PARTNERS: A Model Program for Special-Needs Adoptive Families in Stress

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That adoption status, once begun, does not end for any adoptive family, and that agencies must be ready to help adoptive families whenever needed, has been generally agreed. For families that adopt special-needs children, the availability of help at all times is imperative and involves special considerations. This article sets forth the kinds of services that are needed, and describes a program particularly designed for this purpose.

It is estimated that approximately 18,000 special needs children are adopted annually [Tatara 1988]. Families face enormous challenges and strains in adopting a special-needs child. The demands and stress accompanying the adoption of these children result in approximately one-fifth to one-fourth of the adoptive adjustments reported as unsatisfactory [Kadushin 1980; National Committee for Adoption 1985; Nelson 1985], and contribute to the approximately 10% or more of these adoptions that disrupt [USRE 1985; Festinger 1986; Groze 1986; Partridge et al. 1986; Barth and Berry 1988; Rosenthal et al. 1988].

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A major factor in the problem of disruption is the lack of therapy and mental health resources to support the adoptive family [Hurrell 1985; Barth et al. 1986; Tapan and Reid 1986]. Adoption is not a time-limited process, and adoption-related issues surface throughout the lives of the individuals involved in the adoption [Bourguignon and Watson 1987; Duhl 1986; Winkler et al. 1988]. Involvement with therapy and mental health resources should be considered a normative part of an adoptive family's experience [Winkler et al. 1988]. When intervention is necessary, it must be family-oriented [Hartman 1984; Elbow 1986]. Not only must it be family-oriented, but it must also be sensitive to adoption and to working with "system children" [Grabe and Reitmaier 1986].

Therapeutic expertise that is appropriate to both adoption and child welfare issues is unique, and collaboration among a diversity of services and treatment specialists is extremely rare. Conventional therapy and service-provision methods are not only ineffective, but can undermine the inherent confidence and strengths of adoptive families. Contrary to the view of most traditional adoption specialists, the child's behavior problems were present before adoption, and are therefore seen as key impediments to resolving ambivalence about the adoption. In addition, crisis in adoptive families is usually not the result of chronic dysfunctional patterns but rather a reaction to new demands being made on the family, to life-style changes in the family, and to alterations in the structure of the family relationship system that occur as a result of the adoption [Hartman 1984].

Adoptive families in crisis may have extensive needs in education, behavior management, and/or dealing with emotional difficulties that may require contact and arrangement of services with two or more agencies. In addition, any system of care must pay attention to the importance of the social environment on the family [Hartman 1984]. Kagan and Reid [1986] asserted that the number of people willing and able to offer assistance was associated with placement stability for emotionally disturbed children. In a similar fashion, strong linkages between the schools, educational services, and adoptive families are directly linked with adoption satisfaction [Nelson 1985]. Multisystem therapy is advocated by Forsythe [1986], who notes: "A therapist can be more helpful to families who have adopted older children when that professional becomes well acquainted with the child welfare and court systems." Therefore, an ecological or family-in-environment perspective is also helpful in working with families adopting a special-needs child [Hartman 1984].

Postlegal services must be adoption-specific and service-diverse, and they must also be intensive. Children who have histories of emotional and behavioral problems can present families with stressors beyond what the adoptive family can manage without access to the types of service commonly used in other aspects of the child welfare system. Finding and locating such services are not easy, leaving families with no other alternative short of disruption or dissolution [Nelson 1985]. Adoption preservation projects, such as Oregon Children's Services Division, have found that prelegalization intensive family-based services had the highest success rates of all families served [Showell 1988]. Postlegal adoption preservation services have yet to be in general use, or evaluated.

Finally, intensive postlegal services must make the risk of dissolving the adoption concrete, with planning and services directed toward the dissolution process. Prelegal disruption conferences have been used to provide a structure for promoting subsequent success for the family and child [Fitzgerald 1983; Elbow and Knight 1987]. Disruption conferences may have the same benefit.

In essence, families who adopt special-needs children are faced with a dilemma: finding support and treatment services that meet their needs appropriately and locating service providers with adoption-specific skill and knowledge. Furthermore, each family's needs vary according to its particular combination of child and parent factors [Bourguignon and Watson 1987], requiring a comprehensive and diverse representation of professional disciplines. The Post Adoption Resources for Training, Networking and Evaluation Services (PARTNERS) Program, conducted by Four Oaks, Inc. of Cedar Rapids, Iowa, is designed to address the issues outlined above and serve the needs of families who have adopted children with special needs. Four Oaks is a private, nonprofit, nonsectarian human service agency offering a comprehensive, family-based treatment system program to families in Iowa.

The Four Oaks Approach: Program Overview

Although many communities have treatment, support, and adoption services available to families, few are experienced in or knowledgeable about the combination of special-needs adoption and child welfare services. Even though adoption subsidies provide for services in many states, families do not know how to access them and there are few services available specific to special-needs adoption. The PARTNERS approach creates a program whose core is a specially trained Clinical Review Team of professionals representing a cross-section of the community. Cooperative ventures are the method of choice for human service delivery systems of the future. Although difficult to create and complex to maintain, a strong community-based program can be developed among diverse service providers who share a commonality and vested interest in the joint endeavor.
The PARTNERS team includes those professionals and agencies critical to the adoption, treatment, and community adjustment concerns of special-needs adoptive families, comprising representatives of the department of human services, area education agency, mental health, child psychiatry, and social work. Members of the team participated in advanced training in special-needs adoption theory, practice, and programming sessions before the program began delivering services. The team meets monthly to review case evaluations. Quarterly, the team provides an oversight function for the program’s operation and purposes. Routinely, individual team members are contacted to provide technical assistance and consultation to the program’s staff members and families. In addition to the team, the project employs a half-time project director and child behavior specialist, a full-time family therapist, a quarter-time adoption worker, and a less than quarter-time consultant/evaluator.

The program is designed to be a continuum of therapeutic and support services, with little in both intensity and method of service provision for the variety of circumstances special-needs adoptive children and families encounter. Some families need little more than information and resource referrals; others need intensive clinical intervention and support services. The components of the program are intended to be arranged and combined in ways that deal with the needs of individual families. Using a comprehensive child and family assessment, a “menu” of services and resources is reviewed by the team and recommended to the family in a consultation conference.

Program Design

The program aims to reduce the risk of adoption dissolution and the degree of difficulties experienced by families who adopt special-needs children. Once a family is identified, its members are made aware of the program’s benefits and goals and helped to determine what services and resources can best meet their particular needs.

The treatment model consists of five phases. Figure 1 diagrams the treatment program. The screening phase consists of the initial contact made between project director and families when clarification of services and program objectives is discussed. At the point of referral, families are consulted as to their need for information and resource identification, support networks and services, and clinical consultation and treatment. Those families who request and could benefit receive a comprehensive assessment. All special-needs adoptive families who are referred for comprehensive assessment become part of the program’s database and continue to be followed for two years. In
addition, all program families have access to the information and resources listed under support services.

The second phase is the assessment phase, which includes clarification of services to the family, a structured family interview using risk assessment for placement out of the home [Magura et al. 1987], and administration of instruments with national norms for comparison purposes [the Family Adaptability and Cohesion Scale developed by Olson et al. 1985; the Child Behavior Checklist developed by Auchenbach and Edelbrock 1983]. In addition, a questionnaire previously used with intact, special-needs adoptive families not experiencing stress [see Groze and Rosenhal 1989a, 1989b, 1989c], and a family assessment that includes an ecomap and genogram are conducted. The genogram is particularly useful both to families and the staff because it can visually document a child’s placement history and the multiple influences on his or her life. The comprehensive child and family assessment is conducted by the family therapist and child behavior specialist and completed within 30 days after referral. Upon completion of the assessment, the data are summarized and presented to the team. Case summaries without family-identifying information are mailed to team members seven to ten days before the monthly meeting.

The treatment planning phase begins when the results of the assessment are documented and reviewed by the team, at which time treatment and support service recommendations are incorporated into a treatment plan. The team determines whether to refer the family (1) to service providers in the community that have participated in training or are adoption-sensitive; (2) for support services and counseling; or (3) for family preservation services. For families referred to service providers in the community, the case becomes inactive, although follow-up contact via phone or mail is made at intervals of three, six, and ten months. The other families enter the treatment phase.

The treatment phase includes setting mutually established goals, developing therapeutic interventions to achieve them, and mutually determining the length of time in treatment. In this phase, families become engaged in treatment and begin to see their problems in the context of larger adoptive family issues—separation, attachment, loss, unresolved grief, expectations, and so on [see Winkler et al. 1988 for a list of common issues]. The treatment philosophy is based on systems theory and practice.

As noted earlier, the two types of programming are support services and treatment services. Support services include case management and consultation, referral for respite child care, adoptive parent network assistance, and education/advocacy groups for adoptive parents, children, and siblings. Depending on the family’s treatment needs, case management is assigned to either the family therapist or child behavior specialist. The case manager serves as the primary link to the family for all services and community referrals. The adoption worker conducts the education/advocacy groups, maintains information about resources, provides assistance regarding respite child care and parent networks, and manages the program’s resource repository.

Treatment services provided by the program staff are divided into two categories: intensive adoption preservation services and sustaining adoption counseling services.

Adoption preservation services are provided by a team comprising the family therapist and child behavior specialist, who are available up to ten hours a week, for a service length of 45 to 90 days. This intense service is provided primarily in the family’s home, and focuses on the critical stresses. Adoption preservation services include all aspects of support services and are similar in nature to the type of treatment methods used by adoption counseling services, but are differentiated by the intensity and length of service employed in response to the stress or crisis. Additionally, access to a short-term out-of-home shelter placement option is available, if needed, to avert a permanent disruption. In cases where dissolution (postlegal ending of the adoption) cannot be averted, a dissolution conference is conducted to help the child and family handle the process most productively and to help in future planning.

Adoption counseling services to sustain families use all aspects of support services, with the addition of family and individual therapy. The services are provided with less intensity; the family therapist or child behavior specialist will be available up to two hours a week, for a service length of three to six months.

The termination phase includes planning with the family about the future, dealing with the separation and loss implied by closure, and providing case management when appropriate. In addition, a structured family interview using the same instruments completed during the assessment phase is a part of the termination process [Magura Risk Scale, FACES, and Child Behavior Checklist]. Through the treatment and termination phases, families become increasingly independent of the service agency and confident of their capabilities.

Follow-up contacts are made regularly as described earlier, by phone and/or mail, to ascertain placement status and family functioning following termination. The consultant/evaluator provides quarterly reports analyzing the data from the assessment and termination data on the impact of services on family and child functioning, and also assists in ongoing program planning and development.
Implications

Recent trends in child welfare policy and legislation have produced an increasing number of children in foster care and residential treatment at the same time as the process of termination of parental rights is raising substantially the pool of children with the potential to be placed for adoption. Special-needs adoption programming must be available to improve the capability of families to succeed with these children. Programs similar to PARTNERS that promote adoption as a lifelong process need to be developed. Agencies must consider incorporating a full range of adoption-sensitive educative, support, and therapeutic services in their total service program.

References


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