Integrating Special-Needs Adoption with Residential Treatment

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This article describes a special program for latency-age children entering residential treatment who are available for adoption. The program offers a continuum of care, incorporating the strengths of group living, therapy, and adoption preparation and placement.

An increasing number of children in residential care have adoption as a treatment consideration. Initially, children adopted as infants were reportedly overrepresented in clinical populations [see Bohman 1971; Brinich 1980; Senior and Himadi 1983; McRoy et al. 1988]. Many children are now entering residential treatment whose parents' rights have been terminated and for whom adoption is a permanency goal. One-third of the 70 children in residential treatment and group home care at Four Oaks* have either had their parents' rights terminated or been adopted. These children constitute unique challenges to the service delivery system. This article describes a program to integrate residential and adoption services to both treat adoptable children and prepare them for adoptive placement.

*Four Oaks is a private, nonprofit human service agency providing out-of-home care programs and prevention and support services to families.

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Permanency and Adoption Practice Problems in the Residential Setting

The passage of the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) was intended, in part, to reduce the length of time children remain in placement with no concrete plans for their future and establish permanency planning as an inherent function of child welfare services. The goal of permanency planning is a stable family setting for children during their crucial developmental years.

Initial efforts toward permanency are directed to the biological family. If services to maintain family unity or achieve reunification after placement are not successful, adoption is considered to be the next most permanent placement. Unfortunately, by the time adoption becomes the permanency plan, many children have experienced multiple and lengthy out-of-home placements. In one study of subsidized adoptions in Iowa [Groeze 1990], children had spent an average of 2.5 years in out-of-home care and averaged three placements prior to adoption. The number of placements for legally adoptable children who enter residential treatment at Four Oaks is often considerably more: on average, the children have had ten or more placements, with over half their lifetime spent in out-of-home care by the time they are nine years old.

Two elements that contribute to the occurrence of multiple and lengthy placements are (1) the prolonged decision-making period before termination of parental rights, and (2) the interruption or fragmentation of services experienced by children in out-of-home care when adoption is the permanency goal [Donley and Haimes 1988]. These children have therefore been exposed to multiple losses and traumas, and they are among the most damaged of those who enter the residential treatment setting. By the time they have traversed the full permanency spectrum, the likelihood of the permanency plan succeeding is severely compromised.

Residential and group care focus on the benefits of group living and have a child protection orientation; adoption affords the benefits of family care. These differences can lead to the fragmentation of services for legally adoptable children in residential care. Although the child and family treatment focus must be integrated for all cases in residential care, it becomes particularly important for children who would bring extensive histories of traumas associated with abuse and loss to a new family setting. The children must be adequately prepared for the adoption experience and the families must be adequately prepared for the emotionally disabled child who has lived in a residential setting.

The call for residential-adoption collaboration was begun in the 1980s and continues into the 1990s [Donley and Haimes 1988]. As collaboration efforts continue, some residential facilities have developed internal residential-adoption programs. The practice applications discussed in this article represent the efforts of a residential treatment facility to integrate both treatment and adoption considerations in a Specialized Adoption Treatment Team (SATT) approach.

Practice Applications: The Four Oaks Approach

Children with adoption as a treatment consideration continue to be overrepresented in the residential population. To raise the agency’s effectiveness in the placement and maintenance of older, emotionally disabled children in adoptive homes, a process of planning, implementation, and review was undertaken to define how best to integrate treatment and adoption services.

Program Planning

A planning committee was formed, including administrative and supervisory staff members from residential treatment, group home, therapy (including case management), and adoption, along with a research consultant. The committee identified what needed to be incorporated into a continuum of services that would maximize successful adoptive placements. Strengths of the existing programs were seen as including (1) an established 44-bed residential treatment facility; (2) a well-developed family therapy and clinical component; and (3) a newly licensed adoption program. Impediments to integration included a lack of specialized programming for legally adoptable children and the fact that adoption-sensitive treatment considerations were new and unfamiliar to many staff members.

The goal of the committee, then, was the development of a service model that would reduce the fragmentation of services and create an integrated continuum of care, an adoption-sensitive residential treatment program for children whose primary plan was expected to be adoption.

An Integrated Continuum of Care

Integration, by definition, means that segments function as a whole. It was decided that a restructuring of the units and staff members would further a cohesive treatment focus. A six-bed residential treatment unit and an eight-bed group foster home were established to serve the legally adoptable children. Both the residential treatment unit and the group foster home are co-ed, with an age range of six to 12 in residential care and six and over in group care. All children have a permanency plan of adoption.

At the same time, a clinical "adoption track" was established, with all
cases involving adoption assigned to one supervisory group of therapists. The core SATT for each child comprised residential or group home staff members, a therapist who was also responsible for case management, and an adoption worker.

Treatment Team Roles

For SATT to function as an integrated operation, role definitions for core team members were important in establishing the process by which the child's movement through treatment toward adoption would take place. The staff members of the residential treatment and group home units acted both as a parental subsystem and as treatment providers for behavior management and change. The child care staff members taught interpersonal skills, social adjustment, and developmentally appropriate responsibility; they monitored the children's medical and educational needs. The program used a modified positive peer culture model, resembling a sibling subsystem, with an emphasis on adult caregiving. Aspects that were emphasized include (1) behavioral programming that concentrated on having children take and accept responsibility for themselves; (2) activities for the children that gave them a purpose in the family/group unit (e.g., helping and caring for others); (3) a group-living program that enabled children to see problems as opportunities that could be confronted and resolved; (4) an emphasis on safety, carried out through a structured routine that emphasizes behavioral interventions by the adult; and (5) goals and objectives that placed clear expectations on each child.

The therapist/case manager role provided staff continuity from the treatment phase through adoption legalization. In that role, responsibilities included constructing a child's history and individual and group therapy in relation to victimization and separation and loss. The case manager's responsibilities consisted of coordinating the child's treatment and serving as liaison to the child's guardian (usually the Department of Human Services) and the court.

The adoption worker's primary role was the recruitment and preparation of families for special-needs children. The adoption worker also joined the treatment team six to nine months before the child's expected discharge in order to begin preparing the child. Specific tasks were the recruitment of adoptive parents, adoptive parent homestudy and training, matching, preplacement visiting, and postplacement services.

Program Implementation

Once the treatment team and the structure of the continuum of care were established, program implementation began with training staff members on adoption-sensitive theory and practice skills. The specifics were (1) permanency planning and the adoption process, (2) positive adoption language, (3) child development, (4) attachment, (5) separation and loss, (6) treatment staff roles, (7) milieu structure and routine, and (8) specialized treatment components, including interventions related to victimization, separation and loss, and adoption preparation. Once the basic training was completed, a monthly SATT training/staff meeting offered the opportunity to update training and review progress.

Specialized Treatment Components/Interventions

To complete a transition to an adoption-sensitive continuum of care, specialized treatment components were added to the existing residential and adoption programs. The components dealt with sexual abuse survivor issues common to most residential clients, as well as the adoption-specific components of separation, loss, and adoption practice, for which both group and individual treatment were structured. Tools for individual work included the use of lifebooks and the placement genogram.

Sexual Abuse Survivors Group. This group facilitated the healing process by eliciting feelings about sexual abuse that had been denied or suppressed, enabling the child to gain control over the feelings, improve coping skills, and increase self-esteem. Specific objectives were determined by the age of each child. For six- to nine-year-old children, the objectives were to (1) talk about sexual abuse specifics; (2) articulate feelings, usually fear, shame, guilt, and helplessness; (3) deal with anger; (4) make peace between the 'critical parent' and the 'guilty child' [see James and Jongeward 1971]; and (5) improve coping skills by strengthening ego development.

For ten- to 12-year-old children, the objectives were to talk about the effects of (1) stigmatization—to reduce the child's sense of responsibility, guilt, and self-blame; (2) powerlessness—to reduce the child's anxiety, fear, and helplessness; (3) betrayal—to reduce the child's sense of grief, loss, dependency, and distrust, and his or her impaired judgment; and (4) traumatic sexualization—to reduce the child's preoccupation with sex, sexual misconceptions, and compulsive behavior. Techniques used to help children identify and verbalize feelings included creative visual expression, role-playing, and physical touch when appropriate and therapeutic.

Separation and Loss Group. This group facilitated the grieving process by identifying and processing feelings related to separation and loss (anger, guilt, sadness), and by enabling the child to gain control over them. Techniques used to help the child identify and verbalize his or her experience included
creative visual expression and role-playing. Objectives of the group were to (1) normalize feelings associated with loss; (2) help children understand the role of the child welfare system in their lives; (3) help children identify the good and bad qualities of their biological families; (4) explore the reasons children cannot live with their biological families; and (5) help children achieve a time perspective in relation to past, present, and future families. Both the survivors and separation and loss groups were jointly led by clinical and residential staff members.

Adoption Preparation Group. This group was for children who completed the residential treatment program (including the SATT groups) and moved to the group foster home for adoption preparation and adoptive family recruitment. The adoption preparation group familiarized children with the adoption process to reduce anxieties and encourage them to consider the benefits of a move to a new family. Objectives of the group were (1) helping children to understand the differences and similarities of biological parents, legal parents, and custodial parents, and how families are different and alike; (2) preparing children for the preplacement visiting process; (3) helping children discuss their feelings about trust and love; and (4) helping children explore separating from people in a positive manner. The group is jointly led by the adoption worker and a group home staff member.

Individual Work: Placement Genograms and Lifebooks. The placement genogram is a visual tool that shows a family's existence through time. For the typical individual or family, genograms help examine the impact of intergenerational family history on the individual and family. For children with multiple family and institutional placements, a placement genogram (see figure 1) can be created as a method of organizing and understanding the connections, attachments, and number of systems each child has experienced. Understanding their history through the exploration of events, patterns of living, and roles helps the children reorient their experience toward the goal of joining a new family system [Hartman and Laird 1983; Allen 1990].

In addition to using the genogram in individual treatment with the child, the therapist communicated the information elicited to the treatment team. Although all staff members read case files, the impact of the visual representation of placement histories was a succinct and powerful tool for understanding where the children had been, who had been important, who had hurt them, and why they were where they were now. The information became easy to organize and to retain, and was thus available for recall throughout the months a child is in treatment. For these reasons, the placement genogram was also used during presentations of children to prospective adoptive families.
The lifebook [Wheeler 1978; Aust 1981] is another visual tool to explore and organize the child's history. Like the baby books, photo albums, and scrapbooks families use to trace a child's movement through time and to record important events, the lifebook brings a history and identity to children in the welfare system. Lifebooks can be made from a preprinted format, created on an individual basis, or designed by combining both. They are keepsakes children can take with them to their adoptive families as a reminder of where they come from, as well as a place to record new experiences.

Lifebooks were used in treatment to (1) help children understand and integrate the past, present, and future; (2) help them alter misconceptions about their history; (3) provide answers to questions about their history and further a sense of identity; and (4) help them deal with fantasies and denial. Lifebooks are labor-intensive for the staff, but appropriate investments in the successful preparation of the child and adoptive family.

Program Review

The SATT program was put in place in October 1989. In the next two years, eight children (including two sibling groups of two) were placed in six homes. Two family placements (three children) disrupted and the children have returned to the SATT program for future placement planning. The disruption rate at this point is slightly lower than that reported by Kagan and Reid [1986], in whose study about 53% of the adoptive placements of older, emotionally disabled children disrupted.

Program strengths have been identified as (1) combining residential and adoption programming; (2) integrating team roles, training, and operations; and (3) providing a continuum of services for children with adoption permanency plans. The successful placement of several children in the program's first two years has been gratifying and the disruptions, although not entirely preventable, have afforded important learning opportunities for the staff and for program development. The SATT program design of simultaneously providing treatment, preparation, recruiting, and placement activities has reduced the length of time children have remained in out-of-home placement by an estimated average of six to 12 months, although this was not specified as an outcome goal.

Summary

Current estimates indicate that 76% of Iowa children whose parents' rights have been terminated and who are listed on the adoption exchange are older children with emotional/behavioral disabilities. Residential treatment can play a significant role in preparing difficult-to-place children (e.g., seven- to 14-year-olds with moderate to severe emotional or behavioral problems) for adoptive placement [Powers and Powell 1982]. The SATT model offers the opportunity to effectively manage the risks in adoptive placement for these children.

References


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