

Confronting Barriers to Adoption Success

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There is a large body of professional literature, including several recently completed surveys, describing the barriers that undermine successful adoption outcomes (Macomber, Scarcella, Zielewski, & Geen, 2004; US Government Accounting Office, 2004; Evan B. Donaldson Institute, 2004; Casey Family Services, 2003b). These barriers can be divided into three broad categories. The first type includes both intra-organizational and inter-system obstacles, not only in direct service provider organizations such as child welfare, mental health, education, and health care, but also in the courts and legal system, at federal and state policy levels, and in communities at large. The most frequently noted of these barriers include inconsistent, ineffective, or absent policy; insufficient numbers of staff; high rates of staff turnover; inefficient organizational structures; a lack of essential technology; excessive and often unmanageable work loads; and a lack of interagency and interdisciplinary collaboration and coordination (Children & Family Research Center, 2004; US Government Accounting Office, 2004; Macomber et.al., 2004; Groze, 1996; Evan B. Donaldson Institute, 2004.)

The second major barrier is a chronic lack of specialized services to address the special needs of adopted children and their families, and insufficient resources in many communities to finance their development, or to sustain them over time.

One source contends that the inability of many families to access needed services and resources is the most challenging barrier to achieving permanence and safety for children (Children and Family Research Center, 2004).

A third type of barrier is identified less frequently in the literature, although it is often alluded to in the context of discussion of other adoption issues. There is a widespread lack of knowledge and understanding regarding the unique dynamics of adoption, the typical issues confronting adopted children and their families, the risk factors that undermine adoption, and the factors that stabilize, strengthen, and preserve adoptive families. The literature references gaps in empirical research related to adoption practice (Evan B. Donaldson Institute, 2004; Brodzinsky, 1993; Smith & Howard, 1999; Groze, 1996), identifies a lack of adoption-specific knowledge among many professionals who directly or indirectly serve adopted children and their families (Casey Family Services, 2003b; Smith & Howard, 1999; Groze, 1996), and cites a widespread lack of preparation and continuing education for adoptive families, and for the professionals who serve them (Casey Family Services, 2003; Groze, 1996; Berry, 1997; Rosenthal, 1993). There are also frequent references to the negative impact of misinformation and misconceptions that are prevalent in many groups,

including professionals, communities-at-large, and among many adoptive families and children (Keefer & Schooler, 2000; Smith & Howard, 1999; Berry, 1992).

The purpose of this article is to explore some of the more prevalent barriers to successful adoption outcomes, including knowledge gaps, and to recommend strategies to minimize or eliminate them. At first glance, the scope, complexity, and apparent intractability of many of the large system barriers can be overwhelming. However, these often begin as smaller obstacles that, when not recognized and addressed, can compound over time and eventually assume proportions that defy intervention. By identifying smaller obstacles and bringing early intervention strategies to bear, the professional community can potentially prevent the development of many of the more significant barriers that undermine successful adoption outcomes.

Systemic Barriers to Adoption Success

Fiscal Barriers

Examining the fiscal environment is critical in any analysis of the adequacy of multi-system efforts to promote successful adoptions. While there are several sources of federal and state fiscal support for adoption planning and support

services, there are also significant concerns about the adequacy of funding available through these mechanisms, and about their categorical nature (Macomber et.al., 2004).

The two primary sources of federal funding to support specialized services for children adopted from foster care and their families are: (1) Title IV-B, Subpart 2 of the Social Security Act, which provides funds for a range of child welfare services, including adoption services and supports, and (2) Title IV-E, which provides adoption assistance payments (sometimes referred to as subsidies) and which also covers other adoption-related expenses for children who have special needs (U.S. House of Representatives, 2004).

Funds from Title IV-B, Subpart 2 are appropriated at a fixed level. It is expected that states will use 20% of these funds for adoption services. While states have used Title IV-B, Subpart 2 funding to develop post-adoption services, there continues to be a significant gap between the demand for these services and their availability (U.S. House of Representatives, 2004). Title IV-E funds are open-ended and available for every child determined to be eligible. Title IV-E support is in the form of cash payments, typically set at relatively low levels, to assist adoptive families in meeting some of their children's needs. Children who receive Title IV-E adoption assistance are also eligible for Medicaid, which can be

used to access a range of health, mental health, and developmental services for children.

There is growing concern about the adequacy of the Title IV-E and Medicaid programs to meet the needs of children adopted from foster care. Federal Title IV-E adoption assistance funds require the states to provide matching funds, with levels varying by state. Thus, as the number of children eligible for Title IV-E adoption assistance has grown, many states have also experienced comparable increases in their adoption assistance budgets (North American Council on Adoptable Children [NACAC], 2004). In some states, budget concerns have led to reductions in the level of adoption assistance payments, creating significant stresses for many families, particularly those whose children have health, mental health and developmental problems (NACAC, 2004). Concurrently, Medicaid restrictions, especially limits set on Medicaid payments to providers, have reduced the number of providers in multiple disciplines who are willing to serve children whose only health insurance is Medicaid (Froge, 2004). These fiscal developments have significant implications for the ability of adoptive families to pay for services, provided that these services are even available and accessible (Casey Family Services, 2003a).

Adoption subsidies make it possible for many families to adopt who otherwise could not (Rosenthal, 1993). Lack of subsidies has blocked adoption

opportunities for many minority and low-income families, and for foster parents. These groups have typically had positive outcomes in adopting older children who have special needs (Rosenthal, 1993). In most states, the level of financial assistance for adoption is also significantly lower than it is for foster care, serving as a considerable disincentive for foster parents who are willing to adopt the children in their care.

Legal and Judicial System Barriers

Legal intervention is an integral part of adoption. The legal system governing adoptions includes domestic and international law, the judicial system, and professionals who legally represent the various parties to the adoption. Barriers in the legal system include inconsistencies in the laws and legal processes governing adoption; lengthy delays in court actions and procedures; and the failure of various parties in the legal system to adhere to or to enforce legal requirements.

Courts have responsibility to make decisions regarding the permanent termination of parents' rights (TPR), to pursue adoption as a permanency option for children, to hear appeals by parents contesting TPR rulings, and to finalize children's adoptions. Delays in adoption-related court proceedings have repeatedly been identified as posing significant barriers to successful adoption

(Children and Family Resource Center, 2004; U.S. General Accounting Office, 2002; Macomber et.al., 2004). In a recent survey of states, court case management was one of the five most frequently identified barriers to adoption success, with 43 states reporting obstacles such as overcrowded court dockets, difficulty in scheduling court hearings, repeated continuances, and lengthy delays in achieving permanent termination of parental rights and in hearing appeals (Macomber et.al, 2004). Other barriers included insufficient numbers of judges, court staff, and attorneys to handle large caseloads, and judges who were not supportive of the goals of the Adoption and Safe Families Act of 1997 (ASFA) (US General Accounting Office, 2002). Significant delays also existed in scheduling and conducting court proceedings when birth parents appeal a court decision to terminate parental rights. The appeals process often requires months to years, with one state reporting that it often took a year to simply schedule an appeals hearing (Macomber et.al, 2004; US General Accounting Office, 2002.)

A lack of training for judges, attorneys, and court personnel was cited in several reports as a significant barrier (US General Accounting Office, 2002; Macomber et.al, 2004; Children & Family Research Center, 2004.) One survey determined that barely half (49%) of all judges who presided over abuse and neglect hearings had received any specialized training in child welfare issues prior to hearing these cases (Children and Family Research Center, 2004). The survey further found that in rural areas, fewer than 22% of judges worked in courts that

specialized in child abuse and neglect. Even more disturbing was the number of judges who believed they were held in only low to moderate esteem by their legal colleagues, their state Supreme Courts, and their communities at large. Some contended that the low priority of child abuse and neglect cases in the legal system contributed to an insufficient allotment of time to address these cases, often resulting in poor preparation, and increasing the difficulty in garnering the necessary resources to do a competent job (Children and Family Research Center, 2004).

In a study on court involvement in adoptions of children from foster care, the Pew Commission (2004) determined that courts frequently lacked the tools, information, and resources needed to expedite permanence for children. A lack of accountability, ineffective mechanisms for tracking children through court systems, and an absence of clear performance measures for courts had also contributed to delays in achieving permanence for children in foster care. The Commission indicated that improved accountability through court performance measures could significantly improve adoption outcomes (Pew Commission on Children in Foster Care, 2004).

There are many long-standing barriers related to placing children with adoptive families across state lines, as well as across jurisdictions within the same state. In general, interjurisdictional adoptions are more complex and take longer than

placements of children within the same child welfare jurisdiction. According to recent HHS data, children adopted by out-of-state families typically spend about one year longer in foster care than children who are adopted by families in their own state (U.S. General Accounting Office, 2002).

A pervasive problem is the lack of consistency in domestic adoption law. State laws that dictate legal and court procedures governing the adoption process often vary widely, complicating both the placement of children into adoptive families across state lines and the finalization of these adoptions. States also vary in their procedures for voluntary relinquishment of children by their birth parents, and in the legal procedures governing the involuntarily termination of parental rights (Shur, 2002). State requirements also differ for informing birth parents of their legal rights, and the allowable terms and time frames for withdrawing these relinquishments, including some states where relinquishment is considered final and irrevocable when given (Shur, 2002). States also differ in their requirements for applicant homestudies, which are the formal assessments and documentation of prospective adoptive parents' strengths, needs, and capacities to parent adopted children. The lack of consistency in state laws governing the format, scope, and content of homestudies has created significant barriers to timely and successful interstate adoptions, because homestudies completed in one state may not be acceptable in another state (U.S. Department of Health & Human Services, 2004). Differences in state laws, rules, and the

compacts governing interstate adoption also compound challenges for legal counsel representing children and families in adoption-related matters, as considerable time is needed for research, planning, and preparation to negotiate within this complex legal environment.

Two interstate compacts have been created in an attempt to facilitate inter-jurisdictional placements by promoting communication and increasing cooperation among states. These are the Interstate Compact on Placement of Children (ICPC) and the Interstate Compact on Adoption and Medical Assistance (ICAMA). These compacts were designed to ensure the appropriate application of state law, as well as adequate protection, benefits, and services for children placed for interstate adoption (Oppenheim, Bussiere, & Segal, 2002; U.S. Department of Health & Human Services, 2004). However, a host of barriers to interstate adoptions remain.

Implementing the Interstate Compact on Placement of Children (ICPC) is a lengthy and cumbersome process, and resource limitations, among other factors, have prevented many states from complying with the provisions of the ICPC in a timely manner. Further, there are no mechanisms to mandate states to comply with the ICPC, and no sanctions if they do not. Together, these obstacles have made the ICPC a less than effective tool in facilitating timely interstate adoptions (U.S. Department of Health & Human Services, 2004). Efforts are currently

underway to revise the ICPC to improve its capacity to coordinate and support interstate adoptions (Personal communication, Elizabeth Oppenheim, American Public Human Services Association, (December 27, 2004). The Interstate Compact on Adoption and Medical Assistance (ICAMA) was designed to coordinate the states' respective responsibilities to ensure ongoing adoption subsidies, medical assistance, and other post-adoption services to children adopted across state lines (Oppenheim, Bussiere, & Segal, 2002). ICAMA assigns responsibility for providing subsidies to the state in which the adoption is finalized, and assigns the receiving state (where the family lives) responsibility to provide medical coverage for those children receiving adoption subsidies (Oppenheim, Bussiere, & Segal, 2002). However, since only 35 states are members of ICAMA, inconsistencies remain in the provision of subsidies and medical assistance to children adopted across state lines.

The Hague Convention on Inter-country Adoptions is the principal legislation impacting international adoptions. The United States signed the Convention in 1994, Congress enacted the Inter-country Adoption Act of 2000 to implement the Convention, and the U.S. Senate gave its advice and consent to authorize ratification of the Convention after its implementation. However, the Hague Convention has not been implemented, and unfortunately, it is not clear when final ratification will occur (U.S. Department of Health and Human Services, 2004). The Convention remains the principal legal framework for international

adoptions, but without its implementation as law in the United States, international adoptions arranged by U.S. agencies will continue to lack uniform procedures and can be implemented in a largely unregulated environment. This increases the potential for the arrangement of adoptions without accountability, and the violation of children's, birth parents', and adoptive parents' rights (Freundlich, 2000). The absence of regulatory controls and standards for international adoptions remains of great concern.

Education System Barriers

Adopted children are likely to have special educational needs. Research indicates that adopted children are three to four times more likely to be in special education programs than the general population (Brodzinsky & Steiger, 1991). Many of the conditions impacting children's health and mental health also impact their ability to participate in and benefit from formal educational opportunities. Children with mental retardation constitute the largest proportion of adopted children with developmental disabilities (Smith & Howard, 1999). Other conditions that require special education can include emotional disturbance, neurological impairment, learning disabilities, or cognitive problems associated with fetal alcohol syndrome or fetal alcohol effects.

Many adopted children need a variety of specialized educational services to address their individual learning needs. These services may include comprehensive testing and evaluation, an individualized curriculum, regular tutoring, and communication and close cooperation between adoptive parents and school personnel, both to support learning and to manage children's behavior problems in school (Rosenthal & Groze, 1990; Smith & Howard, 1999).

The Individuals with Disabilities Education Amendments (IDEA) of 1991 sets forth requirements to assure that all children with disabilities and handicapping conditions receive a free, appropriate public education in the least restrictive environment. Individual Education Plans (IEPs) are required and must be based on a complete assessment of each child's educational and developmental needs. School districts must provide needed services at public expense. The law enables families to be fully involved in planning their children's education, including attending meetings, reviewing and receiving copies of records, and requesting testing by an interdisciplinary team. If a parent disagrees with evaluation findings or decisions made about a child's education, a due process hearing can be requested to consider the parent's concerns (Rycus & Hughes, 1998).

However, because of the complexity of negotiating the special education environment, many families may need the assistance of trained advocates to help them navigate bureaucratic barriers and access special education services for

their children. At times they may have to become very assertive or seek legal action in advocating for their children's needs, as school districts in tight fiscal environments may try to reduce the sometimes high costs of individualized special education services (Smith & Howard, 1999).

Successful educational experiences for adopted children appear to be strongly correlated with positive adoption outcomes. Similarly, studies have identified a strong association between children's school problems and adoption disruptions and dissolutions (Casey Family Services, 2003b; Barth & Berry, 1988).

Child Welfare System Barriers

Barriers in the child welfare system include difficulty locating and preparing sufficient numbers of adoptive families for children waiting to be adopted (U.S. General Accounting Office, 2002; Macomber et.al., 2004); delayed or inconsistent use of concurrent case planning and other case management strategies designed to promote timely permanence for children (Macomber et.al., 2004; Evan B. Donaldson Institute, 2004); discontinuities in services to both children and adoptive families resulting from high rates of staff turnover in child welfare agencies (Berry, 1997; McRoy, 1999), and a widespread lack of coordination between child welfare agencies and their corresponding juvenile or family courts

(Pew Commission on Children in Foster Care, 2004; Macomber et.al., 2004; Children and Family Research Center, 2004.)

The difficulties involved in developing sufficient numbers of adoptive families for children with special needs are well documented in the child welfare literature. Even though identifying, assessing, and preparing adoptive families are the shared responsibility of child welfare agencies and their community partners, barriers do exist within many child welfare agencies that impede this process (Rycus & Hughes, 1998). Some agencies lack specialized adoption units, and caseworkers often lack the necessary skills and experience to perform adoption related functions. Many agencies lack the resources and skill to conduct sophisticated outreach, marketing, public relations, and community education programs. Some agencies also lack the capacity to fully assess, train, and prepare families who do respond to recruitment activities (Rycus & Hughes, 1998). An absence of culturally sensitive policies and practices in child welfare agencies contributes to high dropout rates by families of color who have responded to recruitment campaigns (U.S. Department of Health & Human Services, 2000). Until recently, child welfare agencies typically lacked comprehensive post adoption service programs, and while many such programs are currently being developed, services are still insufficient to meet the most pressing needs of many adoptive families (Casey Family Services, 2003b; Smith & Howard, 1999).

Many of the general staffing problems that plague child welfare agencies, such as chronic understaffing and high rates of staff turnover, also impact permanency outcomes for children in care. Macomber et.al. (2004) identified a variety of conditions at all phases of child welfare case management that delay permanence. For example, conducting diligent searches for absent biological parents may not begin early enough in the case management process. Similarly, many agencies fail to implement concurrent case planning (in which alternative permanency options are explored while simultaneously working to promote reunification) and instead, wait until it is certain that reunification will not occur before beginning adoption planning. Delays are also noted in the transfer of cases within agencies from ongoing caseworkers to adoption caseworkers, and the absence of complete information in agency case records makes these transitions more difficult. High levels of staff turnover also appear to impact outcomes for adoptive families after placement. Berry (1997) and McRoy (1999) determined that discontinuities in casework services, brought about by frequent changes in caseworkers and shared casework responsibility by more than one agency, were associated with higher rates of adoption disruption and dissolution.

A lack of collaboration between the courts and both public and private child welfare agencies has been repeatedly identified as a significant barrier to

permanence for children in the child welfare system (Pew Commission on Children in Foster Care, 2004; Macomber et.al., 2004; Children and Family Research Center, 2004.) Macomber et.al. (2004) cited delays in conducting TPR hearings as one of the top five barriers to permanence. Terminating parental rights requires close collaboration and communication between child welfare agencies and courts, particularly around decisions to terminate parental rights. Since agencies and courts may have different perspectives on what constitutes a child's best interests, timely permanency planning can be hindered without such collaboration. (Macomber et.al., 2004). This can be impacted by parents' requests for additional time to pursue reunification, a court's reluctance to terminate parental rights without first identifying an adoptive home for the child, or when agency services have not been sufficient to address parents' problems and needs. These challenges are intrinsic in a system designed to assure and balance the rights of both children and their birth families (Macomber et.al., 2004.)

Most factors that undermine collaboration between courts and child welfare agencies are amenable to resolution through team building and collaborative planning. These factors include differences in organizational mission, structure, operating policies and procedures, and organizational cultures, as well as a lack of formal systems to assure effective communication and collaboration by both managers and line staff. Groza (1999) also identifies turf issues, excessive work demands, and lack of training to develop skills in teamwork as undermining

collaboration. Experience has shown that formal collaboration projects between agencies and courts to address many of these barriers are not only possible, but can have significant positive impacts on permanency outcomes for children (Pew Commission on Children in Foster Care, 2004).

Lack of Health Care, Mental Health, Developmental and Supportive Services

A second barrier to adoption success is an inability by many adoptive families to access specialized services and resources for their children. The health care, developmental, and mental health needs of adopted children can vary greatly, depending on their age at the time of adoption, their circumstances prior to adoption, the degree to which they have experienced physical abuse, neglect, sexual abuse, and other developmental trauma, their physical and mental health histories, and the physical and mental health histories of their birth parents. Children who are adopted from foster care and children adopted internationally may have more complex health, developmental, and mental health needs than other adopted children (Groza & Ryan, 2001; Casey Family Services, 2003b; Groze, 1996; Rosenthal, 1993; Barth & Berry, 1988).

Many researchers have documented a high prevalence of health, mental health, and developmental problems in children removed from their families as a result of child maltreatment (American Academy of Pediatrics, 2002; Simms, Dubowitz,

& Szilagyi, 2000; Simms, Freundlich, Battistelli, & Kaufman, 1999; Simms & Halfon, 1994). These children's more extensive health care, mental health, and developmental needs are often the result of the physiological and developmental effects of child abuse and neglect (Kools & Kennedy, 2003; Simms, Dubowitz, & Szilagyi, 2000; Rycus & Hughes, 1998). Many children in foster care have chronic health conditions such as asthma, malnutrition, skin abnormalities, dental problems, and vision and hearing problems. Some have experienced the long-term developmental sequelae of chronic neglect or failure to thrive, and others have sustained permanent injuries or disabilities as a result of physical abuse (American Academy of Pediatrics, 2002; Hanson, Mawjee, Barton, Metcalf, & Joye, 2004; Leslie, Kelleher, Burns, Landsverk, & Rolls, 2003; Simms et. al., 2000; Simms et. al., 1999; Rycus & Hughes, 1998; Hughes & Rycus, 1998; Simms et. al., 1994). A history of child sexual abuse is a significant contributor to potentially long-standing emotional trauma and a variety of behavior and attachment problems (Smith & Howard, 1999). The number of children affected by prenatal drug exposure, mental health, developmental, and physical health problems appears to have increased over time; an estimated 60-80% of children currently in foster care placement come from families affected by drugs or alcohol; 11% are developmentally disabled; and 18% have learning disabilities (Casey Family Services, 2003b).

Many children adopted internationally appear to have comparable health care and mental health needs as children adopted from the U.S. foster care system (Groza & Ryan, 2001). Their needs may not be immediately evident because accurate or complete health histories or records may not be provided (Simms & Freundlich, 2004). Prior to adoption, many international adoptees are cared for in institutional settings, where their physical, developmental, and emotional needs are often not adequately met (National Adoption Information Clearinghouse, 2001), resulting in potentially significant developmental delays and emotional problems in these children (Groze & Ileana, 1996; Judge, 2003). Some internationally adopted children are also affected by drug or alcohol abuse by their biological parents. Many adoptive parents have expressed concerns that their children's health care needs were not identified or communicated to them prior to adoption, and they have faced considerable financial and other post-adoption challenges in meeting their children's needs (Groze & Ileana, 1996).

The literature consistently reports that behavioral and emotional problems of many adopted children pose considerable challenges for their adoptive families, and have been repeatedly identified as the single largest source of stress in families who adopt older children and children with special needs (Rosenthal & Groze, 1990; Rosenthal, 1993; Smith & Howard, 1999; Groza, 1999; Casey Family Services, 2003b). In one study, Rosenthal and Groze (1992) determined that 41% of children in adoptive placement who were older or had special needs received

scores on standardized child behavior measures that were comparable to scores received by children in mental health treatment. One researcher determined the incidence of emotional, and developmental problems among children in care, including depression, conduct disorders, difficulties in school, and impaired social relationships, to be three to six times greater than the incidence of these problems among children not in care (Casey Family Services, 2003b). Further, adopted children who have experienced traumatic separations and out-of-home placement often struggle with feelings of loss, grief, and anxiety, which may manifest themselves in behavior problems and ambivalent attachments (Smith & Howard, 1999; Casey Family Services, 2003b.) Children adopted from the child welfare system also have higher risk of diagnosis of attention deficit and learning disorders. Unfortunately, the research also indicates that many children do not receive the health care or mental health services they need (Casey Family Services, 2003b).

Accessing specialized health care and mental health services for adopted children is a significant challenge for their adoptive parents. Even though national organizations and advocacy groups have worked diligently to increase availability, quality, and access to mental health services for children and families, the availability of adoption-competent clinicians and service providers remains very limited (Casey Family Services, 2003b). Further, while some children adopted from foster care may be entitled to federal and state funded

Medicaid benefits, most adoptive families must rely on their own resources or private health insurance to cover the costs of their children's medical and mental health treatment. Moreover, there are no federal mandates requiring the government to provide health insurance or support services for children adopted privately or internationally.

Children who qualify for Title IV-E adoption assistance automatically qualify for Medicaid, and ASFA permits states to provide medical assistance through a State program, if medical and mental health benefits are equivalent to those of Medicaid (P.L. 105-89, Section 306). States may also provide benefits for children not eligible under Title IV when a current Adoption Assistance Agreement is in place (Code of Federal Regulations, 42 CFR § 435.227). States monies may also be used to finance adoption assistance programs for children adopted from foster care who are ineligible for federal adoption assistance. Unfortunately, neither federally funded nor state funded programs always provides adequate access to health care services for adopted children. Many health insurance plans, including Medicaid, limit the scope of medical and mental health coverage. Children with special needs often require intensive physical and mental health services that exceed the coverage limits of health plans.

The High Cost of Ignorance

Knowledge gaps comprise a third category of barriers to successful adoption outcomes. There is an extensive professional literature related to all aspects of adoption, which has increased significantly as the adoption of children with special needs has become a central focus of adoption practice. In spite of the availability of this information, knowledge gaps are still evident and have the potential to significantly impact adoption outcomes, even though they may not be fully recognized or appreciated. Their impact on children, on adoptive families, and on the professionals who serve them is a topic in need of more rigorous inquiry.

The Empirical Basis of Adoption Practice

A large body of adoption-related research and literature has been compiled over many decades of study. Even so, adoption professionals suggest that the empirical base underpinning adoption practice still leaves many important questions unanswered (Brodzinsky, 1993; Groza, 1999; Casey Family Services, 2003b).

A primary goal of adoption research is to isolate the variables that either support or impede the achievement of desired outcomes for adopted children and adoptive families. Yet, much of the adoption research has focused on three

outcome variables – parental satisfaction with the adoption, rates of adoption disruption (termination before finalization) or rates of dissolution (termination after finalization) (Smith & Howard, 1999; Groze, 1996). The majority of adoptive families report high levels of satisfaction with their adoptions (Howard & Smith, 2003; Rosenthal & Groze, 1994), and rates of disruption range, on average between 10-15% for children placed when older, and less for infants and young children (Rosenthal, 1993; Casey Family Services, 1993; Barth & Berry, 1988; Goerge, 1995). Based on these criteria, most adoptions appear to have overwhelmingly successful outcomes (Groze, 1999).

Yet, research also indicates that a significant percentage of families and children in all types of adoptions experience considerable stress, and many continue to deal with complex and difficult developmental challenges long after the adoption has been finalized (Casey Family Services, 2003b; Smith & Howard, 1999). The specific long-term outcomes related to family and child functioning, and the factors that influence them, have not been as well researched. Moreover, parental satisfaction ratings do not appear to be correlated with objective ratings of child or family outcomes, but may instead reflect the parents' perceptions of success when measured against their personal expectations (Rosenthal, 1993; Casey Family Services, 2003b.)

Lack of consistency in defining research populations has been identified as a problem in adoption research. For example, some studies combine disruption, displacement, and dissolution together into a single category, making it impossible to determine whether different variables and dynamics contribute to termination of adoptions in different circumstances and at different times (Evan B. Donaldson Institute, 2004). Inconsistent definitions of "special needs" also contribute to potential lack of clarity. The category of "special needs" originally represented a child's eligibility for federal funding and was based on the expected level of difficulty in finding an adoptive family for the child unless a subsidy was provided. However, in general practice, the term has assumed a broader connotation, essentially having replaced the presumptive and less hopeful moniker of "unadoptable." In this sense, the "special needs" category includes all children with emotional, cognitive, or developmental delays, behavioral problems, health conditions, physical disabilities, sibling groups, children of color, and "older" children (although the definition of an "older" child has changed since the 1960s, when two-year-olds were considered "older" children), irrespective of whether subsidies are provided. The term "special needs" has also been used to refer to children served by public child welfare agencies, based on the presumption that prior maltreatment predisposes them to a range of exceptional service needs. Because of the wide differences among children defined as having "special needs," research samples that are presumed

to be comparable may very well not be (Evan B. Donaldson Institute, 2004; Smith & Howard, 1999).

A variety of methodological problems in adoption research have been identified as limiting the generalizability of findings beyond each particular study's sample. Several authors have identified sampling problems in adoption research, including reliance on small, non-randomized and non-representative "snapshot" samples, subjects from a single geographic area, or "convenience" samples of volunteers (Brodzinsky, 1993; Evan B. Donaldson Adoption Institute, 2004; Groza, 1999). Other methodological problems include failure to employ control or contrast groups (Brodzinsky, 1993); a lack of common definitions for terminology, adoption constructs, or for adoption outcomes (Evan B. Donaldson Institute, 2004); and a reliance on retrospective, cross-sectional, and ex post facto study designs, which can effectively describe and identify trends, but which cannot discern correlates nor the reciprocal effects of study variables (Groza, 1999; Berry, 1992). Many adoption research studies do not use standardized, reliable, and well-validated measurement instruments and protocols, making it difficult to determine the validity of study findings (Evan B. Donaldson Adoption Institute, 2004; Brodzinsky, 1993) or to compare results across studies.

Inconsistencies and limitations in data collection strategies may also reduce the utility of research data. Much adoption research has relied on the case study

approach, the use of questionnaires and surveys, and personal interviews with study respondents. While these methods often provide valuable descriptive detail, they lack the scientific rigor necessary to support generalization of findings (Groza, 1999; Brodzinsky, 1993.) Some studies have relied on the secondary analysis of case records as the primary data source. However, these records may reflect the biases of the recorder, and may not include data specific to the research questions, as they are designed for a different purpose (Groza, 1999).

Finally, research on specific therapeutic interventions and their impacts on adoption outcomes for particular types of children and families has also been limited. For example, while contemporary adoption practice advocates family-centered approaches to working with adoptive families, little research has compared outcomes of traditional child-centered therapeutic approaches and those achieved by family-centered models (Groze, 1999). Similarly, while there are many purported benefits of support groups for adoptive families and children, there has been little empirical examination of the role of such groups in improving family situations (Smith & Howard, 1999). There is even less information about families and children who choose not to seek services and who do not follow up on referrals, or who quickly drop out of services offered (Rushton & Dance, 2002).

In short, in spite of rather extensive adoption literature, there is limited empirical knowledge about the correlates and causes of adoption success or failure, the conditions that promote successful adoption outcomes, pre-existing conditions in children and families that contribute to different outcomes, or the types of services and programs best suited to promote desired outcomes for children with different circumstances and needs. Therefore, while the available research is very useful in increasing our understanding of adoption dynamics, and can provide a strong foundation on which to build additional research, the utility of study findings in guiding the selection of appropriate interventions for individual children and families remains limited. A more targeted research agenda is needed that refines research studies to address high priority practice questions.

Unconscious Incompetence

The concept of "blissfully ignorant" is old and generally well recognized. Some of its more recent manifestations appear in communication theory (Howell, 1986) and inservice training theory (Caplan & Curry, 2001; Pike, 1989). Unconscious incompetence in professional practice is characterized by the lack of ability to perform a job in accordance with best practice principles and standards, while not recognizing a need for further development. Even very experienced and well-intentioned practitioners who are committed to the best interests of their

clients can be unconsciously incompetent. They may lack essential knowledge and skill, may fail to recognize or fully understand critical issues, may rely on known and comfortable intervention strategies even when they don't work very well, and may attribute a lack of progress to organizational barriers, or even to client behaviors or characteristics, while remaining unaware that their own actions may be contributing to less than successful outcomes. Unconscious incompetence is frequently exacerbated by insufficient formal education and training in job-critical competencies, and a lack of regular coaching and performance feedback (Caplan & Curry, 2001; Rycus & Hughes, 1998; Hughes & Rycus, 1989).

In spite of significant changes in the theory and philosophy underpinning the adoption field, both professional practice and the public's understanding of adoption may still be subtly impacted by a history of myth, misconception, secrecy, and denial in relation to adoption issues (Keefer & Schooler, 2000; Smith & Howard, 1999). For several decades, adoption practice consisted largely of placing newborn infants of unwed mothers with childless couples in a manner intended to approximate biological parenthood. The goal was to eliminate any visible indicators of difference. Adoptive parents were carefully matched to infants based on a variety of physical and social characteristics, and while many parents were given some background information, it was generally sparse and was often modified to eliminate negative inferences about the birth parents and

circumstances of relinquishment. After a brief obligatory period of agency supervision, families were discharged to function on their own and were encouraged to become "just like any other family." In this environment, continued agency involvement was generally an indication that something was wrong (Smith & Howard, 1999).

This expectation of conformity and invisibility has changed as adoption professionals have debunked these assumptions, as we better understand the importance of realistic expectations and informed decision-making, and as we recognize the potential benefits of various degrees of openness in many adoptions. However, elements of secrecy and denial may still exist, particularly when practitioners and adoptive families have not been appropriately prepared. In a study of 288 adoptive families conducted in the early 1990s, fewer than 40% had given their children complete information about their backgrounds, and over 25% of the families had falsified or omitted information. The majority of the remaining families had provided little or no background information, or had never told their children about the adoption at all (Keefer & Schooler, 2000.) Many people still believe it to be in a child's best interests to minimize or avoid dwelling on the facts or circumstances of adoption, in spite of considerable research that describes the detrimental consequences of secrecy and denial on the long-term well-being of many adoptees (Keefer & Schooler, 2000.) Typical concerns include a fear of creating a negative self image in the child or a self-

fulfilling prophesy of negative behavior, reopening painful wounds, and of upsetting a child unnecessarily. In response to subtle cues from the adults around them, children may suppress their feelings and avoid asking questions, further reinforcing their parents' contentions that their children are really not all that interested (Keefer & Schooler, 2000.) However, adopted children who suffer the greatest distress tend to be those who employ cognitive and behavioral avoidance strategies in attempting to cope with their negative feelings (Brodzinsky, 1993).

It is easy to see how unconscious incompetence can impact professional approaches to work with adoptive children and families. Professionals who do not understand adoption dynamics may not recognize when adoption issues are contributing to identified problems, particularly when these problems emerge long after the adoption has been finalized. Clinicians may fail to recognize or deal with a child's depression or anxiety derived from past trauma, or a youth's identity issues, or a child's delayed social and emotional development, even though these may be primary contributors to more obvious behavior and attachment problems. Some clinicians may not know to ask whether their clients have adoption histories, and this is rarely queried on intake or social history forms. Some families report when they have tried to focus a counselor's attention on the contribution of adoption issues to current problems, their counselors perceive this as inappropriately blaming the child for family

problems (Smith & Howard, 1999). Moreover, professionals who see their primary role as a child advocate may not recognize how attributing problems to parental failures rather than to a child's disruptive behaviors or other child-related stressors can undermine parental empowerment and entitlement, both of which are essential to effective adoptive parenting (Evan B. Donaldson Institute, 2004; Rosenthal, 1988). Caseworkers who are unaware of the impact of a child's lack of knowledge or distorted perceptions of adoption may simply support youth who claim they don't want to be adopted, rather than helping them acquire accurate knowledge, exploring their misperceptions, and helping them realistically and objectively consider all possible options. The absence of adoption-competent professionals in a variety of disciplines has been an important factor behind the move to develop post-adoption services for adoptees and their families, which are accessible to them throughout life (Smith & Howard, 1999; Groze, 1996).

Unconsciously incompetent professionals may also fail to understand the harmful effects of their personal practices or their organizations' policies and routines. Agencies may not understand how culturally insensitive policies may undermine their efforts to recruit and retain minority adoptive families. School teachers may ask children to develop family trees or genealogies, unaware that this may trigger adoption issues for some children. Physicians may treat children for attention deficit disorder or hyperactivity without recognizing that

placement-related anxiety or emotional distress emanating from past trauma may underlie a child's inattentiveness, learning problems, and behavior disorders. And, courts and child welfare agencies may not fully understand the detrimental consequences on children and families of discontinuities and delays resulting from lack of inter-agency collaboration.

As indicated earlier, a lack of formal training contributes significantly to unconscious incompetence in all professions (Caplan & Curry, 2001).

Unconscious incompetence may prevent many professionals from seeking or receiving the specialized training they need to work effectively with adoptive families and children, not only in essential knowledge and skills related to their own disciplines, but in those related to collaborating disciplines as well. Further, failure by professionals to recognize the wide range of educational, developmental, and support needs of adoptive families may contribute to insufficient pre-placement education and preparation, as well as an over-reliance on mental health or counseling interventions to address children's developmental and behavior problems, rather than providing families with ongoing programs of skill development in a variety of competencies related to family development, parenting, and child management interventions.

Not all professionals should be expected to become specialists in adoption related practice. However, professionals in all disciplines must be willing to

recognize when personal knowledge and skill deficits may be affecting the quality or effectiveness of their interventions with adopted children and their families. Professionals must also recognize the need of many families for specialized, adoption-competent services, and help them locate and access these services.

Crisis Theory, Knowledge Gaps, and Impacts on Adoption

Crisis intervention theory originated in the field of psychiatry in the 1960s. It was prompted by clinical observations that anxiety, depression, and other emotional symptoms previously thought to be signs of pathology could also be normal reactions to situations of overwhelming stress (Hill, 1965; Rapoport, 1965). Crisis theory contends that crisis results from an interplay between three factors: a stressor event, usually involving a significant loss or threat; an individual's coping strategies and the resources and supports available to mitigate the stressor; and an individual's perception or interpretation of the meaning of the event. Clinical crisis develops when stressors are (or, are perceived to be) sufficiently intense that one's coping strategies cannot resolve or eliminate them. The typical psychological response to stressors that involve a real or perceived loss is depression. The typical response to stressors that involve a real or perceived threat is anxiety. Therefore, people in clinical crisis typically

experience overwhelming and frequently debilitating levels of anxiety and depression.

Lack of knowledge can be a primary contributor to crisis, as it can impact all three components of the crisis paradigm. The unknown is universally stressful, and contrary to the popular adage, what we don't know can hurt us. Not knowing what to expect or how to negotiate in a strange, unfamiliar environment is fundamentally very threatening. Lack of knowledge prevents people from accurately assessing situations and choosing the best coping strategy. People cannot apply specialized coping skills if they haven't learned and mastered them, or if they don't know they exist. Lack of knowledge also tends to promote the development of unrealistic or distorted perceptions of the meaning of a stressor event.

Impact of Lack of Knowledge on Adoptive Families

Many of the stresses typically experienced by adoptive families can be greatly exacerbated by knowledge gaps. Results from several studies concur that failure to provide families with adequate information about a child's background, health and medical history, the events that have predisposed the child to emotional and behavioral problems, and the child's usual methods of coping, may be the strongest service-associated predictor of adoption disruption (Rosenthal, 1993;

Berry, 1997; Casey Family Services, 2003b; Smith & Howard, 1999). In several studies, parents reported they were not given essential information about the child, or, the information they received was incomplete, inaccurate, and even misleading (U.S. General Accounting Office, 2004). Many families contend they really didn't know what to expect, and in some cases, they hadn't fully understood the meaning or the ramifications of the information that had been provided to them (Donohue, undated; Rosenthal, 1993).

Even though the dynamics in each adoptive family are impacted by unique individual and family traits, it is easy to see how a lack of accurate knowledge about adoption can contribute to the development of unrealistic expectations, as well as to distorted perceptions of their own or their child's success or failure. Even though the myth of adoptive families being, in all respects, "just like other families" has been widely challenged, there remains a belief that love, time, and stability are sufficient to help children who have experienced prior trauma to recover and to heal, and that a family's typical and usual parenting strategies will be effective in promoting this recovery. With this perspective, a family's inability to meet their own expectations may lead them to conclude they have failed as parents, a conclusion which disempowers them, undermines their feelings of entitlement, and may reduce their stamina and commitment to continue. Such unrealistic expectations have often been associated with increases in adoption

stress and even with placement failure (Rosenthal, 1993; Casey Family Services, 2003b; Rycus & Hughes, 1998; Berry, 1992).

Pairing an adoptive family that has unrealistic expectations with a service provider who lacks understanding of adoption dynamics can exacerbate this problem. Parents may be led to feel that they are a significant part of the problem, are isolated and misunderstood, are unloved and rejected by their adopted children, and are fundamentally ineffective adoptive parents (Evan B. Donaldson Institute, 2004; Festinger, 1986; Casey Family Services, 2003b). The extent and depth of their distress and frustration may not become fully apparent to the professional community until the proverbial eleventh hour, by which time their distress has evolved to crisis levels and disruption or dissolution are almost inevitable (Donohue, undated; McRoy, 1999; Rycus & Hughes, 1998). Service providers who lack competence in adoption intervention and fail to recognize the impact of adoption dynamics on presenting issues or problems may fail to intervene appropriately or early enough, thereby exacerbating these problems rather than helping to resolve them.

The adoption literature also contends that adoptive parents are rarely adequately prepared by child placing agencies to parent children with challenging special needs (Smith & Howard, 1999; Casey Family Services, 2003b; Groze, 1996).

While being given thorough and accurate information is essential, it is not

sufficient to help families develop realistic expectations in very complex situations. Deeper levels of understanding necessary to promote realistic expectations can only be derived from personal experience. Adequate preparation must involve providing adoptive families with opportunities to develop a repertoire of skills to cope with the many challenges they are likely to encounter. This includes learning how to access services and other supportive resources that can provide needed assistance. It also includes helping families acquire specific approaches to parenting and behavior management that are best suited for their child's temperament, level of development, and special circumstances. Many families must learn specialized strategies to parent children whose challenging and inappropriate behaviors are primarily manifestations of delayed cognitive, social, or emotional development. Other families will need special skills to parent children with identifiable developmental disabilities, serious medical conditions, or emotional disturbance (Rycus & Hughes, 1998). The social work profession recommends intensive preservice and ongoing inservice training for milieu therapists in residential facilities, as well as for families providing specialized treatment foster care. However, we often fail to acknowledge adoptive families as structured milieus in which adopted children can work through the residual effects of past history and trauma, and develop more effective ways of experiencing and interacting with their world. One of our professional failures has been in not providing

adoptive families with the specialized knowledge and skills they need to facilitate this goal for their children.

The Uninformed Child

As with adults, a lack of knowledge and limited understanding of the realities of adoption can impact children's experience of stress, their ability to cope, and their interpretations of their adoption experience. In general, children's limited capacity to make sense of their complex histories and circumstances renders them more susceptible to high levels of emotional distress, distorted perceptions, and a reduced capacity to cope with change. Young children, particularly, may blame themselves and their actions for traumatic events that are beyond their control, and this self-blame often persists in spite of repeated reassurances that they are not at fault (Rycus & Hughes, 1998). For these reasons, children's expectations of and adjustment to adoption can be colored by their unique interpretations of their past experiences, as well as by a lack of accurate knowledge about adoption, or a reliance on misinformation.

Adoption generally represents a significant change in a child's life and creates the potential for increased stress and crisis for many children, especially those who are adopted by families previously unknown to them. For most children, new environments are potentially threatening simply because they are

unfamiliar. Moreover, the fact of moving can reaffirm once more that families are not permanent, and simply labeling this move "adoption" cannot always convince them that it will be their last move. Further, children who have experienced physical or sexual abuse, severe neglect, traumatic separations, and multiple placements may have already experienced unresolved crises in their lives, which can make them more vulnerable to future crises with less provocation (Hill, 1965; Rapoport, 1965). Their resulting feelings of grief, depression, and anxiety in response to both real and perceived losses and threats may continue well beyond the actual events that precipitated them. These children's adjustment to adoption may be strongly impacted by their responses to past crises, how they interpret adoption, and by the coping strategies they employ. When children view adoption as threatening, stigmatizing, or involving additional significant losses, they are likely to experience confusion, anxiety, sadness, and anger (Brodzinsky, 1993). Their capacity to cope with these changes is further limited by their underdeveloped cognitive capacities. For most children, the lack of even fundamental problem solving skills renders them helpless and vulnerable when they are deprived of their primary coping resource – reliance on stable, predictable, trusted adults in their lives.

For the above reasons, children typically need intensive preparation for adoption in much the same manner as their adoptive families. Their expectations and misperceptions must be explored, and they must be provided with accurate and

complete information about how adoption will impact them, their relationships with siblings and other members of their biological families, and the nature of the adjustments they will face. However, simply hearing this information prior to placement is not sufficient to promote either an accurate understanding or realistic expectations of adoption. Ongoing opportunities to explore and consider important issues is critical. For children, "adjusting" to life in an adoptive family generally involves learning new ways of thinking, behaving, and relating to others, and often requires them to significantly revise their expectations of parents, families, and themselves. It is not realistic to expect most children to master these challenges without assistance.

Finally, children's levels of awareness, perceptions of their adoption, and the scope of information they can assimilate will change as they mature. For this reason, their birth histories and the circumstances surrounding their adoption, including the reasons for being "given up" by their birth families, must be revisited throughout each child's life. Issues take on different scope and meaning as children's cognitive capacities develop (Rycus & Hughes, 1998), and achieving a realistic perspective of adoption and its impacts often takes many years of ongoing discussion and consideration (Keefer & Schooler, 2000.) By providing adequate and accurate information, increasing children's understanding of themselves and their circumstances, and teaching them more effective ways of

coping, we can help strengthen their adjustment to adoption, both as children and in adulthood (Keefer & Schooler, 2000).

Confronting Adoption Barriers: Potential Solutions and Promising Practices

The contemporary adoption literature describes a variety of creative and promising initiatives and strategies designed to address many of the barriers discussed in this article (Macomber et.al., 2004; Evan B. Donaldson Institute, 2004; Children and Family Research Center, 2004; Casey Family Services, 2003b; Howard & Smith, 2003; Freundlich & Wright, 2003; U.S. General Accounting Office, 2002; Festinger, 2001; Keefer & Schooler, 2000; Smith & Howard, 1999; McRoy, 1999; Groze, 1996; Center for the Future of Children, 1993; Rosenthal, 1993; Barth & Berry, 1988). Although further evaluation of many of these programs is needed, they demonstrate that even long-standing and complex barriers to adoption can be challenged and potentially modified.

Based upon information in the adoption literature and the authors' own experiences and conclusions, the following strategies are offered to further reduce or eliminate many of the identified barriers to adoption success.

- 1) Researchers and practitioners should collaborate at the national and international levels to construct a research agenda that identifies,

prioritizes, and seeks to answer critical adoption-related questions, in order to build a stronger empirical base for adoption practice. Adoption research should be subjected to systematic review to identify the most empirically sound intervention strategies to promote desired outcomes.

- 2) It must be recognized that adoption is a highly specialized field of practice in the child welfare profession, and that unique knowledge and skills are needed by researchers, administrators, and direct service practitioners in all disciplines that serve adopted children and their families, as well as by the families and children who are impacted by adoption.
- 3) Professionals must recognize that intractable, large-scale system barriers are often complicated composites of many smaller, less pervasive obstacles at the practitioner, agency, interagency, and community levels, that are often more amenable to change. Professionals should be aware that early intervention may prevent smaller obstacles from evolving into larger, more complex, and more damaging barriers.
- 4) Organizations should commit staff time to identify barriers within each service system, and should expect staff to make recommendations to alter policies and practices that are, themselves, barriers to adoption success. Organizations should create and support problem-solving task forces to

address critical issues related to training, inter-agency collaboration, policy and procedures, adoptive family development, and community education.

- 5) Adoptive and foster families should be empowered and involved as partners in evaluating systemic barriers to successful adoption and in devising strategies to overcome them.

- 6) Adoption professionals should shift the paradigm from adoptive family "recruitment and assessment" to adoptive family "identification and development." An expectation should be established that adoption is a life long process that requires a variety of skills to deal with developmental changes over time. Agencies and communities should provide a variety of continuing education opportunities to all adoptive (and foster) families. In addition to classroom training, families should be provided with opportunities for self-directed learning, small group skill building, and in-home coaching and mentoring provided by skilled adoption specialists and/or experienced adoptive parents. Families should also be given opportunities to experience caring for children who have special needs by serving as volunteers, foster parents, or respite care providers before they are expected to assume full responsibility for parenting adopted children. These interventions should be evaluated to

determine their impact on retention of applicant families, the capacity of families to cope with adoption challenges, families' ability to meet their children's needs, the quality of family life, and developmental outcomes for children.

- 7) Children should be fully prepared for adoption and should be empowered to consider their options and contribute to making choices about their futures in a manner consistent with their developmental level. Placement strategies should be designed to minimize children's stress, to increase their capacity to cope with changes and challenges, and to elicit and help them modify their misperceptions and unrealistic expectations.

- 8) Professionals responsible for developing post-adoption services should consider that the most effective long-term support systems for adoptive families often exist in the families' own networks of extended family, friends, and communities, and professionals should help adoptive families build a variety of support services into these environments. Families should be enabled and supported in creating and operating their own community based support groups, respite networks, and buddy systems. Further, the development of community based adoption resource centers, based on models of "wraparound services," "one stop shopping" and "children's advocacy centers" currently being developed to

serve maltreated children and their families should also be considered.

Training should be provided to persons and groups who serve as naturally-occurring supports and resources, such as pastors and school guidance counselors, to recognize and respond to the needs of adopted children and their families.

- 9) Adoption specialists should be identified within all disciplines and should be trained to provide assistance to adopted children and their families.

This includes well-trained judges to preside over permanency hearings for abused and neglected children, attorneys to help families negotiate the maze of interjurisdictional or interstate adoption law, educators who can work with adoptive families to devise consistent approaches to individualized education and child management in school and at home, mental health clinicians who can help children deal with residual effects of past psychological trauma, skilled trainers to educate families in essential competencies to cope with changes in family dynamics brought about by adoption and to more effectively manage their children's behaviors, physicians to meet the health care and developmental needs of adopted children, and child welfare practitioners to serve as consistent case managers to guide cases from identification of a need for permanency planning to finalization of a permanent home through reunification, guardianship, or adoption.

- 10) All interventions on behalf of adopted children and families should be evaluated, and reliable data should be collected and compiled to contribute to the empirical base to determine the interventions that work best to achieve desired outcomes for children and families. Program evaluation data should be used both to identify promising practices, and to generate research to more definitively establish the effectiveness of these practices.

Eliminating barriers to successful adoption is the shared responsibility of professionals in many service systems and disciplines. For all professionals, our first responsibility is recognizing and acknowledging when our personal actions, our lack of knowledge, or our organizations' structures and processes are, themselves, barriers to adoption success, and making a commitment to modify or eliminate these conditions. If we can all address the intra- and inter-system barriers within our own disciplines and organizations, we may collectively be able to strengthen adoption services, make all systems more responsive and adoption-competent, and ultimately promote more effective outcomes for adopted children and their families.

The authors would like to acknowledge Susan Yingling and Quyen Le for their assistance in conducting the research for this article.

References

- American Academy of Pediatrics. (2002). Health care of young children in foster care. *Pediatrics*, 109 (3), 536-541.
- Avery, R. & Ferraro, R. (1997). Unequal treatment: Adoption subsidy support in New York state." *Adoption Quarterly*, 1(2).
- Barth, R.P. & Berry, M. (1988). *Adoption and disruption: Rates, risks, and responses*. New York: Aldine de Gruyter.
- Barth, R.P. & Berry, M. (1991). Preventing adoption disruption. *Prevention in Human Services*, 9, 205-222.
- Bartholet, E. (Spring, 1993). International adoption: Current status and future prospects. *Future of Children: Adoption*, 3(1), 89-103.
- Berry, M. (1997). Adoption disruption. In R.J. Avery (Ed.), *Adoption policy and special needs children*, 77-106. Westport, CT: Auburn House Press.
- Berry, M. (1992). Contributors to adjustment problems of adoptees: A review of the longitudinal research. *Child and Adolescent Social Work Journal*, 9(6), p. 525-540.
- Brodzinsky, D. (1993, Spring). Long-term outcomes in adoption. *Future of Children*, 3(1), 153-162.

- Brodzinsky, D. & Steiger, C. (1991). Prevalence of adoptees among special education populations. *Journal of Learning Disabilities, 24*(9), 484-489.
- Caplan, P. & Curry, D. (2001). *The wonder years: Professional development in child welfare*. 2001 Finding Better Ways Conference Presentation Recap. Washington, DC: Child Welfare League of America.
www.cwla.org/programs/treichman/2001fbwDaleCurry.htm
- Casey Family Services. (2003). *Creative strategies for funding post-adoption services*. New Haven, CT: Author.
- Casey Family Services, Casey Center for Effective Child Welfare Practice. (2003, October). *Strengthening families and communities: Promising practices for adoption-competent mental health services: A white paper*. New Haven, CT: Author. www.caseyfamilyservices.org/pdfs/casey_mhpaper_sum.pdf
- Center for the Future of Children (1993, Spring). *The Future of Children: Adoption* 3(1). Los Angeles: Center for the Future of Children, The David and Lucille Packard Foundation.
- Children and Family Research Center, Fostering Results. (2004, July). *View from the bench: Obstacles to safety & permanency for children in foster care. Summary of key findings from a national survey of dependency court judges*. Urbana-Champaign, IL: School of Social Work, University of Illinois at Urbana-Champaign. www.fosteringresults.org

- Dobbin, S.A., Gatowski, S.I., & Maxwell, D.M. (2004). *Building a better collaboration: Facilitating change in the court and child welfare system*. Reno, NV: National Council of Juvenile and Family Court Judges, Permanency Planning for Children Department.
- Donahue, P. (undated). Disruptions: A little understanding goes a long way. *The mental health challenge of special needs adoption: A resource book for working with adoptive families*. OR: Children's Psychiatric Day Treatment Center, Oregon Health Sciences University. 91-95.
- Evan B. Donaldson Adoption Institute. (2004, November). *What's working for children: A policy study of adoption stability and termination*. New York: Author. www.adoptioninstitute.org/publications/Disruption_Report.pdf
- Festinger, T. (1990). Adoption disruption. In D.M. Brodzinsky & M.D. Schechter (Eds.), *The psychology of adoption* (pp. 254-273). New York : Oxford University Press.
- Festinger, T. (2001). *After adoption: A study of placement stability and parents service needs*. New York: Shirley M. Ehrenkranz School of Social Work, New York University.
- Festinger, T. (1986). *Necessary risk: A study of adoptions and disrupted adoptive placements*. Washington, DC: Child Welfare League of America.

- Freundlich, M. (2000). *Adoption and ethics: The market forces in adoption*.
Washington, D.C.: Child Welfare League of America.
- Freundlich, M. & Wright, L. (2003). *Post Permanency Services*. Washington, D.C.:
Casey Family Programs.
- Frogue, J. (2004). *Medicaid reform: Getting the incentives right*. Minneapolis, MN:
American Legislative Exchange Council.
- Ghose, D. (2002). *Health insurance for adopted children*.
www.adoptioninformation.com/resources/article/012802a.htm
- Goerge, R.M., Howard, E.C., Yu, D. & Radomsky, S. (1997). *Adoption disruption
and displacement in the child welfare system, 1976-1994*. Chicago: Chapin Hall
Center for Children, University of Chicago.
- Groh, A., & Kroll, J. (Summer, 2001). New adoption tax credit signed into law
[Electronic Version]. *Adoptalk*.
<http://www.nacac.org/policyarticles/newtaxcredit.html>
- Groza, V. & Rosenberg, K. (1998). *Clinical and practice issues in adoption: Bridging
the gap between adoptees placed as infants and as older children*. Westport, CT:
Praeger.

- Groza, V. & Ryan, S. (2002). Pre-adoption stress and its association with child behavior in domestic special needs and international adoptions. *Psychoneuroendocrinology* 27, 181-197.
- Groza, V. (1999). Innovations in Adoption. In D. Biegel & A. Blum (Eds). *Innovations in practice and service delivery across the lifespan*. New York: Oxford University Press. p. 79-101.
- Groze, V. and Ileana, D. (1996). A follow-up study of adopted children from romania. *Child and Adolescent Social Work Journal*, 13, 6, pp. 541-565.
- Groze, V. (1996). *Successful adoptive families: A longitudinal study of special needs adoption*. Westport, CT: Praeger.
- Groze, V. (1996). A 1 and 2 year follow-up study of adoptive families and special needs children. *Children and Youth Services Review*, 18(1/2) p. 57-82.
- Hanson, R., Mawjee, F., Barton, K., Metcalf, M. & Joye, N. (2004). Comparing the health status of low-income children in and out of foster care. *Child Welfare*, 83(4), 367-380.
- Hill, R. (1965). Generic features of families under stress. In H. Parad (Ed.). *Crisis intervention: Selected readings*. NY: Family Service Association of America. 32-52.

- Howard, J. & Smith, S. (2003). *After adoption: The needs of adopted youth*.
Washington, DC: Child Welfare League of America.
- Howell, W. (1986). *The empathic communicator*. Prospect Heights, IL: Waveland.
- Hughes, R.C., and Rycus, J.S. (1989). *Target: Competent staff. Competency-based inservice training for child welfare*. Washington, D.C.: Child Welfare League of America.
- Hughes, R.C. & Rycus, J.S. (1998). *Developmental disabilities and child welfare*.
Washington, DC: Child Welfare League of America, and Columbus, OH:
Institute for Human Services.
- Keefer, B. (1997). Helping foster families to adopt: Planning to break the barriers. *Changing Hats: Foster to Adopt*. Columbus, OH: Institute for Human Services.
- Keefer, B. & Schooler, J. (2000). *Telling the truth to your adopted or foster child: Making sense of the past*. Westport, CT: Bergin & Garvey.
- Kools, S. & Kennedy, C. (2003). Foster child health and development: Implications for primary care. *Pediatric Nursing*, 29 (1), 39-46.

Lewis, R.G. & Heffernan, M.S. (2000). *Adolescents and families for life: A toolkit for supervisors*. Gloucester, MA: High Popples Press.

Lutz, L. (2003). *Achieving permanence for children in the child welfare system: Pioneering possibilities amidst daunting challenges*. New York: National Resource Center for Foster Care and Permanency Planning, Hunter College School of Social Work.

Macomber, J., Scarcella, C., Zielewski, E.H., (2004). *Foster care adoption in the U.S.: A state-by-state analysis of barriers & promising approaches*.
www.urban.org/url.cfm?ID=411108.

McCarthy, J. (2002). *Meeting the health care needs of children in the foster care system*. Washington, DC: Georgetown University Center for Child and Human Development.

McDonald, T.P., Propp, J.R., & Murphy, K.C. (2001). The post-adoption experience: Child, parent, and family predictors of family adjustment to adoption. *Child Welfare*, 80, 71-94.

McGlone, K., Santos, L., Kazama, L., Fong, R., & Mueller, C. (2002). Psychological stress in adoptive parents of special-needs children. In Mallon, G. & Leashore, B. (Eds). *Contemporary issues in permanency planning*. Washington, DC: Child Welfare League of America.

McRoy, R. (1999). *Special needs adoptions: Practice issues*. New York: Garland Publishing.

National Adoption Information Clearinghouse (2004). *Adoption assistance for children adopted from foster care: A factsheet for families*. Washington, DC: US Department of Health and Human Services.

National Adoption Information Clearinghouse (2001). *Intercountry adoption*. Washington, DC: US Department of Health and Human Services.
http://naic.acf.hhs.gov/pubs/f_inter/f_interb.cfm

National Adoption Information Clearinghouse (2004, December). *Adoption disruption and dissolution: Numbers and trends*. Washington, DC: US Department of Health and Human Services, Administration for Children and Families, Children's Bureau.

North American Council on Adoptable Children (2004). *Forever families: support for families of children with special needs: A policy analysis of adoption subsidy programs in the United States*. St. Paul, MN: Author.

North Carolina Division of Social Services, and Family and Children's Resource Program (2004, December). Removing barriers to supportive post-adoption services. *Children's Service Practice Notes* (10)1, 1-4.
www.practicenotes.org/vol10_n1/removing.htm

- Oliver, S.R. (1996). *Developing collaborative efforts between foster care and adoption staff to improve child welfare services. Final report.* Washington, DC: National Adoption Information Clearinghouse.
- Oppenheim, E., Bussiere, A., & Segal, E. (2002). Adoption assistance for children with special needs. In J. Hollinger (Ed.), *Adoption law and practice.* Newark, NJ: Matthew Bender.
- Pew Commission on Children in Foster Care. (2004). *Fostering the future: safety, permanence and well-being for children in foster care.* Washington, D.C.: Georgetown University Public Policy Institute.
- Pike, R. (1989). *Creative training techniques handbook: Tips, tactics and how-to's for delivering effective training.* Minneapolis, MN: Lakewood Books.
- Proctor, C., Groza, V., & Rosenthal, J. (undated). *Social support and adoptive families of children with special needs.*
<http://msass.case.edu/faculty/vgroza/adoption/Reports/SSAFCSN.htm>
- Rapoport, L. (1965). The state of crisis: Some theoretical considerations. In H. Parad (Ed.). *Crisis intervention: Selected readings.* NY: Family Service Association of America. 22-31.
- Riggs, Diane (undated). *Denying Access to Black Families Hurts Children.* Adoption Network Law Center. <http://library.adoption.com/Resources->

and-Information/Denying-Access-to-Black-Families-Hurts-Children/article/3681/1.html

- Rosenthal, J.A. (1993, Spring). Outcomes of adoption of children with special needs. *The future of children*, 3(1), Spring, 77-88.
- Rosenthal, J. & Groze, V. (1994). A longitudinal study of special-needs adoptive families. *Child Welfare*, 73, 689-706.
- Rosenthal, J. & Groze, V. (1990, September.). Special-needs adoption: A study of intact families. *Social Service Review* 64(3), 475-505
- Rushton, A. & Dance, C. (2002). *Adoption support services for families in difficulty: A literature review and UK survey*. London: British Association for Adoption and Fostering.
- Rycus, J. & Hughes, R. (1998). *Field guide to child welfare. Volume IV, Placement and Permanence*. Washington, DC: Child Welfare League of America, and Columbus, OH: Institute for Human Services.
- Shur, W.M. (2002). Attorney's role in private agency adoption. In J. Hollinger (Ed.), *Adoption law and practice*. Newark, NJ: Matthew Bender.
- Simms, M., Dubowitz, H., & Szilagyi, M. (2000). Health care needs of children in the foster care system. *Pediatrics*, 106(4), 909-918.

- Simms, M. & Freundlich, M. (2004). Adoption. In R. Behrman, R. Kliegman, and H. Jansen (Eds.) *Nelson Textbook of Pediatrics*. 17th ed., Philadelphia, PA: Elsevier Health Sciences, 113-115).
- Simms, M., Freundlich, M., Battistelli, E. & Kaufman, N. (1999). Delivering health and mental health care services to children in family foster care after welfare and health care reform. *Child Welfare*, 78(I), 166-183.
- Simms, M. and Halfon, N. (1994). The health care needs of children in foster care: A research agenda. *Child Welfare*, 73(5), 505-525.
- Smith, S. & Howard, J. (1999). *Promoting successful adoptions: Practice with troubled families*. Thousand Oaks, CA: Sage Publications.
- U.S. Department of Health and Human Services. (2004). *The AFCARS Report*.
www.acf.hhs.gov/programs/cb/publications/afcars/report8.htm
- U.S. Department of Health and Human Services, Children's Bureau (2003, June/July). Study explores use, helpfulness of post-adoption services. *Children's Bureau Express*, 4(5)
http://cbexpress.acf.hhs.gov/articles.cfm?article_id=657
- U.S. Department of Health and Human Services, Children's Bureau (2000). Recruiting families for special needs children. *Children's Bureau Express*,

1(3), available at http://cbexpress.acf.hhs.gov/articles.cfm?issue_id=2000-05&article_id=85 (accessed 4/18/05).

U.S. Department of Health and Human Services. (2004). *Hague Convention on Intercountry Adoption*. www.travel.state.gov/family/hagueinfo2004.html

U.S. General Accounting Office. (2002, June). *Foster care: Recent legislation helps states focus on finding permanent homes for children, but long-standing barriers remain*. GAO-92-585. Washington, DC: Author.

U.S. House of Representatives, Committee on Ways and Means. (2004). *The 2003 green book*. Washington, D.C.: U.S. Government Printing Office.

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