worker who could be called 24/7 by any member of the adoptive family and who met with the family at least every six months. MAGS workers spent an average of 65 hours a year with each family. There were no significant baseline differences in both groups; however, after two years, children in the MAGS group scored significantly lower on the Child Behavior Checklist. After five years, governmental costs for children in the Guided Services group were significantly less than for those in the Standard Services group (Lahti & Detgen, 2004; Lahti, 2006).
- An evaluation of the Illinois Adoption Preservation Program (for adoptive families of any type) examined outcomes for 1,162 children in 912 families served over a two-year period; 80 percent of the children were adopted from care. The possibility of adoption dissolution was raised by 30 percent of parents, and 13 percent of children were placed outside the home at the end of services (39% of them with a goal of returning home). A majority (58%) of families returned evaluations, and 92 percent were satisfied with services. They rated outcomes slightly more positively than did workers. Frequently reported areas of improvement were: feeling supported (92%), knowing where to get help (89%), understanding child (87%), parenting skills (85%), reduced family stress (79%) and child's behavior (74%) (Smith, 2006).
- Developmental Dyadic Psychotherapy (DDP), developed by Daniel Hughes (2007), seeks to increase parent-child attachment while helping children make sense of and cope with their painful histories and the related feelings and behaviors. A 2006 review (Craven & Lee, 2006) of the evidence base for 18 therapeutic interventions for foster children classified DDP at a category 3 (supported and acceptable) on a scale ranging from 1 (well-supported, efficacious) to 6 (concerning treatment). Subsequent to this review, additional evaluative research extending follow-up to four years after treatment was published (Becker-Weidman, 2006; Becker-Weidman & Hughes, 2008). In the latter report, the 34 youth in the treatment group demonstrated significant improvements on all scales of the Child Behavior Checklist, and these gains were sustained four years after treatment, while the 30 subjects in the comparison group receiving other forms of treatment did not demonstrate sustained gains on any subscales.
- Rushton and Monck (2009) developed early intervention parent-training programs in England involving two 10-session manualized interventions; one was a cognitive behavioral training based on The Incredible Years, an evidence-based intervention, and the other was an educational program focused on understanding negative behaviors as survival strategies. An evaluation using random assignment to three groups found that when compared to the standard care group at the six-month followup, adopters receiving both parent training programs were more satisfied with parenting, and negative parenting approaches were reduced; however, no significant improvements in child problems were found (Rushton, et al., 2010).
- ARC (Attachment, Self-Regulation and Competency) was implemented in the ADOPTS post-adoption program of Bethany Christian Services, beginning in Michigan in 2004 and later at eight other sites. It was used with pre- and post-adoptive youth ages 8-18 and their parents in an 18-week course of treatment, after which families could continue to work on other issues if desired. The treatment included a six-week group with children and another with parents. The evaluation

reported significant improvement across all subscales of the Trauma Symptom Checklist, except the Sexual Concerns subscale, and gains were maintained after a year (Blaustein & Kinniburgh, 2010; Kinniburgh & Blaustein, 2006). A subsequent Alaska project implementing ARC compared children completing a course of treatment with those dropping out, finding a 19-point improvement in CBCL scores for clients completing ARC treatment, compared to a 2.5-point improvement with clients not completing treatment (Arvidson, et al., 2011).

A conclusion that has been evidenced through evaluations of post-adoption programs is that being able to receive services for as long as they are needed rather than for a time-limited period is linked with more positive outcomes (Atkinson & Gonet, 2007; Gibbs, Siebenaler, & Barth, 2002). For parent-training programs, it is likely that the success of an early intervention would be enhanced by the opportunity for families to obtain follow-up support and counseling to apply principles or strategies in their own family situations and to address the needs of the children and adults. For example, parents completing the Alaska ARC program described above had an average of 50 sessions with children and caregivers.

PART V: CONCLUSIONS AND RECOMMENDATIONS

Permanency through adoption or guardianship is the most beneficial alternative for children who cannot safely grow up in their original families, and adoption of children from the child welfare system has become a federal mandate and a national priority in recent decades. The federal government has aggressively promoted adoptions from foster care, resulting in dramatic increases in these adoptions. Less attention has been paid, however, to providing supports and services after adoption in order to insure that children can remain in their "permanent" families and that their parents can successfully raise them to adulthood.

Children's Adjustment after Adoption

Most children adopted from U.S. foster care or from other countries have had early life experiences that pose some risks for their ongoing positive development and that increase the likelihood that they will face emotional, behavioral and learning challenges. Some children adopted as infants also come to their families with risks for later challenges. Research indicates that a substantial proportion of adopted children receive mental health services including 46 percent of children adopted from foster care, 35 percent adopted internationally and 33 percent adopted as infants (Vandivere, et al., 2009). Many children who have experienced deprivation, early trauma and multiple caregivers will encounter challenges over the course of their development, and emotional issues such as grief, post-traumatic stress and identity issues will resurface again and again as they mature.

Adoptive parents vary in their ability to compehend and address their children's needs. It is important to help them understand the specific child whom they are adopting and to forecast potential needs, but such pre-adoption preparation can only go so far. Most children are placed with their adoptive families before they start school, so the nature of their challenges is often not yet apparent, and parents often are not ready to understand or know how to address challenges that arise later (Brodzinsky, 2008). The LONGSCAN study found that when children adopted from foster care were compared to those reunified or remaining in care, they had superior outcomes as young children (home environment, stability, behavior) but more behavioral and emotional problems as teens (Litrownik, 2012). Also, the National Survey of Adoptive Parents found that 57 percent of teens who were child welfare adoptees received mental health services, so it is clear that adolescence is the period of greatest need for these young people (Vandivere et al., 2009).

There are many barriers to these children receiving effective treatment, in particular the reality that most mental health professionals themselves report that they lack "adoption competence," so they are not able to address the complexity of issues present in many of these families (Smith, 2010; Brodzinsky, 2013). In addition, very few evidence-based practice interventions address the nature of complex trauma, as well as attachment and identity issues and other coexisting developmental challenges confronting many of these children. Adoptive parents often report seeing many different professionals who are not able to effectively help them, and in fact, some do more harm than good (NACAC, 2007; Atkinson et al., 2013).

Recommendations

- **Prepare parents for the reality that challenges are likely to arise and that issues may resurface over the course of their children's development; that is, help parents to understand their children in light of their history.**
- **Identify high-risk children and families and provide them with early intervention and seamless supports both before and after finalization** in order to prevent the compounding of problems in all facets of their lives. Some risk indicators for children include difficulty in giving and receiving affection, a high level of oppositional behaviors, repeated traumatic experiences and a family history of mental illness. Adoptive parents who lack key protective factors associated with positive adoption adjustment might need early intervention as well. These include: realistic expectations, a positive parenting style (warm, responsive, authoritative), adequate social supports and a secure attachment style.
- **Provide intensive adoption-competency training to community mental health professionals who want to serve adoptive families, as well as to clinicians working in specialized post-adoption programs and residential treatment centers.** Therapists need additional training in evidence-based practices most relevant to addressing the needs of children with complex trauma and other salient issues for this population.
- **Fully involve adoptive parents in interventions to help their children.** Help them to understand their children's issues, address their own and their children's emotional needs, interrupt dysfunctional patterns of interaction, and facilitate a healing environment for their children.

- **Provide funding for research and the development of evidence-based practices to effectively meet the needs of this population, particular for adopted teens.**

Post-Adoption Instability

Adopted children and their families who are not able to effectively address challenges are at risk for chronic, severe stress and post-adoption instability. This can threaten the functioning of the entire family, leading to compounding of child problems, intense conflict, threats to the marriage and safety of other children in the family, and can even compromise the safety of the adopted child. Adoptive parents who are desperate for help may resort to dangerous types of treatments or "rehoming" practices that have been in recent news reports; that is, sending their child to another family without professional oversight and legal safeguards. In extreme situations severe punishment or unsafe therapies have resulted in child deaths. An adoptive mother served by an adoption preservation program in Illinois described this family condition vividly:

> *We were lost, sinking, destroying our family rapidly before these services. We spent thousands upon thousands of dollars, not counting the time involved in seeking help. This was the only place we could find help, information, relief … an understanding of how these troubled kids work and how to try and cope with their behaviors. How to deal with the emotions these kids stir up in us. How to still love them … It's so hard to try to put into words the devastating effects on the family these kids could have … It is so difficult … the destruction, the financial drain, the breakdown of the marriage, breakdown of physical health … At times, the fear of your life and safety of the siblings …*
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> Smith, 2006, p. 170.

Inability to get effective help also may result in the child leaving their home, either temporarily or permanently. The adoptive placements of foster children disrupt before finalization in approximately 10 percent of cases, but few of them leave their homes between adoption and the pre-teen years. The LONGSCAN study found that by age 16, 87 percent of youth adopted from foster care were living with their adoptive families, but 28 percent had lived away from their families at some point after adoption. These numbers were higher still at age 18. Many of these temporary placements were not through the foster care system (Proctor & Litrownik, personal communication, December 5, 2013).

The new research on post-adoption instability contained in this report focuses on one type of instability – post-adoption placements paid for by the child welfare system. It is important to recognize that there are other circumstances in which adopted children leave their homes – placements that are arranged and/or funded by other public or private organizations such as Departments of Mental Health or Education or by parents themselves. For reasons discussed earlier in this report, researchers are currently not able to determine a valid rate of foster care re-entry of children previously adopted from care. The closest approximation is Ohio's survival analysis of close to 35,000 adoptions, which yielded a re-entry rate of 9.5 percent and an adoption dissolution rate of 2.2 percent.

Only about 15 percent of those re-entering care are under age 10. Most adopted youth re-entering care do so six or more years after their adoptions. While older age at adoptive placement is a primary risk factor for adoption disruption, it appears to have much less of an association with the occurrence or timing of foster care re-entry. Most children who re-enter care do so as pre-teens or teens, regardless of when they were adopted.

There are two primary implications of the older age of adopted youth re-entering foster care. First of all, they are much more likely to be in high-level placement settings that are more costly than the average placement. While the average foster placement costs the federal government about $22,000 a year more than the average federal cost of an adopted child receiving subsidy, the costs for an adopted child in a group home or residential treatment center are far higher.

Adopted youth re-entering care also are at much higher risk of leaving the system without being reunified with their families than are other foster children. Thirty-six percent of adopted youth are reunified with their families before leaving care, as compared to 52 percent of other foster children. Re-entering adopted youth are almost 3½ times more likely than other foster youth to exit care through emancipation.

Some families struggling with adopted children who have severe mental health needs have to surrender custody of their children to the child welfare system in order to obtain needed residential treatment (NACAC, 2007). Such policies are detrimental to the well-being of children and families by reinforcing children's fears that they have lost their parents, thus creating additional trauma to them, and by removing parents' abilities to assume full parental responsibilities in their child's treatment. Adoptive parents also often report judgmental and threatening treatment from an array of professionals who set up roadblocks to their receiving help. Child welfare workers, staff in mental health settings, police officers and others also need to be educated about helpful strategies for assisting adoptive families.

Recommendations

- **Provide intensive adoption preservation services from skilled clinicians to families struggling with very challenging situations.** The types of post-adoption services required to help these families goes beyond weekly counseling sessions; they involve family therapeutic interventions with home-based service availability, 24-hour phone support for emergencies, advocacy for other needed services, case coordination with other professionals and respite care.
- **End forced custody relinquishments to obtain needed services unless there is evidence of maltreatment.**
- **Track post-adoption outcomes of children adopted from foster care in order to assess the extent and nature of post-adoption instability and to develop strategies for improving outcomes.**
- **Educate child welfare professionals, educators, doctors and other auxiliary professionals about the needs of adoptive families and helpful strategies for assisting them.**

The Imperative for Adoption Support and Preservation

Given the traumatic life experiences that most children in foster care have endured, a substantial proportion of them will continue to have ongoing adjustment issues that may intensify as they age. Likewise, other types of adoptive families will confront challenges that they could better meet if they received specialized services from knowledgeable professionals. Preparing and supporting adoptive families both before and after adoption not only helps to stabilize and preserve adoptions, but also offers children and families the best opportunity for success (Brodzinsky, 2008). A continuum of adoption support and preservation services is needed to address the information, support and therapeutic needs of children and their families. The overall body of adoption research generally has linked receiving post-adoption services with more positive outcomes and unmet service needs with poorer outcomes (Leung & Erich, 2002; Reilly & Platz, 2004; Child Welfare Information Gateway [CWIG], 2012). It is vital to help families understand these realities so that they have realistic expectations of their children and appreciate the benefits of accessing post-adoption services.

Adoptive families have a continuum of service needs; – some face only a few challenges, but at least 40 percent will likely require therapeutic counseling services to understand and effectively address their children's emotional and behavioral issues and to facilitate a positive family adjustment. It is important to develop services that address the range of needs that families encounter. Those whose children have the greatest challenges require more-intensive supports such as respite care and specialized adoption preservation services. Being able to receive services for as long as they are needed, rather than for a time-limited period, is linked with more positive outcomes (Atkinson & Gonet, 2007; Gibbs, Siebenaler, & Barth, 2002).

Many mental health professionals themselves acknowledge that they lack adoption competence. The complex nature of child and family problems in some families also requires skilled clinicians who have expertise in trauma-informed therapies as well as other types of conditions, such as fetal alcohol spectrum disorders or sensory processing disorder, that are more common among some of the children.

Funding for ASAP services has been scarce, leading some existing programs to be cut back or be provided on a very limited basis. Failure to receive needed services, however, is linked with lower parent satisfaction with adoption, lower quality of the parent-child relationship, more negative impact of the adoption on the family and the marital relationship, and greater adoption instability (Gibbs, Barth, & Houts, 2005; Reilly & Platz, 2004). Thus, supporting and preserving adoptive families is essential to avoid compounding problems, decreasing the incidence of poor outcomes and enhancing the prospects for success.

Recommendations

- **Create an array of adoption support and preservation services and make them accessible to families.** These should include preventive and early-intervention services, as well as clinical interventions for very challenging situations. Some are more formal and offered by professionals, while others may be informal and be provided under adoptive parent-sponsored programs or through the internet. These services would include:

  - an information and referral system that is supportive of consumers and that links them to adoption-competent services
  - educational and supportive services available to all adoptive parents and youth
  - adoption-competent therapeutic counseling services for families encountering significant challenges
  - intensive support (respite, 24-hour crisis call, etc.) for those parenting children with significant challenges
  - specialized adoption preservation services for families experiencing severe difficulties, including case coordination, advocacy and state-of-the-art assessment and intervention
  - residential treatment services for children who clearly need them in a manner that maximizes parents' ability to continue in that role

- **Enhance funding for adoption support and preservation services by creating a federal funding stream dedicated to post-adoption services and developing partnerships among organizations across a range of auspices at the federal, state, and community levels. The federal government needs to provide clear guidance to states that these services are integral to the adoption process and work to support their development.** A number of additional recommendations for enhancing federal policies to better meet families' needs after adoption are included at the end of Part I on Federal Policy and Funding.
- **Develop partnerships among organizations across a range of auspices at the federal, state and community levels** in order to maximize the development and accessibility of ASAP services.
- **Educate pre-adoptive parents on the benefits of adoption support and preservation services,** not only for their children but also for themselves. Reframe help-seeking as a strength rather than a sign of parental inadequacy, as some parents believe. Let them know where they can find these services and provide ongoing information and access.
- **Develop a system for addressing the needs of families that "fall through the cracks,"** such as a board to resolve disputes about which state agencies bear payment responsibility or how costly services such as residential treatment can be accessed.
- **Maximize ASAP services available to all types of adoptive families.** At least 20 states currently make their post-adoption services available to all types of adoptive families, including many that have intensive home-based therapeutic counseling programs (Smith, 2014). Others make lower level services such as support groups or training available to all types of families, while reserving more costly services such as respite, for child welfare adoptions. At least one state (Tennessee) provides intensive adoption preservation services free of charge to families who adopted from foster care in the state, but will provide these services to other types of adoptive families for a sliding scale fee. The Hague Convention requires the U.S., as a country that ratified the treaty, to 'promote the development of adoption counseling and post-adoption services in their States.'

"Keeping the Promise" reflects the covenant that is made between parents and children when adoptions take place: to become a safe, permanent family. In practice, however, the covenant is much broader – and should be. It is also between child welfare professionals and the families they serve, and between state and federal governments and the families they create. In adoptions from foster care, in particular, the state's child welfare authority removes children from their original families, arranges

temporary care for them for a period of years (sometimes compounding the harm) and ultimately selects the families who adopt them, with an agreement to provide needed supports over the course of childhood.

When families struggle to address the developmental consequences of children's early adversity, they should be able to receive – as a matter of course integral to the adoption process, and not as an "add-on" that can be subtracted – the types of services that meet their needs and sustain them. Adoptive parents, professionals, state and federal governments and we as a society share an obligation to provide the necessary supports to truly achieve permanency, safety and well-being for the girls and boys who we remove from their original homes. In the 21st Century, given the profound changes that have taken place in the characteristics of children being adopted (that is, most are from foster care), adoption should be reshaped into an institution that not only creates families, but also enables them to succeed.

APPENDIX I: ASHLEY'S STORY

The following narrative was e-mailed to the Adoption Institute by a young woman who did not experience a legal dissolution of her adoption but, rather, a suffered a complete emotional severing of the parent-child relationship when she reached the age of majority. With Ashley's permission, it is included in this report to illustrate how unaddressed trauma in a child, insufficient preparation, training and support of adoptive parents, and an overall void of post-adoption services can lead to the compounding of problems and severe negative consequences for all. (Ashley's words are in italics; comments about services that were needed are in bold type.)

My name is Ashley and I am 25 year old adoptee. My biological brother and I were adopted at the ages of 4 and myself 8 years old. We were adopted after spending years in and out of foster care because our birth family struggled with addiction. My brother was blessed with being young enough that our adoption was a clean slate for him. He was to be raised by two people that would be the only parents he would ever know. I had seen too much, been through too much in my first eight years. I had an abusive birth father and a mother who was so involved with her addiction that we were frequently pulled in the middle of the night to be put into various foster homes.

We met our adoptive parents in the fall. … I can't recall exactly what I was feeling, other than I was excited at the thought of living in a lovely home with these "nice" people. They took my brother and I on fun weekend outings before we were able to actually live with them and we were able to meet the people that would be our family members. Eventually we were placed in their care. I left the horrible foster home behind and settled into my new life. I was told later on in life that they had chosen adoption because my adoptive mother had fertility problems and was not able to have children.

We had problems right from the start. I had not had adults in my life showing me consistent love and care and I did not know how to handle a new "mom" and "dad". I was acting out in many ways. In desperate need of attention, even if it was negative. I remember one of our first issues was my constantly feeling sick. I would spend most of my days at school with the school nurse. I did not know how to properly socialize with children my age.

Both Ashley and her family needed extensive preparation, as well as early intervention by an adoption-competent professional. Ashley needed help in understanding and coming to terms with the events she had experienced and support in making the transition to a new family. Her adoptive parents needed education, support and counseling to understand and address the impact of trauma and loss on their children and to be able to help Ashley process past events in her life.

About a year later I had my last visit with my birth mother before we were to be legally adopted. I again don't remember what I was feeling. I don't think I understood what this meant. I was 9 years old. My birth family gave me a huge photo album that would remain on my shelf for years at my new home.

The following years brought out repressed feelings from me. I was still acting out. I was either mad and argumentative or in wild need of love. I started to lie to my adoptive parents about things that were just not necessary. It seemed that I had taken on bad traits that I had seen from my birth family without even knowing it. My adoptive mother was a teacher and schoolwork became a big issue. I was either 100% into school or not at all depending on how I felt and how things were at home. She was an extreme perfectionist and this caused major problems.

During this time I overheard my adoptive mother discussing whether or not she could send me back. Needless to say, I had a problem taking to her after this. She assumed I should be happy. She herself was raised by a family other than her birth family…

Ashley was struggling mightily with a host of negative feelings and did not seem to have anyone in her life who was helping her to address them. She and her mother did not develop a secure attachment relationship. It is particularly hard for inexperienced adoptive parents to understand their children's lack of or inconsistent responsiveness to overtures of affection and their acting out behaviors that contribute to further distance. Through support groups with other adoptive parents and specialized adoption-competent counseling, parents can be helped to understand children's feelings and needs and to use techniques that support attachment, while responding in therapeutic ways to negative behaviors. This adoptive mother needed support herself to understand the feelings that Ashley provoked in her and how to connect with her daughter on a feeling level. Ashley also would likely have benefitted from a support group.

At this point my adoptive parents had no idea what to do to motivate me. Their form of punishment was for the most part shutting me off from everyone and anything for years. I was allowed to go to school and be in my bedroom. … This backfired and made me more distant. I didn't know how to voice the pain I was in. I was never put in therapy. The 8 years prior to them knowing me were a big mystery they never asked about.

As I got older I became curious about my birth family and I went searching for any paperwork that may be related around my house. They were not having this. They established a rule that I was not allowed around the house unless they were home. When I got home from school I had to stay in our basement until someone else came home. They were helpless and I was helpless.

In high school things remained the same. It was a constant battle between us. One that was only dealt with by punishing me. I was so lost and hurt all the time. My grades were either straight A's or F's. There was no happy in between with anything in our household.

When my high school graduation was nearing, I was so detached from our relationship that I chose to move out right away. An incredibly silly move on my part but at the time I needed to be away from them. Far far away. We emailed every so often. The older I got and looked for a healing process the more angry I got with them for not seeing clear signs of how badly I needed help. I read countless books on the signs of child abuse and what to expect from a child of addicts. I was the poster child. The more I tried to talk it out with them the further away they went. They said they would only see me and talk to me if I mailed them a pay stub every single week I worked. In their eyes this meant I was being a proper adult and worthy of their attention.

Ashley's adolescence increased the growing gulf with her parents. No one helped them to communicate about sensitive issues, such as Ashley's birth family and her lack of a sense of belonging in her adoptive family. Their relationship was a protracted power struggle, and the parents resorted to extreme measures to control Ashley, such as confining her to her room or the basement much of the time.

Four years ago when I had turned 21 I received an unprompted email from them. They told me that they considered this a failed adoption and did not wish to have me a part of their life anymore. They said they hadn't connected with me as a child and that it had become impossible to try to have one with me

as an adult. They said that my brother would have to decide what to do with a blood relative. Wished me the best and that was it.

There are so many variables here. Present day I have no family but have a huge open heart that is aching for someone to love me. I think I still don't quite understand what it would mean to have a family, but I'm aware of its absence. I have not been able to see my dear brother in over 8 years because they would not allow it.

The irony is that I have transitioned into a very mature, loving, smart, kind young woman. At least I would like to think so. I find it hard to give myself any kind of credit as I was not wanted by not just my birth parents, my adoptive parents as well. I have a great job I work hard at. A stunning apartment in a beautiful neighborhood. And most of all, I have a healthy lifestyle. I thank my lucky stars I was never tempted as my birth family was by drugs or alcohol.

Four years later now I still struggle with their decision. … For some reason, unknown to me, I have kept a sane mind. I strive to be a good person. I see a bright future ahead of me. I have had many years to think about their decision, and while it is hard for me to wrap my head around, I have thought about their point of view. I find it so unfortunate that they were so ill informed and/or prepared for the adoption of an older child. I have a certain amount of compassion and sympathy for my adoptive mother who was not able to have children. Unfortunately they do not have the capacity to extend the same compassion towards me. Most people who know me have said something along the lines of "you should really write a book about this." I have never met anyone in my position and want to voice my story in hopes of helping someone else.

This account of a promise not kept provides insights into the extreme angst and missed opportunities for all of the individuals involved – and demonstrates the long-term, severe consequences of this failure, particularly for Ashley. She lost her brother and two sets of "permanent" parents. No one can know how the outcome might have been different with the provision of needed services along the way, but it is evident that their absence contributed to the breakdown of this adoption.

APPENDIX II: EXCERPTED FROM *SECOND TIME FOSTER CHILD*, BY TONI HOY (2012)

The Hoy family fought for years to address their son Daniel's need for mental health care in a residential treatment center. As an infant, Daniel and his brother, Chip, who was 18 months older, entered the foster care system due to severe neglect and were placed with the Toni and Jim Hoy when Daniel was 2. Chip later struggled with violent rages, which after several years were diagnosed as bipolar disorder (a rare diagnosis in a child), and these were stabilized with medication. Daniel's violent episodes were more frequent, and he was admitted to the psychiatric ward for the first time soon after entering the fifth grade. Toni describes her family's experience of seeking help and fighting an uphill battle to get him

the help he needed over many years. Below are a few excerpts describing the many barriers they encountered, as Daniel was admitted and discharged from psychiatric hospitals.

We put the local crisis team phone number on speed dial. Often we had to call 911 first. We developed our own family safety plan. …We trained our other children to respond to one of his outbursts in the same way most families practice for a fire drill. Subsequently, the same chain of events followed the "safety plan," calls to the crisis team, and 911.

Each hospital tried to set his discharge up for success at home. Usually, we added another therapy to the litany of those we already had: psychiatry, individual therapy, family therapy, EMDR therapy, therapeutic school, art therapy, music therapy, play therapy, tai chi, and respite. Essentially, we had therapy in one form or another every single day. Still, we were calling 911 and spinning in the psychiatric revolving door. Every therapist began to ask us the same question, 'Have you considered a residential placement?' In fact, we had. We learned that the cost of such treatment was exorbitant, currently costing between $150,000-$180,000 per year. We called our insurance company. Not covered. We called Medicaid …

After school, Chip came into the house to tell Jim about something inappropriate Daniel had been doing outside. Daniel stormed into the house, picked Chip up, threw him down the stairs, and began beating on him with his fists. Jim had to pull Daniel off of Chip. When I arrived home from work, the police were there and the crisis team was on their way. I asked the SASS worker to follow me outside to my car. I showed her the suitcases in my car. There was one for me and one for each of our other three kids. 'This is what it's come to,' I told her, 'we were ready to split our family, leave, and live in two separate homes to keep the other kids safe. Before I could get them to safety, he'd beaten our other son and we called 911. We can't continue on like this anymore.' They admitted him to the psychiatric hospital for the 11th time within 2 years.

(One week later) *The hospital wants him discharged. We tried to arrange for a residential placement, but couldn't get funding. The hospital was pressuring us to pick him up.* [The child welfare department] *told us that if we picked him up, they intended to charge us with child endangerment for failure to protect our other children. If we refused to pick him up, they intended to charge us with neglect. They wouldn't give us any other options nor tell us how to resolve our dilemma.*

We weighed all the possible choices as carefully as we could. Using foresight, we tried to predict what lay at the end of each path. Which path would give Daniel the treatment he so badly needed while keeping everyone safe? Which path would leave the least negative scar on everyone? …. After speaking with the therapist, my husband called to tell me that it was best to tell Daniel in person, that we were unable to bring him home for safety reasons … He said, 'Son, Mom and I love you so much! What we are going to do will hurt you and us very much, but it is something we must do to get you the help you need…We will do our best to know where you are and promise to come see you just as soon as we can. Until then, we want you to know that we love you very, very much and that will never change.' Our son cried, the therapist cried. My husband cried all the way home…. We spent the rest of that night in a blur of emotion, which included deep sadness, fear, helplessness, uncertainty, isolation, despair, grief, and so much more… It felt like the calm before the storm. We knew that the hospital was going to call the child abuse hotline. We knew we'd be investigated … we'd have to appear in court.

The following day an investigator came to the home. Jim gave her a ream of mental health records, copies of police reports where we'd made 911 calls to protect ourselves. He told her about a clinical staffing at the child welfare department in two more days and that the hospital had refused their requests to hold Daniel until a solution could be worked out to keep everyone safe. They asked where

Daniel had been taken but the investigator refused to tell them. A clinical staffing was held at which residential treatment was recommended, but they said it would take three to four months to get approval for the funding.

The Shelter Care hearing: *Today my husband and I would not sit at the back with the others who were 'advocating for our son's interests.' We were directed to the 'accused' chairs, which sat directly facing the judge, and in between the attorney seats…. I was the only woman in the court room not allowed to have my belongings at my side. As I returned to my seat, a wave of shame swept over me. I don't know why I felt shame in that moment, I hadn't done anything wrong. Perhaps it was because most everyone else present incorrectly surmised that we'd done the unthinkable. Hurt a child…. The judge looked at us with panic, fear, and disgust. She announced that it was a Shelter Care hearing and shouted at us. "I HAVE THE POWER TO TERMINATE YOUR PARENTAL RIGHTS!"*

After a conference in chambers with the attorneys, the judge concluded that the Hoys had gone above and beyond in trying to help Daniel. He was taken into temporary custody. The judge and attorneys had reviewed the Juvenile Court Act to see if the case could be a dependency case from the start but concluded they had to be charged with neglect first. Once the state took custody, they could amend it to no-fault dependency. It was almost a month until the Hoys could see Daniel, and he was moved to three different placements before ending up in a residential treatment center not quite two months later. The Hoys were "indicated" in the investigation, and their names were placed on the state central child abuse registry. They appealed, and the juvenile court amended the neglect finding to no-fault dependency. Then they went to another court to have their names expunged from the registry.

The child also suffers mentally, emotionally, and therapeutically while the parents are being criminalized in exchange for treatment…. The immediate emotion for the child is fear. The child may experience fear of the unknown, fear of interrogation, confusion, fear of separation and loss of family, loss of identity, and unresolved grief and abandonment. These fears infiltrate the child's soul, exacerbating his already compromised emotional state… Daniel's emotional pain was exacerbated by a system that sought to drive away his strongest support system, his family.

The Hoys also went to federal court to get Daniel's treatment paid for. Finally, a little over three years after surrendering custody of their son, they successfully petitioned the court to regain custody of Daniel, who remained in treatment.

Later that evening, we phoned Daniel… Jim said, 'Daniel, WE ARE YOUR PARENTS!' He let out a shriek of utter joy, 'REALLY?!' It was the happiest moment of all… Daniel continues to work on emotional stability. Our family, as a unit continues to work on emotional healing

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