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Post-adoption support and interventions for adoptive families: Best practice approaches

An expertise for the German Research Center on Adoption (EFZA)

Julie Selwyn

efza Expertise- und Forschungszentrum Adoption

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Die vorliegende Expertise „Post-adoption support and intervention for adoptive families: Best practice approaches“ wurde von Prof. Julie Selwyn im Rahmen des Expertise- und Forschungszentrum Adoption (EFZA) verfasst.
Prof. Julie Selwyn (CBE) ist Direktorin des „*Hadley Centre for Adoption and Foster Care Studies*“ an der Universität Bristol (GB). Vor Ihrer universitären Laufbahn arbeitete sie 15 Jahre lang als Sozialarbeiterin mit Kindern und Familien. In den letzten 20 Jahren lagen ihre Forschungsschwerpunkte vorrangig in den Bereichen Pflegekinder und Adoptionen aus dem Pflegekindersystem.

Abteilung Familie und Familienpolitik
Nockherstraße 2
81541 München
Telefon (089) 6 23 06 0
Telefax (089) 6 23 06 – 162
E-Mail: info@dji.de

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1 Introduction

This rapid literature review was commissioned by the German Research Centre on Adoption (EFZA) located at the German Youth Institute in Munich (Germany). The overall aim of the review was to consider the support needs of domestic and intercountry adoptive families and the evidence for effective interventions. Step-parent, relative and domestic private adoptions were excluded.

The review focused on three key questions:

a. What are the kinds of services that adoptive parents and children require?
b. What is known from the literature on adoptive families' use of services and the barriers and enablers to access?
c. What is known from the existing literature about the effectiveness of interventions, which support domestic and inter-country adoptive families?

A database search was undertaken of Social Care Online, Zetoc, and Web of Science. Only publications in the English language were selected and searches were limited to literature published since 2000. In addition, a wider literature was examined on interventions for maltreated and traumatised children, as the majority of adopted children have been abused and/or neglected. Three reviews of the literature on adoption support were also drawn upon: Livingstone-Smith, S. (2010) *Keeping the Promise,* Evan B. Donaldson Institute; Livingstone- Smith S. (2014) *Facilitating adoptions from care.* London BAAF and Stock et al., (2016) *Independent Evidence Review of Post-Adoption support interventions*, London, Department for Education.

There are also numerous US databases that evaluate interventions, mental health treatments and promising practices, which were relevant for this review e.g. www.effectivechildtherapy.org; www.nctsn.org/resources/audiences/parents-caregivers/treatments-that-work and www.cebc4cw.org/. Specialist 'evidence-based' online registries and databases were trawled including the US Children's Bureau and Child Welfare Information Gateway. One of the most useful resources was the catalogue produced by the US based National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG http://qic-ag.org/). The catalogue itself is not an evidence based review system but collates the evidence from 15 US evidence based review systems on interventions that have either been:

a. Designed specifically for families and children with plans for a permanent placement or those who need support post placement i.e. pre and post placement services
b. Interventions that are well supported by evidence of effectiveness on other populations but might need adapting for adopted children and families

Rating the effectiveness of interventions
A commonly used framework of rating interventions was used (see www.cebc4cw.org/) with, in this review, only the first three levels considered:

LEVEL 1: **Effective and Proven by Research**. Interventions at this level are well-supported with positive evidence published in the peer reviewed literature from two or more randomized controlled trials (RCTs). In at least one of these RCTs, the practice has shown to have a *sustained effect at least one year* beyond the end of treatment, when compared to a control group. Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects. There are no data suggesting a risk of harm to those receiving the intervention. The intervention has a book, manual, and/or other available writings that specify components of the service and describe how to administer it.

LEVEL 2: **Supported by Research**. At least one rigorous randomized controlled trial (RCT) published in the peer reviewed literature has found the practice to be superior to an appropriate comparison. In that same RCT, the practice has shown to have a *sustained effect of at least six months beyond the end of treatment,* when compared to a control group. Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects. There are no data suggesting a risk of harm to those receiving the intervention. The practice has a book, manual, and/or other available writings that specify the components of the interventions and describe how to administer it.

LEVEL 3: **Promising practice** At least one study utilizing some form of control (e.g., untreated group, placebo group, matched wait list study) has established the practice's benefit over the control, or found it to be comparable or superior to an appropriate comparison practice. The study has been reported in published, peer-reviewed literature. Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects. There are no case data suggesting a risk of harm and there is a book, manual, and/or other available writings that specify the components of the intervention and describe how to administer

It was clear from all these sources that some of the interventions used by adoption support agencies do not meet the scientific criteria to be included in an "evidence based" review. Interventions may lack an evidence base for many reasons such as lack of research funding or the difficulty of implementing random control trials in a social care setting.

The review begins with a summary of the characteristics of adopted children and their adopted parents. The next chapters examine the need for services and the support services that are available. The final chapter provides a brief overview of evidence based interventions and interventions that are in common use.

2 Adoption

Several decades ago, there was great optimism that any child could be placed for adoption and that a favourable family environment would compensate and undo any early disadvantage. Since then, as a result of research, practice experience, and the voices of adoptive families it is now recognised that 'love is not enough' and that the effects of deprivation, maltreatment and trauma can be long-lasting. Adoption does provide the opportunity for developmental recovery and a considerable body of research highlights that adoption is better for children than institutional or foster care (e.g. Van IJzendoorn & Juffer 2006) but support is likely to be needed at some point across the lifespan. Hartinger-Saunders and Trouteaud (2015) argue that it is unrealistic to expect adoptive families to remain intact without access to appropriate services.

2.1 Adopted children in the UK and US

In England and the US, the majority of adoptions involve children adopted from foster care. In England about 5,000 children are adopted from foster care each year whilst only approximately 250 children are adopted from overseas-intercountry adoptions (DFE 2016). Few infants are relinquished for adoption.

Similarly in the US, the majority of adoptions concern those in out of home care. Annually, about 50,644 children are adopted from the foster care system and 5,647 children are intercountry adoptions (AFCARS 2015).

The majority of domestic adoptions in England and the US are of children removed from their birth families because of maltreatment and a court has decided that adoption is in the best interests of the child. In England, the child's average age at the time of the Adoption Order is 3 years and 3 months and the majority (approx. 84%) are adopted by strangers (DfE 2016). In the US, children are on average older (6 years) at the time of the order but unlike England about 52% are adopted by a former foster carer and therefore have been living with their permanent family for some time before the legal order is made (AFCARS 2015). In the US about 45% of children were placed with their family under 1 year old (ASPE 2011).

2.2 Characteristics of children adopted from foster care

Children adopted out of care are known to carry risks to normal development. The risks stem from their early experiences and genetic vulnerability.

2.3 Pre-birth risk factors

UK and US research studies have found that 60-70% of mothers, whose children were adopted out of care, misused drugs and/or alcohol during pregnancy (ASPE 2011, Selwyn 2010) Prenatal exposure restricts foetal growth, and the chronic impact of alcohol abuse results in irreversible neurological and physical abnormalities. Whilst the evidence on the detrimental effects of alcohol is now widely accepted, there have been fewer studies that examined the longer term impact on children's development of substance misuse during pregnancy. One of the difficulties with researching the impact of drugs on foetal development is that mothers often use multiple substances, sometimes combining with alcohol misuse, have a poor diet lacking in essential vitamins and minerals and little ante-natal care. Recent Norwegian research (Nygaard *et al.,* 2015) tracking longer term outcomes of infants whose mothers misused drugs has shown that cognitive deficits, such as difficulty with sustained attention and self-regulation of behaviour, identified at 4 years old were still present at 17-22 years old.

The risk of impaired cognitive development, ADHD, conduct and emotional problems are also known to stem from mother's experiencing chronic and sustained stress whilst pregnant (Talge *et al.,* 2007; Glover 2011). One of the principle sources of stress is living with a violent partner. Research on family violence (Barnish 2004) has found that about 30% of domestic violence begins or is of greater severity during pregnancy. Many children placed domestically for adoption were born to mothers with a violent partner.

2.4 Genetic risks

Children also carry genetic vulnerabilities, as their birth parents often have mental health problems. Genes and the environment interact and therefore removing children to an adoptive environment reduces the risks of developing mental illnesses. An adoptive family can be a protective factor. However, if the adoptive parents struggle to parent the child, the risks of the genes being expressed increases again (Tienari *et al.,* 2004). It is not known whether the increased risk stems from a) adoptive parents having poor parenting skills from the outset, b) the child placed having an undiagnosed condition c) emerging difficult behaviour and therefore more challenging to parent (Woolgar 2016). The need for support to enable parents to manage in these circumstances is essential.

2.5 Early experiences

In England, data collected nationally shows that the majority of children (74%) placed for adoption out of the foster care system entered care because of abuse

and/or neglect (Department for Education 2016). Research studies (e.g. Sturgess & Selwyn 2007) examining the characteristics of children adopted out of care report that many adopted children have suffered multiple types of abuse. Commonly, children have been neglected, physically abused and been exposed to domestic violence. Although less common, sexual abuse is found in 14-23% of domestic adoption samples (Dance & Rushton 2005; Sturgess & Selwyn 2007, Selwyn *et al.*, 2010) and other children will also have been rejected by their birth parents (Rushton & Dance 2003). Even before entering care, many children will have experienced household changes as mothers change partners or relatives temporarily take over the care of the child (Selwyn *et al.,* 2006; Ward *et al.,* 2012). The removal of the child from the birth family can be traumatic, and there is often further instability once removed due to changes of foster carer or failed attempts at reunification. US research (Newton *et al.,* 2000; Rubin *et al.,* 2007) has highlighted how moves in foster care (even when controlling for background factors) are associated with the later development of mental health problems.

2.6 Effects of maltreatment

There is an extensive literature on the detrimental developmental effects of maltreatment. Effects are seen during childhood in four main areas:

- Intrapersonal competencies (e.g., sense of self and self-development)
- Interpersonal competencies (e.g., capacity to form and engage in healthy relationships with others)
- Regulatory competencies (e.g., capacity to regulate and modulate emotional and physiological experience)
- Neuro-cognitive competencies (e.g., controlling and focusing attention; inhibiting impulsive behaviors, act meaningfully on the world) (Blaustein & Kinniburgh, 2010)

The effects can be seen in the elevated rates of mental health problems in the care populations. In the UK, 10% of the general child population have mental health problems whereas the foster care population rate is closer to 35% (Ford *et al.,* 2007). Similar rates have been reported for the US and Australia (Pecora *et al.,* 2009; Tarren -Sweeney 2008).

Children entering care have also been found to have physical complaints. A UK study (Meltzer *et al.,* 2003) found in a sample of 1,039 children in out-of-home care that two-thirds had at least one physical complaint reported by their caregiver. Common complaints were asthma, bed wetting, and vision impairments. Other early services often required are for speech and language services, as the development of language is delayed due to neglectful parenting.

More recently elevated rates of autism have been identified in UK adoption samples. For example Green (2016) found that about one in ten of a sample of

adopted children showed the full range of DSM5 autistic spectrum disorder symptoms i.e. impairment of social reciprocity and empathy, repetitive behaviours, unusual interests and stereotyped behaviours. A further 18.5% had partial features. Similar high rates of childhood autism were found in a study of adoption disruption in England (Selwyn *et al.,* 2015).

2.7 Inter-country adoption - characteristics of children

In comparison with domestic adoptees, generally less is known about the backgrounds and early histories of inter-country adoptees. Nevertheless there are many similarities in domestic and inter-country adoptees' early history.

2.8 Pre-birth risks

Similar to domestic adoptees, birth mothers are reported as often misusing alcohol and drugs. The extent of substance misuse differs by country. A Swedish study (Landgren *et al.,* 2006) of 76 children adopted from Eastern Europe identified a history of alcoholism in 33% of the sample and psychological problems in birth mothers for 16%. Five years after adoption 46% of the children had at least one neurodevelopmental problem. In the US, the International Adoption Project (IAP) has been collecting data on children adopted from overseas into Minnesota families for more than a decade. In 2015, their register contained details of 5,500 internationally adopted children and their families. Surveys of their adoptive parents found that 44% of those who had adopted children from Europe and 15% of those with children from Latin America reported that their child's birth mother had misused alcohol or drugs. In comparison this was the case for only 9% of those who adopted a child from Asia (Table 1).

Unlike UK domestic adoptees, birth mothers had frequently placed their child in an institution because of poverty and/or because of being a single parent and being financially unable to care for a child. Low birth weight of many of the babies suggests that mother's may have suffered malnutrition. Low birth weight by itself is associated with risks of cognitive impairment and learning problems (Gunnar & Kertes 2005).

2.9 Early experiences

Few studies (e.g. Dobrova-Krol *et al.,* 2010; Smyke *et al.,* 2007; The St. Petersburg-USA Orphanage Team, 2005) have reported on the characteristics of children *at the time* they entered the institution. Generally, the infants

entering had higher rates of adverse perinatal circumstances (e.g., low birth weight, length, head and chest circumference) than was typical for children in that country and their physical and general behavioural development was often delayed at arrival to the institution. Not all children had entered at or shortly after birth: some of the children had been cared for by their birth families or by relatives prior to entering the institution. The St. Petersburg-USA Orphanage Team (2005) found that was the case for about 30% of those adopted out of orphanages.

Similar to domestic adoptees, intercountry adoptive parents report physical abuse and neglect of the children prior to adoption, although it is not always clear whether maltreatment occurred in the birth family or in the institution /orphanage. Sexual abuse is rarely recorded.

Table 1: Parent report of known adversities experienced by the child pre-adoption by country of origin

	Europe n=417 %	Latin America n=711 %	Asia n=1,042 %
Pre-natal alcohol/drug exposure	44	15	9
Prenatal malnutrition	50	41	24
Premature birth	30	14	28
Physical neglect	45	26	12
Social neglect	57	22	13
Physical abuse	13	6	3
6 months or more in an orphanage, hospital	79	17	13

Source: International Adoption Project Newsletter 2002

2.10 Health and developmental needs

Similar to domestic adoptees, international adoptees are at high risk for vision and hearing abnormalities as well as speech and language problems. However, whilst diagnoses for domestic adoptees are likely to be made in foster care, this is not the case for those coming from institutions. Even if diagnosed, it is unlikely that treatment would have been provided in the country of origin (IAP). Newly arrived children frequently have incomplete or missing preadoption immunization records. In a survey of 504 children, just over a third (35%) had preadoption immunization records (Schulte *et al.,* 2002)

Unlike domestic adoptees, many intercountry children join their adoptive families with health problems such as malnutrition, skin diseases and intestinal parasites. International adoption medicine, a relatively new specialty in paediatrics in the US has emerged to address the specific health care needs of these children. Miller (2005) helpfully sets out the role of paediatrician and the health checks and support that might be needed. She identifies the following conditions as needing screening: tuberculosis, hepatitis B and C, HIV infection, syphilis, intestinal infections (with parasites, enteric bacteria, or Helicobacter pylori), skin infections (especially scabies and impetigo).

Some countries that allow inter-country adoption prioritise or only allow special needs adoptions (O'Dell *et al.,* 2015). Countries of origin determine what qualifies as 'special needs' and whilst there is variation by country 'special needs' are typically categorised as minor (correctable such as anaemia or rickets) and moderate to major (demanding life-long management or requiring frequent treatment such as cerebral palsy, HIV, or Down syndrome). However, not all conditions are known at the time of adoption. A survey of 1,000 US parents (Donaldson Adoption Institute 2013) of whom 47% stated they had adopted a child with special needs found 50% had only been diagnosed post adoption. Similarly Miller and Hendrie (2000) found in a study of children adopted from China, 18% had undiagnosed medical conditions such as congenital heart conditions, hearing or visual impairments. Health conditions may emerge post adoption.

2.11 Effects of institutional care

Unlike foster care, institutional care does not provide opportunities for developmental recovery. There are a few studies that show that the quality of care does vary by institution (e.g. Storbergen *et al.,* 2010) but the overwhelming evidence shows that orphanage care results in severe growth and developmental delays for children and the earlier the removal from the institution the more likely the child will recover.

The Bucharest Early Intervention Project (BEIP) is a randomized controlled trial of foster care as an intervention for children abandoned at or around the time of birth and placed in one of six institutions for young

children in Bucharest, Romania (Zeanah *et al.,* 2003). The researchers have found that early institutionalization leads to profound deficits and delays in cognitive (i.e., IQ) and socio-emotional behaviours (i.e., attachment), a greatly elevated incidence of psychiatric disorders and impairment, and differences in brain electrical activity. Those placed from the institution into high quality foster care showed improvements but for specific domains of neural activity such as language, cognition, and social-emotional functioning there appeared to be sensitive periods regulating their recovery. That is, the earlier a child was placed in foster care, the better their recovery. Although the sensitive periods for recovery varied by domain, results suggest that placement before the age of 2 years is key to a full recovery. Further information on the project can be found at:
hwww.bucharestearlvinterventionproiect.org/BEIP-Publications.html)

Studies of children adopted in England, from the extreme and severe conditions of the Romanian orphanages (Kreppner *et al.,* 2007) found that those removed under six months of age achieved complete catch-up in all areas of development. However, whilst the majority of late placed children improved, about a third of those removed later continued to have significant difficulties such as ADHD and quasi-autistic behaviours into their adulthood. This group tended to be unemployed and have few educational qualifications.

The window for developmental recovery seems to be wider for children who have not experienced the extreme deprivation that the Romanian children suffered. Nevertheless, the length of time spent in institutions is strongly associated with behavioural difficulties, risk of insecure/disorganised attachments and developmental delay.

2.12 Age at adoption

Age at adoption has long been recognised as a proxy for length of exposure to maltreatment or adversity. Older age at adoption is known to be a key predictor of later adoption breakdown and of a greater likelihood of having more challenging behaviour (Selwyn *et al.,* 2015). Consequently in the UK and US there have been policy initiatives and changes in social work practice to speed up the adoption process and get children into their adoptive families as quickly as possible. The opposite seems to happening for those adopted internationally. It is of concern that while the number of inter-country adoptions has been declining worldwide (Selman 2012) children are remaining longer in institutions before adoption (Julian 2013). Half of the 7,100 children adopted internationally in the US in 2013 were over the age of 3 years old. A study (Tan *et al.,* 2015) investigating whether country of origin was associated with the parent-child relationship quality found no statistical association but age at placement, gender and special health needs were predictive of the quality of relationships.

The International Adoption Project concluded (IAP 2002 and 2006) that

age at adoption was one of the largest predictors of a child's outcome. Risk factors and age at placement were highly correlated; meaning the longer it takes a child to be placed into a family the more likely that child is to have many risk factors. Surveys completed by parents found that children placed before 6 months had few pre-adoption risk factors, while those placed over 24 months often had many. Most intercountry adopted children with few risk factors were doing extremely well in every area covered by the survey. Very few were failing at school, and many were doing exceptionally well academically. If anything, they were over-represented in educational programmes for the gifted and talented. The picture was different for children with many pre-adoption risk factors, especially if they were adopted after 24 months of age. Many have significant behavioural and emotional problems, a significant number were falling behind in school, and a high percentage had received special education services. A half of children placed over 2 years old had four or more known risk factors. It is interesting to note that the Adverse Childhood Experiences studies (ACEs), which are being undertaken worldwide with *adults in the general population,* have also found that four or more risk factors experienced in childhood, predict later adverse adult outcomes such as drug/alcohol misuse and risk of disease (for more information on ACEs see www.who.int/violence injury prevention/violence/activities/adverse childhood ex periences/en/).

Importantly research is highlighting that children adopted out of foster care have more difficulties and have poorer welfare outcomes than those adopted internationally (Howard *et al.,* 2004; Juffer & van IJzendoorn 2005).

2.13 Domestic adoptive parents

For some time in England, the social work task has been to find families for the approximately 3,000 children waiting to be adopted. The task is no longer to supply infertile couples with a child but to find adults who are willing to become therapeutic parents to help children recover from trauma and maltreatment. Consequently, practice and legislation has changed to encourage a wider pool of prospective adopters to come forward. However, the profile of adopters has not changed hugely. In England, the majority (74%) of adoptive parents are married, 10% are single parents and 10% are co-habiting. There is a growing number of gay/lesbian adopters: 5% of adopters are in a civil partnership but in addition some of those in the 'married' category will also be same-sex adopters. Same-sex marriage was legalised in England in 2014.

Adoptive parents tend to be older than first time parents in the community and to be financially secure. Most adopters in the UK do not have any previous connection with the child: only 16% were previous foster carers. Relatives rarely adopt, as there are other legal orders available, which do not change the relationship of the adult and child. For example, if an aunt adopted she would become the child's mother and courts would prefer the aunt to become the child's legal guardian keeping family relationships unchanged.

Prospective adopters do tend to have some connection with children and/or adoption. Many are employed in occupations such as teaching, social work or psychology or have a personal connection to adoption through knowing someone adopted. Awareness on the need for more adopters has been raised through First4Adoption (www.first4adoption.org.uk/) who provide a range of on-line resources and support for those thinking about becoming an adoptive parent.

In the US, the majority (52%) of adoptive parents were the child's previous foster carer, 34% of children are adopted by a relative with non-relatives making up only 14% of adoptions from care (AFCARS 2015). As in the UK the majority (67%) are married, 4% are cohabiting, but there are more single adopters in the US (single females 26% and single males 3%).

Many US adopters (91%) receive a financial adoption subsidy and over half of US families with adopted children also include birth or step children (Kreider 2003). Unlike the UK the majority of adopted children from care are of minority ethnicity and therefore transracial adoptions are common (Vandivere & McKlindon 2010).

It has been found that whilst infertility is still one of the main reasons for wishing to adopt, adults also come forward for religious or humanitarian reasons. Gay and lesbian adopters often make adoption their first choice rather than because of failed infertility treatments (Golombek *et al.,* 2013). Parents open to adopting children with disabilities tend to have large families, and view themselves as successful, experienced and skilled parents (Good, 2016).

2.14 Intercountry adopters

The International Adoption Project has found that the backgrounds of the parents choosing to adopt internationally has not changed much since the 1990s. The overwhelming majority of parents are still upper middle-class (over half making more than $76,000 per year), are Caucasian (95%), and married (86%). Most of the mothers are working full or part-time, although around one-third say they are full-time, stay-home parents. Fathers/partners are most likely to be working full-time. One noticeable difference between parents adopting in the US today and those adopting in the 1990s is the mother's age at adoption. Mothers are getting older (mean age now 40) and are highly educated: 80% college graduates and 40% with a higher degree (Masters, doctorates, etc.) Third, families of internationally-adopted children are providing stable, stimulating homes. Most are in middle- to upper-income homes. Extremely few had experienced instability due to divorce or parental death. Beyond schooling, parents were providing many enrichment experiences that required additional fees and parent effort.

2.15 Conclusion

Adopted children are likely to have experienced maltreatment and perhaps been traumatised by their experiences. Their adoptive parents may have a full history of the child's early experiences or there may be significant gaps. Adoptive parents are asked to cope with a great deal of developmental uncertainty but research shows that the biggest intervention in children's lives is adoption. Growing up in a loving adoptive family brings about developmental recovery. The majority of international and domestically adopted children do not have severe or persistent medical, developmental or behavioural problems. Nevertheless some children continue to experience many difficulties.

So how can adoptive families be supported in their task of providing therapeutic parenting? The importance of a good assessment should be stressed. Concerns have been expressed that children's problematic behaviours are automatically assumed by social workers and psychologists to be 'attachment difficulties' (Barth *et al.,* 2005). Conduct disorders or autism are missed (Woolgar & Baldock 2015; Green *et al.,* 2016). Consequently, therapies are applied which will be ineffective and not treat the underlying disorder causing more distress to the child and family.

Deterministic views should also be avoided, as should seeing children as 'damaged'. Children respond differently to their experiences. We cannot predict with any certainty how children will be affected and which children will be more resilient than others. Therefore, personalised packages of support are needed which can be responsive to the changing needs of children and families. If families know they have access to such support in a timely way then they will feel much more resilient in managing. Berry and colleagues (2007) identified that the best predictor of family intactness 12 months after placement was the quality of post adoption support.

In the next chapter, the additional lifecycle tasks for adoptive families are considered and the need for services to support parents and enhance the development of children.

3 The adoption lifecycle and service provision

At some point in the adoption life cycle most adoptive families will require and benefit from services. Adoption family life cycle models incorporate a pre-adoption period which includes tasks for adoptive parents such as coping with infertility, learning about adoption and accepting the need for scrutiny by social workers. Post-placement Brodzinsky (1998) points out that in addition to coping with the changes that occur in any kind of family and through children's psycho-social stages there are additional adoption related tasks that emerge for adoptive families. Developmental tasks for adopted children include:

- Family adjustment to adoption
- Resolving loss and grief
- Identity formation -learning one's adoption story and integrating adoption into one's identity
- Coping with adoption stigma
- Consideration of searching for one's birth family

These developmental tasks are outlined in a Child Welfare Information Gateway publication (CWIG 2012) that collates the most frequently requested services. These are:

3.1 Preparation for domestic and inter-country adopters

In the UK, all prospective adoptive parents are expected to first educate themselves over a two month period using Elearning materials (http://firststeps.first4adoption.org.uk/) and other materials supplied by their agency. An intensive four month period of preparation classes/seminars and a home study assessment then follows. Children being placed for adoption out of foster care have a full medical assessment that includes information on their birth and, where consent has been given, relevant information on the birth parents medical history. A full description of the child's early life is also provided by the social worker in the form of a Child Permanency Report. All this information should be given to the adoptive parents.

The Hague Convention lists topics that should be available in pre-adoptive training for those adopting inter-country. Topics include: discussion of risk factors associated with institutionalisation, common health problems, legal processes as well as education on attachment theory, identity formation and loss. The International Adoption Project (2002) found that people who received pre-adoption training were more likely to seek medical consultation prior to adoption, which resulted in a reduction in unexpected medical health

problems. However, unlike the UK (where medical treatment is free) the medical interventions children need are not always met by health insurance and families had to fund treatment themselves (Leung & Erich 2002). Welsh and colleagues' review (2007) of interventions for intercountry adopters notes that not all adopters receive good preparation. Unlike English domestic adopters where attendance at preparation groups is compulsory some intercountry adoptees receive their preparation on-line or none at all. Thereby losing out on the benefits of meeting other prospective adopters and the mutual support gained from the group.

3.1.1 Family dynamics and adoption adjustment

Using Census data, Krieder (2003) found that almost half of US families with adopted children also included birth or step-children. A survey of 390 adopted families in England found that 50% had adopted more than one child. Adopted families can therefore contain adopted, birth and step children and some adopted families also continue to foster children. Adoptive parents may struggle in their new role as parents and there may be conflict between the parents. Some adoptive parents suffer from post adoption depression or continue to experience grief and loss of their own because of infertility or other experiences such as the death of a birth child. There are also additional adjustments if a second child is adopted or a birth child is born.

It is argued that adoptive parenthood is unique because in comparison with other new parents adopters often face parenthood after a period of infertility and treatment; they become parents at an older age; are likely to be parenting a child with existing emotional and behavioural difficulties, perhaps parenting a child of a different ethnicity and have to cope with stigma of being an adoptive parent (McKay *et al.,* 2010). Although there are hundreds of research papers on the adjustment to parenthood of biological parents, a systematic review undertaken by McKay and colleagues (2010) found only 11 papers that were specifically concerned with adjustment to adoptive parenting. Their review found that in respect of mental health, adoptive parents had lower rates of distress in comparison with biological parents but post placement depression (associated with lack of sleep, coping with difficult behaviour, expectations unmet) was fairly common. Poor marital and social supports represent risk factors in biological new parents for depressed mood in the first year post birth. Therefore interventions are needed that improve marital relationships and boost support (see Harold *et al.,* 2016 for a review of what works to enhance inter-parental relationships).

3.1.2 Resolving loss and grief

All adopted children have experienced loss. Children may need help understanding why they were placed for adoption and/or they may be grieving loss of previous foster carers, siblings (if separated), and their birth families. Children who have been abandoned may face particular difficulties as they

know nothing about their backgrounds and the reason for the abandonment. Feelings of grief, anger, self-blame may surface and reappear at different points in the life cycle (e.g. starting school, puberty, etc.)

3.1.3 Identity formation

Identity formation is linked with the child having a coherent narrative of their history and family background. Young people have to figure out "Who am I?" and "How am I the same/different than my parents?" Adopted children have two sets of parents and relatives to integrate into their sense of self. It may be more difficult for children who have been adopted transracially. Older children may face enormous disruptions in culture, language, routine, and education, and their new families may have limited knowledge of the children's previous culture or way of life to facilitate their adjustment (Hegar & Watson, 2013).

3.1.4 Birth family contact

Adoptive families often need advice and support on how to ensure that contact with birth family members is beneficial for their child. They want advice on the content of letters that are exchanged, on any meetings that might take place and on how to prepare and support the child before and after any contacts. At some point in their lives adoptees may also want to access their case file or renew contact with their birth family.

Intercountry adoptees often return to their birth country with or without their adoptive parents. Some families prefer to take group tours, while other families create their own itinerary. Trips may enhance racial and ethnic identity development (Song & Lee, 2009) but planning such a trip needs careful consideration (Wilson & Summerhill-Coleman, 2013).

3.1.5 Effects of early experiences

The challenge of making and sustaining relationships with children who have often had previously very complex and difficult experiences is really unique for adoptive parents. Adopters also need help in understanding the real nature of their child's presentation. There might be a complex picture mixing "neurodevelopmental" problems such as ADHD and ASD or foetal alcohol syndrome, with problems of attachment, adjustment and response to trauma. Adoptive parents ask for help with children's behaviours such as self- harming, sexualised behaviours, aggressive and controlling behaviours and children's difficulty in seeking comfort and response to intimacy, coping with new situations/ transitions and making friendships. Behaviour in school can also be problematic and many adopted children have special educational needs. In addition adopted children are often the targets of bullying (Selwyn *et al.,* 2015). Children may also have difficulty sleeping, may wet and soil, hoard food or gorge not recognising when they are full.

3.2 Seeking help

Families use of post adoption services increases over time. In the US the Californian longitudinal adoption study reported that use of clinical services grew from 9% two years post adoption to 31% eight years post adoption. General adoption services such as visits by social workers also increased (Wind *et al.,* 2007). In the US, a National Survey of Adoptive Parents found that whilst 10% of children in the general population received mental health services, much greater use was made by adopted children: 46% of foster care adoptions, 35% of international adoptions (Vandivere *et al.,* 2009). In the US, those adopting from overseas were more likely to have met with someone from the agency to discuss post adoption support than those adopting domestically (Merrit & Festinger 2013). In England, adoptive families report the most difficulty during the teenage years with 14 years being the peak age of adoption disruptions (Selwyn *et al.,* 2015).

Several studies of post-adoption therapeutic programs indicate that most families come to these services many years after the child was placed with them, typically when the child is approaching or in early adolescence. In the US most families have sought counselling previously (Atkinson & Gonet, 2007; Lenerz *et al.* 2006). Evaluations of post-adoption programmes suggest that being able to receive services for as long as they are needed rather than for a time-limited period is linked with more positive outcomes (Atkinson & Gonet, 2007; Gibbs *et al.,* 2002). For parent-training programs, it is likely that the success of an early intervention would be enhanced by the opportunity for families to obtain follow-up support and counselling to apply principles or strategies in their own family situations and to address the needs of the children and parents (Selwyn *et al.* 2016).

Parents state they want:

- A quick response and services delivered in a timely manner
- Professionals who understand the adoption context, are 'adoption aware' and have specialist knowledge and skills
- Who strengthen the family's relationships and boost parental competence
- Who do not blame the parents or the child for the difficulties
- Who are compassionate in their response

Based on several evaluations of post-adoption programmes Livingstone-Smith (2015), sets out the tasks for workers. Professionals should first *actively engage* demonstrating to the family that he/she is indeed there for them by really listening in an accepting and non-blaming manner and validating their feelings and strengths. Family members need to feel truly heard and understood. A *responsive approach to service delivery* is critical, including being accessible and willing to respond to the family's needs, such as seeing them in the evenings or

going to their home, as well as returning phone calls and responding to crises promptly.. Workers need to *join with and support parents in a way that increases parental entitlement* and empowers parents to find solutions to their problems. When professionals also work individually with children, parents should be kept informed of the focus of the work and the children's progress and should learn how they can work on issues at home. Parents who are really struggling may have become isolated. *Opening family communication* is critically important in adoptive families, including facilitating communication within the family (between spouses, parents and children, and with previous attachment figures as appropriate) and opening communication with professionals. *Providing interventions that help parent's manage the child's behaviours* in ways that are nurturing and facilitate emotional regulation and reflective thinking. *Helping parents to focus on taking care of themselves* may involve a range of goals from working with the couple to increase their support of each other, helping them plan time to do something enjoyable, and linking them with outside supports. This process requires parents' gaining self-awareness and self-care skills (Hart & Luckock, 2004, 2006; Atkinson & Gonet, 2007).

3.3 Barriers to service use

Services in the past were often dismissive of family's difficulties and therefore adoptive parents were reluctant to ask for help and waited until crisis point. It is only in the last few years that adoptive parents have been given the message that it is *expected* that they will need help at some point in the adoption life cycle. Research (McKay & Ross 2011; Livingstone- Smith 2010; Selwyn *et al.,* 2015) has found that the barriers to service use are that:

- Parents feel they will be judged as inadequate and failing if they ask for help
- Parents and social workers lack knowledge about available services
- Assessments are poorly conducted
- Quality and availability of services differs markedly across the country.
- Lack of clinicians/practitioners with the necessary skills and knowledge of interventions - not adoption aware
- Support services provided at times that do not fit family's availability
- Access to services require high threshold or criteria that adopted children do not meet
- Financial cost

There are agencies who specialise in providing post adoption support. In the UK this includes the Post-Adoption Centre and in the US the Center for Adoption Support and Education. In England, the U.S. and Canada, there are adoption agencies that have developed specialized post-adoption assessment and therapeutic programmes, such as the Kinship Center in California, which

has a mental health clinic providing adoption-competent services and a program of Adoption/Permanency Wraparound services to prevent child placement outside the adoptive family. In England, agencies such as AdoptionPlus provide comprehensive multidisciplinary assessments and interventions such as DDP.

There are also therapists in private practice who are "adoption-competent" but these are a rarity and in most routine community services, therapists are "adoption blind" (Hart & Luckock, 2004). As reported in an English study of meeting families' needs after adoption, some adopters ultimately rejected services to which they were referred because they felt blamed for difficulties or felt the professional did not understand the complexities of adoption (Rees & Selwyn, 2009).

3.4 Assessment

Green and others (see www.sallydonovan.co.uk/2016/02/02/professor-jonathan-green-the-mental-health-needs-of-adopted-children/#comments) argue that families need an assessment process that is efficient and skilled enough to be able to sort out the different components of the problem and prioritise elements for intervention. The assessment process needs to be built on the best research and clinical evidence. He argues that:

- Services should be concentrated in co-ordinated regional networks of excellence linked to research centres
- Development of good screening for problems so that families and social workers and others can know when to refer on to more specialist services
- Specialist services themselves need to be co-ordinated to produce individualised effective treatments
- A recognition that these problems usually endure and that families need support and sustenance through the development of their children; they will not need help all the time but they need to know where they can get it if there is a crisis, so the availability of longer term support is crucial.

In comparison with the UK, the US has had fewer and has placed less emphasis on preventative services. However, the US has now recognised the importance of early intervention. The National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG) is a newly established five-year project working with eight sites that will implement evidence-based interventions or develop and test promising practices. A Permanency Continuum Framework has been created built on the premise that children in adoptive or guardianship families do better when their families are fully prepared and supported to address needs or issues as they arise. The

framework emphasizes *prevention and preparation.* To achieve optimal effectiveness, services and supports are preventative in nature, and focus on proactively identifying risk and protective factors and putting supports in place before difficulties burden the capacity of the family to address challenges. For further information see http://qic-ag.org/continuum-framework/.

3.3.1. Specific support accessed by intercountry adopters

In the UK, there is little research on the support accessed by inter-country adopters. These families have not been able, until very recently, to access the same range of support or specialist therapeutic services as those who adopt from care. Prior to 2016, many would have had to self-fund therapy for their child or themselves but medical care is free.

US research has found that intercountry adopters share in common with domestic adopters feelings of not being prepared for the task, especially emotional and psychological issues (Paulsen & Merighi 2009). The International Adoption Project surveyed parents of 820 children to ask about services for learning and behavioural needs. Almost 50% of parents reported that their child was receiving academic services through school: 41% of children were receiving Speech/Language services, 24.5% were receiving services for reading, 24% services for Mathematics and almost 18% of these 820 children were in occupational therapy: 7.7% were receiving occupational therapy specific to sensory skills and 9.9% specific to motor skills.

In addition outside the education system 33% of children had help from a private tutor, 32% were receiving private mental health services, 18% receiving private speech/language services, 12% were seeing an audiologist, 10% receiving private occupational therapy services and 7% were receiving private physical therapy services. Half of the parents reported that their children were receiving all the services they needed. 16.2% reported their children needed additional academic services, 7% needed additional speech/language services and 6% of children needed additional mental health services.

Despite generally accepted protocols (Miller, 2005) for " best practice" in the medical treatment of internationally adopted children, one study estimated that only about 15-20% of IA children received the evaluations recommended by adoption medicine specialists (International Adoption Project, 2002).

In English speaking countries there are gaps in the provision of adoption support services. Gaps are sometimes because of fewer services in rural areas, or individual agencies not investing in the development of services to meet the needs of the children being placed. However there are also some excellent services. In the next chapter some of the support services available in England are described.

4 Adoption services in England

In England, all adopters receive preparation and post placement have access to services supplied by their adoption agency. Services vary but typically include regular adoptive parent support groups, specific events such as a summer BBQ or Christmas party, training and workshop events and regular newsletters. Some agencies also provide a more extensive range of services such as adoption information sessions for extended family members and friends, buddy schemes for new and approved adopters, as well as weekend camps for adopted children and teenagers. It is important to note that adoption services have been for many years only available to those adopting domestically and it is very recent that some services have become available to inter-country adopters and adoptees. All UK agencies provide intensive telephone support and the opportunity for parents to come into the office or have home visits from their adoption worker.

4.0.1. Providing support for children and young people

Most agencies provide some activities for young people such as arts and crafts, music events, outdoor adventure activities, horse handling for those with special needs and disabilities, youth clubs for older children, groups for children age 8-11 years and under 5s play days (where parents can also meet for coffee).

A few agencies [recognising the need for adoptive parents to have some respite and for adopted children to meet other adopted children] run residential weekends for older children, summer day camps [during the school holidays] and activities on Saturdays and Sundays. These activities have proved very popular and are thought of by social workers as providing respite without placing

Typical training courses available for adoptive parents

Attachment theory and its application

Baby massage

Caring for children who have experienced trauma

Developing attachment through play and music

Educational issues

Internet safety

Life story work

Managing difficult behaviour

Paediatric first aid

Post adoption birth family contact

Safeguarding children

Sibling rivalry

The power of music

Telling

Theraplay

a child back with foster carers (Selwyn *et al.*, 2015). Respite is also sometimes provided by the adoption agency funding daytime child-minding or by commissioning activity holidays provided by large national companies. Most agencies provide life story work to help with identity integration.

4.0.2. Life story books and life story work

Children adopted from foster care have often experienced multiple foster placements and many changes of social worker prior to moving into their adoptive home. Unlike most families where parents keep mementos, children in care have often had no consistent adult helping them understand the moves that occurred in their lives or kept photos or other memorability safe. Consequently, children often have gaps in their knowledge of whom they lived with and when and why they were taken into care or adopted.

Life story books and life story work encompass a range of approaches. In England, it is a legal requirement that children being placed for adoption must have a life story book within ten days of the Adoption Order being made. In the US. there is variation in the extent to which states mandate the development of life story books. Good practice suggests that they are begun when children enter care. If children are reunified, it helps them and their parents to have a record of their experience, and if they transition to adoption, life story books provide the pieces of their life history to assist them and their adoptive parents in the future (Johnson & Howard, 2008; Livingstone-Smith, 2015).

A life story book is a product that is assembled often by the social worker in preparation for adoption but can also be co-produced with the child and adoptive parent at any time in the adoption life cycle. Books often need to be updated as the child's need for more detailed information increases with their chronological age. A life story book should give information about the birth family, previous foster placements and why the child was adopted. There is little research evidence (Watson *et al.,* 2015) on the usefulness of life story books but practitioners and adoptive families believe that life story books can be an integral part of understanding and coming to terms with the past. A dedicated worker or team of workers who specialise and develop their skills in the production of life story books produce higher quality and more effective books. One of the very few studies that have asked children their views on life story books (Thomas, 1999) found that in a sample of 33 domestically adopted children the majority were positive about their books but some children did not understand the information in them and some were of poor quality. A study on adoption disruption (Selwyn *et al.,* 2015) found that children who did not understand the reasons for their adoption or who held mistaken beliefs about their past often struggled with their adoptive identity, especially in adolescence.

Life story work can be considered as a form of therapy and is about assimilating past events and the effect of significant people on a child's life. Life story work can lead to the production of a life story book, use an existing life story book as

part of the therapy or be a stand alone therapy. The underpinnings of life story work lie in attachment and loss theory. Life story work encourages reflection and for children or young people to construct meaning and explanation of feelings with the assistance of a trusted adult (Rose & Philpot, 2005). This exploration helps children make the connections between "cognition and emotion, thinking and feeling" (Schofield & Beek, 2006, p. 358). Having a coherent account of one's past is also associated with recovery from trauma and PTSD.

There are a large number of books to guide workers in the making of life story books or undertaking life story work with children (e.g. Golding, 2014; Rose, 2012; Rees, 2009) and books specifically written for children (e.g. Alper, 2015, Naish & Jeffries, 2016). There are likely to be additional issues to address if children are placed transracially.

4.0.3. Involving adoptive parents in post adoption support services

Many agencies involve experienced adoptive parents in the provision of adoption support. Parents may share their experiences during training events or act as buddies or mentors to newly approved adopters. Market research (Bange *et al.,* 2014) has found that adoptive parents respond positively to input from other adopters and like personal accounts.

4.0.4. Financial support

In England, there is means testing to ascertain whether a family can receive an adoption allowance. There must be no element of reward in the allowance but it can be paid to enable a child to be adopted. There are also transitional arrangements for foster carers who are adopting but generally these enhanced foster carer payments only last for the first two years reverting to the lower adoption allowance. The adoption allowance is usually much less than a fostering allowance. The lower allowance may explain why fewer foster carers adopt in England in comparison with the US. In the US the availability of financial support in the US was found to be the most important determinant of a child being adopted by their former foster carer (Hansen and Hansen 2006). Other US surveys have also confirmed that the availability of subsidies was an important factor in people's decision to adopt, as a substantial number of adopters have very low incomes and depend heavily on adoption subsidies. Families receive Medicaid cards to help with dental and medical costs, including psychiatric and mental health expenses (Livingstone-Smith, 2010). However, many US adoptive families report that the subsidies are inadequate and do not cover medical expenses and that some providers especially dentists reject Medicaid cards.

In England, 'settling in grants' are frequently paid: a one off payment to pay for items such as new beds, clothes etc. In some cases, the settling in grant can be large where for example a sibling group is placed and a new car is needed or a child with a disability needs a bedroom on the ground floor and house

alterations have to be undertaken.

4.0.5. Statutory adoption leave and pay in England

Adopters who are employed are entitled to up to 52 weeks of adoption leave. There is no qualifying period of employment. Adopters are also entitled to a maximum of 5 days leave from work during the 'matching period' to allow them to visit the child. If adopting as a couple there is also 2 weeks of paternity leave. Maternity and paternity leave can be shared between the couple. An adopter (one of a couple) who has worked for their employer continuously for at least 26 weeks by the week they are matched with a child or notified of a fostering for adoption placement, may qualify for statutory adoption pay. This is 90% of earnings for the first 6 weeks, and £139.58 (2015-16) or 90% earnings, whichever is lower, for a further 33 weeks. To qualify they must earn at least £112 per week before tax (2015-16). (www.first4adoption.org.uk /adoption-support/adoption-leave-pay/).

4.1 Child and Adolescent Mental Health Services (CAMHS)

CAMHS are services provided freely by the National Health Service (NHS) for children with mental health problems in England. Referrals for interventions must be made by a doctor and/or social worker. Nationally mental health services are very under-funded and stretched and adopted parents often complain that they cannot access services. There are often long waiting lists or adopted children do not fit the strict criteria for a diagnosable mental health problem.

Consequently, specialist adoption mental health services have developed in two cities to meet the needs of children and families. For example, a London specialist service is a NHS clinic for adopted and fostered children that also takes referrals from across the country www.national.slam.nhs.uk/ services/camhs/camhs-adoptionfostering/.
The psychiatrists and psychologists who work within the team provide:

- Assessment of the young person, their attachments and identity, the family environment and their school functioning
- Psychometric assessment of the young person's abilities and emotional profile
- Assessment of educational attainment
- Specialist neuropsychological and social communication assessments
- Individual Cognitive Behavioural Therapy
- Skilled work on improving the parent and child relationship using real-time coaching
- Liaison with school and education services, including school visits and advice on behavioural management and learning strategies in class

- Consultation with social services, for example where there are multiple placement breakdowns
- Medication prescribed or reviewed

Whilst the clinics provide excellent services, most families live many miles away and cannot get to the clinics.

4.2 Therapeutic services within social work departments

Some Children's Services have built capacity within their own department and have created multi-disciplinary therapeutic teams. Teams usually comprise social workers, clinical psychologists, child psychotherapists, occupational therapists and sometimes educational psychologists and music/art therapists. The teams work with adopted children and their families and sometimes children in other types of permanent care e.g. kinship care. Teams usually have Dyadic Developmental Psychotherapy (DDP) qualified therapists working within the service, as well as other types of therapy such as family or art therapy. They also offer consultation time for members of the adoption teams. Sometimes the consultation might be about the suitability of a match or plan for adoption, as well as providing advice on supporting families. Some of the specialist teams also attend the preparation groups so that adopters have often met the therapists/psychologists before needing to ask for help. This type of service is highly valued by adoptive parents (Selwyn *et al.,* 2015). The teams work on an inclusive model and are more likely to work through the adoptive parents, rather than work directly with the child. In comparison, generic mental health services often have a private relationship with the child and the work is not discussed with parents. This can be a very unhelpful dynamic in adoptive families and can encourage splitting. The specialist services have a more inclusive model.

Access to these specialist mental health services has depended on where families lived. Those living in rural or poorer areas often had no access to services and therefore the government has funded the Adoption Support Fund. Families can apply for an assessment of need when they believe a therapeutic intervention is needed. Families then receive the intervention. The average spend per family has been about £5,000 - a small amount to invest in therapy compared with the cost of an adoption disruption and children returning to care.

4.3 Educational support for domestic adoptions in England

Educational support for adopted children is the least developed area of adoption support. There is great variation in the willingness of schools to consider adopted children's needs. However recent legislation has ensured that the additional educational support that children in care receive has been extended to cover adopted children too. Adopted children now have priority school admission and the school receives £1,600 per year for each adopted child (age 4-16 yrs). The school can choose how to use the funding to improve the educational gap. For example, children may need help at the start of the school day transitioning from the parent to the classroom, or help to stay calm moving between lessons, or additional help with reading. A personalised education plan may be developed to help the child.

There has also been encouragement for teachers to understand the basics of attachment theory and to be more sensitive to the needs of adopted children and those in care. http://www.attachmentawareschools.com/video section two.php_Teachers are also encouraged to use the strategies developed by Louise Bomber (2011) and for further information see www.theyellowkite.co.uk.

In a few areas of the UK, educational psychologists play a key role in supporting adoptive placements. For example they offer consultations to adoptive parents, provide trainingworkshops on educational matters and help teachers develop strategies to manage challenging behaviour and working with those at risk of exclusion Less commonly, educational psychologists accept referrals for video interactive guidance (www.videointeractionguidance.net/aboutvig) for adopted children, as a means to improve and support attachments.

4.3.1. Occupational therapy services

A few adoption support teams also include an occupational therapist (OT). The OT provides work on sensory processing and integration because of the extreme neglect many of the children suffered before being placed for adoption. Sometimes their work is combined with attachment based work (e.g. www.sensoryattachmentintervention.com/).

New services are constantly being developed, as there has been government funding available to innovate. As well as professionals innovating, the influence of adoptive parents on the content and delivery of services has increased in importance. Parents are involved at all levels: sitting on government expert working groups, responding to consultations and coworking with professionals on preparation groups. Adoption UK, set up by adoptive parents and run by adoptive parents, (www.adoptionuk.org.uk) has a major influence on policy and practice development. A more recent development has seen adoptive parents responsible for the delivery of a

support service (http://theadoptionsocial.com/blogless-blogging/an-interview-with-co-founder-of-the-cornerstone-partnership/).
This development is currently being evaluated.

In the last chapter, therapeutic interventions used in adoption families are described.

5 Interventions

In this chapter, specific interventions are described. These have been selected because they have either built a firm evidence base for their effectiveness or they been adapted for an adoption population from an evidence based programme. There are many other programmes delivered to adoptive families where there is less robust evidence. These include in the UK the Safebase parenting programme, (www.safebase.org.uk/) supported by the Department of Education and delivered in many areas of England and in the US an intervention known as ARC (attachment, self-regulation and competency). ARC is designed for work with children and young people who have multiple or prolonged traumatic stress. ARC has been used with adopted children (Hodgdon et al 2015) and is used by many clinicians practising in the area of child trauma (www.traumacenter.org/research/ascot.php). The creative therapies using music and art are also frequently used.

Due to limits on length and available time to complete the review these and many other interventions have had to be excluded. Very few interventions have been specifically adapted for intercountry adoptions (Welsh *et al.,* 2007).

The rating system used in this chapter for interventions is:

1 **Well-Supported by Research Evidence** The intervention must have at least two rigorous randomized controlled trials (RCT) with one showing a sustained effect of at least 1 year.

2 **Supported by Research Evidence** The intervention must have at least one RCT showing a sustained effect for at least 6 months

3 **Promising practice**, the intervention must have at least one study where a control group was used to establish benefit.

The interventions selected are: Attachment and Biobehavioral Catchup (ABC) , Circle of Security (COS), Dyadic Developmental Psychotherapy (DDP), Eye Movement Desensitization and Reprocessing for Children and Adolescents (EMDR), Nurturing Attachments: a group parenting programme, Parent-Child Interaction Therapy (PCIT), The Incredible Years (adapted), Theraplay, Trauma-Focused Cognitive-Behavioural Therapy (TF-CBT) , Videofeedback Intervention to promote Positive Parenting (VIPP), and AdOpt: a group parenting programme.

5.1 Attachment and Biobehavioural Catch-up (ABC).

Website: http://www.infantcaregiverproject.com/
Scientific rating: 1 Well supported by research evidence

5.1.1. Target Population

The ABC Intervention was initially designed for children ages 10 - 24 months old in foster care but has been adapted for younger children (younger than 10 months) and older children (from ages 24 to 36 months), as well as children being cared for by high-risk birth parents and **inter-country adopted children and their parents**. Many of the foster parents who received the intervention in reported studies were or went onto become **adoptive parents** for the child in their care (personal communication from Mary Dozier). ABC is delivered in Australia, UK and US. In Germany the certified coach is Ina Bovenschen: ina.bovenschen@psy.phil.uni-erlangen.de.

5.1.2. Brief Description

The intervention is based on attachment theory and stress neurobiology. *ABC* targets several areas that have been identified as problematic among children who have experienced early maltreatment and/or disruptions in care. These young children often behave in ways that push their caregivers away. While ABC is a manualized intervention that also incorporates video-feedback and homework, the most crucial aspect of the intervention is the parent coach's use of "In the Moment" comments that target the caregiver behaviours of nurturance, following the lead, delight, and non-frightening behaviours. These are used throughout the home visiting session while working with the parent.

5.1.3. Goals

- The ABC Intervention is designed to help parents provide:
- Nurturance even when children do not appear to need it
- Mutually responsive interactions in which caregivers follow children's lead
- Care that is not frightening or overwhelming to children, such as refraining from verbal threats
- Increase caregiver nurturance, sensitivity, and delight
- Decrease caregiver frightening behaviours
- Increase child attachment security and decrease disorganized attachment
- Increase child behavioural and biological regulation

5.1.4. Delivery

Ten hourly sessions delivered by a parent coach in the family's home. Parent coaches provide "in the moment" feedback to parents. They also videotape each session and review video feedback of past and current sessions with parents to highlight their strength.

5.1.5. Homework

Parents make and record weekly observations. For most weeks, daily activities are suggested.

5.1.6. Training

Potential parent coaches participate in a screening prior to training followed by a 2-3 day training at the University of Delaware and a year of supervision through videoconferencing to become a Certified Parent Coach.

5.1.7. Evaluations

Fewer children in the ABC intervention developed disorganized attachment than children randomly assigned to an alternate intervention (32 vs. 58%), as reported by Bernard *et al.* (2012). Children in the ABC intervention also showed more normative levels of cortisol production as measured across the day and in response to stress (Dozier *et al.,* 2006, 2008). ABC children were also better in regulating anger in a task designed to be frustrating, developing better inhibitory control, and showing more mature theory of mind, relative to children in the control condition. There is an RCT in progress comparing ABC with development education for families (DEF). The sample is inter-country adoptive parents.

5.1.8. Publications

Lind, T., Bernard, K., Ross, E., & Dozier, M. (2014). Intervention effects on negative affect of CPS- referred children: Results of a randomized clinical trial. *Child Abuse & Neglect,* 38(9),

Bick J. & Dozier M (2013). The effectiveness of an attachment based intervention in promoting foster mothers' sensitivity towards foster infants. *Infant Mental Health Journal,* 34(2), 95-103. doi:10.1002/imhj.21373

Bernard, K., Dozier, M., Bick, J., Lewis Morrarty, E., Lindhiem, O., & Carlson, E. (2012). Enhancing attachment organization among maltreated infants: Results of a randomized clinical trial. *Child Development.* Mar-Apr; 83(2):623-36.

Dozier, M., Peloso, E., Lewis, E., Laurenceau, J., & Levine, S. (2008). Effects of an attachment based intervention on the cortisol production of infants and toddlers in foster care. *Development and Psychopathology,* 20, 845-859

5.2 Dyadic Developmental Psychotherapy

Websites: http://ddpnetwork.org/about-ddp/ and http://ddpnetwork.org/usa-canada/
Evidence rating: 3 Promising practice
Developed by Dan Hughes, a US clinical psychologist. Since 2000, DDP has gained popularity in the UK. Many social workers in England have been trained to Level 1/2 and it is a common intervention used by adoption support teams with adoptive parents who are struggling to parent traumatised children.

5.2.1. Target Population

DDP is a treatment for families with adopted or fostered children (age 2-21yrs) who have experienced neglect and abuse in their birth families and suffered from significant developmental trauma.

5.2.2. Brief Description

It is based on and brings together theories on attachment, developmental trauma, intersubjectivity, child development, and the neurobiology of trauma. Troubled children may have had many changes of carer, find it hard to trust adults, and have developed insecure attachments. Children may try to stop their new parents from becoming emotionally close to them. The therapy helps the children learn to trust. It is family-based and involves the child with his or her caregivers. The therapeutic model provides a new way of day to day parenting based on the principles of PACE: playfulness, acceptance, curiosity (about the child's mental states) and empathy. There has been controversy regarding Dyadic Developmental Psychotherapy as an appropriate treatment. Based on the available literature, there is no evidence of harm from the use of DDP as described by the developers.

5.2.3. Goals

- Help parents and children to have a better relationship
- Help parents to make more sense of what might be the reasons behind or underneath their child's more concerning, confusing or worrying behaviour
- Help the child, with the parent alongside, to make sense of their current day to day feelings, thoughts and behaviours as well as the things that have happened in the past
- Help the child to understand how the parent's motives are different from the motives of past caregivers who provided them with inadequate care.

5.2.4. Delivery

Therapy normally begins with the therapist meeting with the parents to understand the nature of the difficulties and gathering any relevant background information on the child or the parents. The child then joins the therapy and through a range of techniques including talking, drawing, using puppets, and reading books together, the child is encouraged to describe their inner world.

Occasionally, the therapist only meets with the parents. The number of sessions depends on family circumstances.

5.2.5. Training

Before training candidates need to have a relevant degree and in the UK to be a registered with a relevant professional body or in the US to be a licensed therapist. Level one introduction is 28 hours of training. Level 2 is a further 28 hours- 56 hours of face to face training provided by a certified and approved DDPI trainer. When the candidate is ready to begin the Practicum, which is a supervised skills-based process that requires a minimum of 10 recorded reviews of DDP work. The work is reviewed and commented upon by a DDP consultant and forms part of the final assessment for accreditation. The DDP Institute is the official body that oversees accreditation.

5.2.6. Evaluations

A follow-up of four years after treatment (Becker-Weidman & Hughes, 2008) found that the 34 youth in the treatment group demonstrated significant improvements on all scales of the Child Behaviour Checklist, and these gains were sustained four years after treatment, while the 30 subjects in the comparison group receiving other forms of treatment did not demonstrate sustained gains on any subscales. An RCT is underway in four sites in the UK. The research is led by Professor Helen Minnis from the University of Glasgow.

5.2.7. Publications

Becker-Weidman, A. (2012). Dyadic Developmental Psychotherapy: Effective Treatment for Complex Trauma and Disorders of Attachment. Illinois Child Welfare, 6(1), pp 119-129.

Becker-Weidman, A., & Hughes, D. (2008). Dyadic developmental psychotherapy: An evidence-based treatment for children with complex trauma and disorders of attachment. *Child and Family Social Work, 13,* 329-337. http://ddpnetwork.org/backend/wp-content/uploads/2013/12/Dyadic-Developmental-Practice-Paper-BPS-CYP-Review-.pdf

5.3. Eye Movement Desensitization and Reprocessing for Children and Adolescents (EMDR).

Website: www.emdr.com
Scientific rating: 1 well supported by research evidence
Target Population: Children (age 2-17yrs) who have experienced trauma who are suffering from posttraumatic stress, phobias, and other mental health disorders. It has not been adapted for adoption populations.

5.3.1. Brief Description

EMDR therapy is an 8-phase psychotherapy treatment. During the EMDR trauma processing phases, guided by standardized procedures, the child/young person attends to emotionally disturbing material in brief sequential doses that include their beliefs, emotions, and body sensations associated with the traumatic event while simultaneously focusing on an external stimulus. Therapist directed bilateral eye movements are the most commonly used external stimulus, but a variety of other stimuli including hand-tapping and audio bilateral stimulation are often used. Using standardized procedures, therapy accesses the stored memories, activates the brain's information system and, through reprocessing, helps move the disturbing information to adaptive resolution. When working with children and young people EMDR integrates play therapy and other tools for working with children. A therapeutic relationship is established, the child is comprehensively assessed and prepared for processing. Focused target assessment and memory reprocessing are conducted throughout the complete eight-phases of EMDR therapy.

5.3.2. Goals

- Target the past events that trigger disturbance
- Target the current situations that trigger disturbance
- Determine the skills and education needed for future functioning
- Reduce subjective distress
- Strengthen positive beliefs
- Eliminate negative physical responses
- Promote learning and integration so that the trauma memory is changed to a source of resilience

5.3.3. Delivery

Usually one 50 or 90-minute session per week. Length of treatment varies from 3-12 sessions. Delivered in an office.

5.3.4. Homework

This program does not include a homework component.

5.3.5. Training

Must be either fully licensed mental health professionals or be enrolled beyond the first year in a Master's or Doctorate level program in the mental health field (Social Work, Counselling,

Marriage Family Therapy, Psychology, Psychiatry, or Psychiatric Nursing) and on a licensing track working under the supervision of a fully licensed mental health professional. There is a manual that describes how to implement this program, and there is training available www.emdr.com . The basic training consists of two 3-day training modules. In addition, 10 hours of case consultation are required to learn to implement the protocol. Qualified trainers are listed on the following webpage: www.emdria.org

5.3.6. Evaluations

Overviews of EMDR research (e.g. Fleming 2012) note that EMDR has solid research support for the treatment of Type I traumas (e.g. natural disasters, road traffic accidents, burglaries). It may be more efficient than cognitive behavioural therapy (de Roos *et al.,* 2011), and its application results in significant remission of symptoms (depression, anxiety, PTSD) with results maintained at long-term follow-up. However, it has only preliminary evidence for the treatment of Type II traumas, with just one study showing its effectiveness with sexually abused girls (Jaberghaderi *et al.,* 2004). The results are promising, but more research is needed to assess EMDR's effects with children who have suffered repeated interpersonal traumas, and evidence suggests in some cases it may be beneficial to provide EMDR as part of a multimodal treatment package including family therapy.

5.3.7. Relevant Publications

Adler-Tapia, R., & Settle, C. (2009). Evidence of the efficacy of EMDR with children and adolescents in individual psychotherapy: A review of the research published in peer-reviewed journals. *Journal of EMDR Practice and Research,* 3(4), 232-247.

Fleming J. (2012). The Effectiveness of Eye Movement Desensitization and Reprocessing *Journal of EMDR Practice and Research,* 6 (1) 16-26.

Rodenburg, R., Benjamin, A., de Roos, C., Meijer, A. M., & Stams, G. J. (2009).Efficacy of EMDR in children: A meta-analysis. *Clinical Psychology Review, 29,599-606*.

de Roos, C., Greenwald, R., den Hollander-Gijsman, M., Noorthoorn, E., van Buuren, S., & de Jongh, A. (2011). A randomized comparison of cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) in disaster-exposed children. European Journal of Psychotraumatology, 2, 5694-5704

Rubin, A., Bischofshausen, S., Conroy Moore, K., Dennis, B., Hastie, M., Melnick, L., & Smith, T. (2001). The effectiveness of EMDR in a child guidance center. *Research on Social Work Practice,* 11(4), 435-457.

5.3.8. Other information

Materials are available in Danish, Dutch, English, Flemish, French, German, Haitian Creole, Hebrew, Italian, Japanese, Mandarin, Spanish, and Swedish

5.4. Circle of Security (COS)

Website: www.circleofsecurity.net
Scientific rating: 3 promising practice. There are several different COS interventions designed for different age groups but only COS-HV4 has a scientific evidence rating. COS is included because it is used throughout the world and is popular with practitioners. An RCT is underway in Germany with mentally ill mothers and their infants (see http://bmcpsychiatry. biomedcentral.com/articles/10.1186/1471-244X-14-24 It has not been adapted for adopted populations.
Target population COS-HV4 for irritable infants and their parents

5.4.1. Description

COS is based on attachment and object relations theory and family systems theory. It is primarily used in the US but also Australia, Germany, Italy, Japan, Norway, New Zealand and Romania. Core components are: helping the mother recognise the infant's signals, helping mothers respond to both attachment and exploratory behaviours and understanding how responses affect the infant. Interactions are videoed and reviewed the following day with the worker pointing out where the mother has been attuned to the infant and those where 'serve and return' went awry.

5.4.2. Goals of COS-HV4

- Increase security of attachment of the child to the parent
- Increase parent's ability to read child's cues
- Increase empathy in the parent for the child
- Decrease negative attributions of the parent regarding the child's motivations
- Increase parent's capacity to self-reflect
- Increase parents capacity to pause, reflect, and choose security promoting caregiving behaviours
- Increase parent's capacity to regulate stressful emotional states triggered by the child's behavior

5.4.3. Delivery

Through home visits and group settings. COS-HV4 has a mandatory 4 home visits consisting of one 3-hour assessment session followed by a 1.5-hour session every two to three weeks.

5.4.4. Homework

Parents are asked to notice "Circle Moments" between sessions. These are moments where their child shows a need on the Circle. Each meeting starts with asking the parent to share what they noticed that week.

5.4.5. Training

The professional (who works with the parent throughout the whole intervention) are mental health professionals with a Master's level degree and must have completed the advanced 10- day Circle of Security training, passed the competency exam, and received supervision from a Circle-of-Security-approved supervisor for 5 complete interventions (each intervention consists of an

evaluation and four home visits). There is a manual.

5.4.6. Evaluations

Studies show a statistically significant decrease in disorganised and insecure attachments in the treatment group.

5.4.7. Relevant publications

Cassidy, J., Woodhouse, S.S., Sherman, L.J., Stupica, B., & Lejuez, C.W. (2011). Enhancing infant attachment security: An examination of treatment efficacy and differential susceptibility. *Journal of Development and Psychopathology, 23,* 131-148.

Powell B Cooper G & Hoffman K (2013). The Circle of Security Intervention: Enhancing Attachment in Early Parent-Child Relationships. Guildford Press

Powell, B., Cooper, G., Hoffman, K., & Marvin, R. (2009). The Circle of Security. In Zeanah, C. H. (Ed.), *Handbook of infant mental health* (3rd ed.), Guilford Press.

5.5. Trauma-Focused Cognitive-Behavioural Theapry (TF-CBT)

Website: https://tfcbt.org
Scientific rating: 1 well supported by research evidence
Target Population: Parents of children (3-18 yrs) with a known trauma history who are experiencing significant Post-Traumatic Stress Disorder (PTSD) symptoms, whether or not they meet full diagnostic criteria. In addition, children with depression, anxiety, and/or shame related to their traumatic exposure. Children experiencing Childhood Traumatic Grief can also benefit from the treatment. It has not been adapted for adoption populations.

5.5.1. Brief Description

TF-CBT is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioural difficulties related to traumatic life events. It incorporates trauma-sensitive interventions with cognitive behavioural, family, and humanistic principles.

5.5.2. Goals

The overall goal of TF-CBT is to address symptoms resulting from a specific traumatic experience or experiences. This includes:

- Improving child PTSD, depressive and anxiety symptoms
- Improving child externalizing behaviour problems (including sexual behaviour problems if related to trauma)
- Improving parenting skills and parental support of the child, and reducing parental distress
- Enhancing parent-child communication, attachment, and ability to maintain safety
- Improving child's adaptive functioning
- Reducing shame and embarrassment related to the traumatic experiences

5.5.3. Delivery

In the home or a clinic setting, weekly sessions of 30-45 minutes for child and 30-45 minutes for parent. The programme model also includes conjoint child-parent sessions toward the end of treatment that last approximately 30-45 minutes. Treatment lasts 12-18 sessions.

5.5.4. Homework

Parents are given weekly assignments to practice the treatment components at home, both alone and to reinforce and practice these with their children. Children are also given homework during certain sessions to reinforce and practice skills learned in therapy sessions.

5.5.5. Training

Professionals must have a Master's degree and experience of working with children and families. Training comprises an Introductory Overview: 1-8 hours, Basic Training: 2-3 days, Ongoing Phone Consultation (twice monthly for 6-12 months): groups of 5-12 clinicians receive ongoing case consultation to implement TF-CBT for patients in their setting. Advanced Training: 1-3 days. In addition there is a ten-hour basic web-based training free of charge, is available at

www.musc.edu/tfcbt. A free web-based consultation product in implementing TF-CBT is available at www.musc.edu/tfcbtconsult (completion of TF- CBTWeb is required prior to accessing this product). Information about training and consultation and support for implementation is available from the National TF-CBT Therapist Certification Program at https://tfcbt.org.

5.5.6. Evaluations

Children assigned to TF-CBT, demonstrated significantly more improvement in comparison with controls with regards to PTSD, depression, behaviour problems, shame and abuse- related attributions. Parents assigned to TF-CBT also showed greater improvement on selfreported levels of depression, abuse-specific distress, support of the child, and effective parenting practices.

5.5.7. Relevant Publications

Deblinger, E., Thakkar-Kolar, R., & Ryan, E. (2006). Trauma in Childhood. In Follette, V.M. & Ruzek, J. (Eds.) *Cognitive behavioural therapies for trauma.* New York: Guilford Press.

Dorsey, S, Pullman, MD, Berliner, L, Koschmann, E, McKay, & Deblinger, E (2014). Engaging foster parents in treatment: A randomized trial of supplementing Trauma-focused Cognitive Behavioral Therapy with evidence-based engagement strategies. Child Abuse & Neglect, 38, 1508-1520.

Cohen, JA, Mannarino, AP & Iyengar, S (2011). Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence. Archives of Pediatrics and Adolescent Medicine, 165, 16-21.

Kind, N, Tonge, BJ, Mullen, P, Myerson, N, Heyne, D, Rollings, S, Martin, R & Ollendick, TH (2000). Treating sexually abused children with posttraumatic stress symptoms: a randomized clinical trial. Journal of the American Academy of Child & Adolescent Psychiatry, 59, 1347-1355.

5.5.8. Other information

Materials are available in Dutch, German, Japanese, Korean, Mandarin, Polish, Spanish

5.6. Parent-Child Interaction Therapy (PCIT)

Website: www.pcit.org
Scientific rating: 1 Well supported by research evidence
Target Population: Children age 2 - 7 years old with behaviour and parent-child relationship problems. May be conducted with parents, foster parents, or other caretakers.

PCIT is available throughout the world. The PCIT program in Schweinfurt, Germany, is located at the Leopoldina Child and Adolescent Psychiatry and Psychotherapy program, which offers comprehensive outpatient, inpatient and day treatment services for children and adolescents (2-18yrs) and their families.

5.6.1. Brief Description

PCIT is based on Baumrind's (1966) developmental theory of parenting. PCIT is a highly specified, step-by-step, live coached sessions with *both* the parent/caregiver and the child. It teaches parents traditional play-therapy skills to use to encourage positive child behaviour and management skills to decrease negative behaviour. Parents are taught and practice these skills with their child in a playroom while coached by a therapist. The coaching provides parents with immediate feedback on their use of the new parenting skills, which enables them to apply the skills correctly and master them rapidly. Therapists typically coach from an observation room with a one-way mirror into the playroom, using a "bug-in-the-ear" system for communicating to the parents as they play with their child. Concluding each session, therapist and caregiver together decide which skill to focus on most during daily 5-minute home practice sessions the following week. Change is assessed through regular use of standardised measures. The distinctiveness of this approach lies in the use of live coaching and the treatment of both parent and child together. PCIT is the only evidence-based practice in which the parent and child are treated together throughout the course of all treatment sessions.

5.6.2. Goals

- For children to reduce noncompliance, aggression, rule breaking, disruptive behaviour, dysfunctional attachment with parent, internalizing symptoms.
- For parents to address ineffective parenting styles (e.g., permissive parenting, authoritarian parenting, and overly harsh parenting)

5.6.3. Training

Certified PCIT therapists must have a Master's degree or higher, or an international equivalent in a mental health field and be a practising mental health therapist /psychologist/social worker or be in the third year of training and be conducting supervised clinical work. There is lengthy initial training: 40 hours of face to face training or 10 hours on-line +30 hours face to face. Training continues for a further year focusing on active practising of skills. A manual is available.

5.6.4. Delivery

One or two 1 hour sessions per week delivered in an agency or clinic setting. Needed are two connected rooms with a one-way mirror on the adjoining wall (one room for client, other room for coach) or another method for the therapist to unobtrusively observe the parent. A wireless

communications set consisting of a head set with microphone and an ear receiver (i.e., "bug in the ear") and a VCR and television monitor to tape record sessions for supervision, training, and research purposes. However, PCIT adaptations have been made for treatment settings that lack one way mirrors and/or "bug-in-ear" devices by using walkie-talkies or having the therapist sit in the room. The average number of sessions is 14, but varies from 10 to 20 sessions. Treatment continues until the parent masters the interaction skills to pre-set criteria and the child's behaviour has improved to within normal limits.

5.6.5. Homework

During the first phase of treatment, homework consists of a daily 5-minute parent-child play interaction in which the parent practices the relationship enhancement skills.

5.6.6. Evaluations

Research compiled over three decades has shown that PCIT is associated with significant and enduring impacts on externalizing problems among children ages 2-7 years. Emerging evidence suggests that PCIT may reduce internalizing problems such as anxiety and depression as well and enhance parenting attitudes and skills while reducing caregiver stress Studies have replicated these results with child welfare service recipients, including children in foster care.

An evaluation of the intervention with 85 adopted children found that there were significant improvements in positive parenting techniques, reductions in parenting stress, and reductions in externalizing and internalizing concerns among the children (Allen *et al.,* 2012).

5.6.7. Relevant Publications

An up to date list of relevant research is available at http://www.pcit.org/literature.html

Allen, B., Timmer, S. G., & Urquiza, A. J. (2014). Parent-Child Interaction Therapy as an attachment- based intervention: Theoretical rationale and pilot data with adopted children. Children & Youth Services Review, 47334-341

Bertrand, J. (2009). Interventions for children with fetal alcohol spectrum disorders (FASDs): Overview of findings for five innovative research projects. *Research in Developmental Disabilities,* 30(5), 9861006.

Child Welfare Information Gateway. (2013). *Parent-child interaction therapy with at-risk families.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau

Mersky, J. P., Topitzes, J., Grant-Savela, S. D., Brondino, M. J., & McNeil, C. B. (2014).Adapting Parent- Child Interaction Therapy to foster care outcomes from a randomized trial. *Research on Social Work Practice.* Advance online publication. http://uwm.edu/icfw/wp-content/uploads/sites/384/2016/05/PCIT.pdf

Nixon, R. V., Sweeney, L., Erickson, D. B., & Touyz, S. W. (2003). Parent-child interaction therapy: A comparison of standard and abbreviated treatments for oppositional defiant preschoolers. Journal Of Consulting And Clinical Psychology, 71(2), 251-260.

Timmer, S. G., Urquiza, A. J., & Zebell, N. (2006). Challenging foster caregiver-maltreated child relationships: The effectiveness of parent child interaction therapy. Children & Youth Services Review, 28(1), 1- 19.

Timmer, S. G., Urquiza, A. J., Zebell, N. M., & McGrath, J. M. (2005). Parentchild interaction therapy: Application to maltreating parent-child dyads. *Child Abuse & Neglect,* 29(7), 825-842.

Timmer, S. G., Urquiza, A. J., & Zebell, N. M. (2005). Challenging foster caregiver maltreated child relationships: The effectiveness of parent-child interaction therapy. *Child and Youth Services Review,* 28, 1-19.

5.7. Nurturing Attachments Groupwork Programme

Website: http://ddpnetwork.org/
Scientific rating: 3 promising practice
Target Population: Adoptive parents, kinship carers or foster carers who are parenting children who have experienced trauma and/or who have attachment difficulties.

5.7.1. Brief description

This UK based programme daws on attachment theory, reflective functioning theory and research on trauma and neuroscience. It is strongly influenced by the concepts that underpin DDP. Kim Golding, a clinical psychologist and the programme's developer was trained by Dan Hughes and sits on the board of the DDP Institute. In the 'House Model of Parenting' promoted by the group work programme, behavioural change is believed to come from secure foundations. Discipline is informed by empathy and connection. Parents are introduced to the concepts of mentalization and the concepts of PACE (playfulness, acceptance, curiosity and empathy), as a means to transform relationships and practice new skills (Hughes 1997). Parents are encouraged to manage behaviours but within the much broader context of building children's trust and security and enhancing their development. Practical suggestions are offered and are grounded in theory so that parents can develop a deeper understanding about what they are trying to achieve, and can be flexible in the way that they use and adapt the ideas being discussed.

5.7.2. Goals

The programme aims to:

- Improve parents/carers understanding of attachment /trauma theory and the implications for the development of relationships
- Develop parent's capacity for mentalization and sensitive parenting
- Use the concept of PACE in their day to day parenting
- Improve communicative openness within the family
- Help parents/carers to be more aware of the need for self care and to pay attention to their own well-being

5.7.3. Delivery

Nurturing attachments consists of three modules each containing six three hour sessions - 18 hours of training. It is delivered to groups of parents. The programme is manualised and contains a training resource that includes theoretical content, process notes, and a range of activities supported by reflective diaries, activity sheets and handouts.

5.7.4. Homework

There is no set homework but parents/carers are encouraged to use the learning from each group in between sessions. The length of the programme allows parents/carers to practice and raise questions about the approach.

5.7.5. Training

There is a no training currently available and as a new intervention there is no accreditation body. There is a published manual.

5.7.6. Evaluations

A few small-scale evaluations showed some small statistically significant differences on standardised measures after receiving the programme. In contrast, the qualitative accounts of participants in those studies described high levels of satisfaction, increased understanding of difficulties, greater mentalization and lower parental stress. One evaluation (Wassall *et al.,* 2011) using an intervention vs waiting list control group found that carers' sense of competence and confidence improved immediately after and eight months following the programme but other outcome measures showed no improvement. A more recent evaluation (Selwyn 2016) found that: the programme met the goals that parents had *independently* set for themselves before the training began. Parents did show a statistically significant increased capacity for reflective functioning post-training and the biggest change was seen on the scale that measures curiosity and interest in children's mental states. Those skills are very important in not jumping to conclusions about children's behaviours or assuming negative intentions. Improved skills in this area should lead to parents being able to stay self-regulated which over time could increase children's self-regulation. However, that study did not include a control group and therefore the programme remains as a 'promising practice'.

5.7.7. Relevant publications

Golding, K. S. (2013) *Nurturing Attachments Training Resource. Running parenting groups for adoptive parents and foster or kinship carers.* London: Jessica Kingsley Publishers

Golding, K. S. and Hughes D. A. (2012) *Creating Loving Attachments. Parenting with PACE to nurture confidence and security in the troubled child.* London: Jessica Kingsley Publishers

Selwyn, J. (2016 in press) *An evaluation of Nurturing Attachments group work programme*

Wassall, S. (2011) *Evaluation of an attachment theory based parenting programme for adoptive parents and foster carers.* Clin.Psy.D. thesis, University of Birmingham.

5.8. The Incredible Years Parenting Programme adapted for use with adoptive parents Website

Website: http://incredibleyears.com/
Scientific rating: 1 for the IY programme but there is no rating for the programme adapted to meet adoptive parent's needs.

5.8.1. Target Population

Adoptive parents who have children aged 3-9 yrs. Targeting parents of high risk children and those with behaviour problems.

5.8.2. Brief Description

The Incredible Years (IY) programme is a well established and respected parenting programme. It consists of four elements: play, praise and reward, effective limit setting and dealing with non-compliance, handing misbehaviour. The orginal IY programme has been adapted by Coram (a large English adoption agency). Amendments included adding material on the function of play for maltreated children, regression, developing strategies for praise that do not lead to disruptive behaviour , telling about adoption. More detail on the amendments are available at http://archive.c4eo.or. The amendments were approved by the programme's developer Carol Webster-Stratton and have been manualised.

5.8.3. Goals of the amended programme

- Improve adoptive parents' ability to deal with parenting issues
- Enable adopted children and adults to feel more positive about their background
- Provide adopters with a 'toolkit' of strategies to use to encourage positive engagement
- Provide a forum for peer support.

5.8.4. Delivery

12 parenting groups delivered weekly with a crèche available for the children allowing both parents to attend.

5.8.5. Homework

Weekly assignments for parents to practice new strategies. Sessions begin with a round up of the previous week and a discussion of how the homework tasks have gone.

5.8.6. Evaluations

There have been three evaluations of the adapted programme using standardised measures and feedback of those attending but none have used a control or comparison group. One of the evaluations included a 12 month follow-up. Parenting stress levels overall fell (although this failed to reach statistical significance). Parents reported feeling significantly more competent after the course, found their children significantly more positively reinforcing, and reported significantly fewer difficult life events after the course. They found their children's characteristics less stressful and found interactions with their child(ren) more positively rewarding and enjoyable. There were

also reductions in parental reports of conduct disorder and a reduction in the general level of behavioural difficulties reported by parents amongst their children. In addition, during interviews and group sessions, parents reported feeling supported and understood by the group and that they valued the experience of being with highly trained adoption social workers and other adoptive parents. The research also demonstrated that over a period of a year, the adopters continued to report that they felt their competence as parents had been enhanced, and that they were, overall, managing their children more effectively. Families benefited most if the parents attend within six months - two years of the child joining their family

5.8.7. Training

Coram and the Anna Freud Centre (London) run 'train the trainer' courses twice a year for professionals who are already familiar with the Incredible Years programme. Coram has produced a manual for facilitators delivering the Parenting Skills for Adopters training programme. This manual is available to those attending the 'train the trainers' course

5.8.8. Publications

Henderson, K. & Sargent, N. (2005). Developing the Incredible Years Webster-Stratton parenting skills training programme for use with adoptive families. *Adoption and Fostering,* Vol 29, Number 4, pp 34-44

Menting, A. T., Orobio de Castro, B., & Matthys, W. (2013). Effectiveness of the Incredible Years parent training to modify disruptive and prosocial child behavior: A meta-analytic review. *Clinical psychology review,* 33(8), 901-913.

And http://archive.c4eo.org.uk/themes/adoptionfostering/vlpdetails.aspx?lpeid=472.

5.9. Video-feedback Intervention to promote Positive Parenting (VIPP)

Website: www.leidenattachmentresearchprogram.eu/vipp/en
Scientific rating: 1 well supported by research evidence
Target population Adoptive parents with children 0-12 months and VIP-SD for children aged 1-4.

5.9.1. Brief Description

Based on insights from attachment theory and building on knowledge from meta-analytic studies, Video-feedback Intervention to promote Positive Parenting (VIPP) was developed by Juffer and colleagues at the University of Leiden. Since 2000 Dutch parents can ask for this service for each newly adopted child, including special-needs or older-placed children and sibling placements.

It is a short term home-based intervention directed at sensitive parenting by utilizing video feedback. The structure of the VIPP intervention closely follows the components of Ainsworth's concept of sensitivity by paying attention in the first and second home visit to teaching parents how to *accurately perceive and interpret their child's signals,* and in the third and fourth session by reinforcing and promoting parents' efforts to respond to their child's signals in *prompt and adequate ways.* VIPP has been adapted to work with parents of children beyond infancy with a focus on sensitive discipline VIPP-SD and to be used with fathers and in groups.

5.9.2. Goals

The main objective of the VIPP is to promote the parent's sensitivity by showing and reinforcing moments of sensitive parenting of the parent herself in video fragments.

5.9.3. Delivery

4-6 sessions in the home or in groups. In the VIPP programmes, parent and child are videotaped during daily situations at their home (e.g. playing together, bathing, mealtime) during brief episodes of 10-30 minutes. Parents are encouraged to react to their children the way they normally do. In the period between the home visit and the intervention session, the professional views the videotape and prepares comments on the parent-child interaction as shown on the videotape. The professional writes down these comments, directed by the guidelines of the protocol and screens the videotape for suitable fragments to connect the information in the guidelines to the video fragments, and this script serves as a guide for the video feedback in the intervention session.

5.9.4. Training

The Leiden Centre for Child and Family Studies offers regular training courses on how to use VIPP and VIPP-SD in practice (www.leidenattachmentresearchprogram.eu/vipp). It has a manual and protocol. Five days of training is followed up by coaching and supervision of practice.

5.9.5. Evaluations

VIPP has been tested in various countries in a number of RCTs with at-risk parents or children. All studies have shown an increase in maternal sensitivity and those with a longer follow up reduced risk of conduct problems for children at age 4-6yrs. Research is showing that children are differentially susceptible to intervention effects. A study of children aged 1-3yrs screened for relatively high levels of externalizing behaviour found the VIPP-SD program proved to be effective in decreasing daily cortisol production in children with the DRD4 7-repeat allele (a variant of the dopamine receptor gene that is associated with motivational and reward mechanisms and ADHD in children), but not in children without the DRD4 7-repeat allele. Similarly mothers of highly reactive infants were more susceptible to the influence of VIPP and gained more in sensitivity, and that highly reactive infants in their turn were more susceptible to (changes in) their mothers' sensitivity.

5.9.6. Publications

Juffer, F., Bakermans-Kranenburg, M.J., & Van IJzendoorn, M.H. (2008). Promoting positive parenting: An attachment-based intervention. New York: Lawrence Erlbaum / Taylor & Francis.

Juffer, F., Bakermans-Kranenburg, M. J. and van IJzendoorn, M. H. (2005), The importance of parenting in the development of disorganized attachment: evidence from a preventive intervention study in adoptive families. *Journal of Child Psychology and Psychiatry, 46: 263-274.*

VIPP-SD brochure detailing publications
file:///C:/Users/swits/Chrome%20Local%20Downloads/brochure%20VIPP-SD%20English.pdf

5.9.7. Other information

VIPP is available in the UK, the USA, Australia, Finland, Portugal, Israel and Kenya.

5.10. Theraplay

Website: www.theraplay.org
Scientific rating: 3 promising practice
Target Population: Children ages 0-18 who exhibit behavioural problems and their caregiver (biological, adoptive, or foster). Usually provided for individual families but can be group based

5.10.1. Brief Description

Theraplay is a structured play therapy for children and their parents. The sessions are designed to be fun, physical, personal, and interactive and replicate the natural, healthy interaction between parents and young children. Because of its focus on attachment and relationship development, it has been used for many years with foster and adoptive families and is provided by some agencies in England (see http://www.adoptionplus.co.uk/userassets/Theraplay_-_quick_guide_final.pdf). Using the *Marschak Interaction Method (MIM),* in which the child and one parent perform a series of interactive tasks together The *MIM* is a structured technique for observing the relationship between two individuals. It consists of a series of simple tasks designed to elicit a range of behaviours in four dimensions: Structure (key concepts: Safety, Organization, Regulation); Engagement (key concepts: connection, attunement, acceptance, expands positive affect); Nurture (key concepts: regulation, secure base, worthiness); Challenge (key concepts: competence, confidence, supports exploration). The interactions are videotaped and later analyzed by the therapist(s) in preparation for a fourth session with the parents where the plan for intervention is agreed. Direct theraplay with the family is used for the remaining sessions.

5.10.2. Goals

- Increase child's sense of felt safety/security
- Increase child's capacity to regulate affect
- Increase child's sense of positive body image
- Ensure that caregiver is able to set clear expectations and limits
- Ensure that caregiver's leadership is balanced with warmth and support
- Increase caregiver's capacity to view the child empathically
- Increase caregiver's capacity for reflective function
- Increase parent and child's experience of shared joy
- Increase parent's ability to help child with stressful events

5.10.3. Delivery

Families typically receive 30-45 minute weekly sessions (shorter for younger children) for approximately 18 months (weekly for 18-24 weeks then four follow-up sessions) in the home or office/clinic setting. Ideally, an agency would have a large treatment room with a small couch and two gym mats. Optimally there would be very few other games/toys/furniture in order to reduce distraction. Optimally there would be an adjacent observation room with a one-way mirror to see the session. This requires some type of audio system (e.g. .baby monitors). Equipment is needed to record the sessions.

5.10.4. Homework

Parents use the play activities at home with their child, starting with activities that have been enjoyed during therapy.

5.10.5. Training

Professionals must already have a Master's degree in a relevant field. Training is offered in several countries with some distance learning available. The Introductory training is 26 contact hours over four days. Intermediate training is 19 contact hours over three days. The supervision practicum to become certified includes an additional 40 supervised hours.

5.10.6. Evaluations

Since Theraplay replicates normal parent child interactions it is easily understood by parents and is enjoyable. It is particularly suited to infants and toddlers. Evaluations have found that it has improved communication in newly formed adoptive families, reduced internalising (shy withdrawn) behaviours in children and improved significantly children's assertiveness, self confidence and trust.

5.10.7. Relevant Publications

Booth, P. B. (2000). Forming an attachment with an adopted toddler using the Theraplay approach. In: *The Signal. Newsletter of the World Association for Infant Mental Health, July-Sept,* 8(3).

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5.10.8. Other information

Materials are available in Finnish, German, Japanese, Korean, Spanish, Swedish

5.11. AdOpt: a group parenting programme Website

Website: www.adopttraining.org.uk/
Scientific rating- none but currently being evaluated by Professor Gordon Harold , Director of the Rudd Centre for Adoption Research and Practice at the University of Sussex.
Target population adoptive families with children aged 3-8 years.

5.11.1. Brief Description

This new programme (not to be confused with the US programme Adopts) is a group parenting programme specifically designed for adoptive parents to offer parenting techniques which address the specific difficulties that adopted children may present. The intervention is informed by learning from neuroscience, behavioural psychology and attachment theory. It is designed as a *preventative* programme to help parents understand and respond to the often complex needs of their children and get off to a healthy start. The programme is a collaboration between Professor Phil Fisher (Professor of Psychology, University of Oregon and Senior Scientist at Oregon Social Learning Centre), who is an adoptive parent, the National Implementation Service and the Department for Education (DfE), who commissioned the programme. The programme's origins lie in the experience of a number of local authorities in England who had been implementing the Multidimensional Treatment Foster Care programme for young children (MTFC-P) and the KEEP programme (Keeping Foster and Kinship Carers Trained and Supported) were receiving referrals to their programmes of young children who were either adopted or placed for adoption. It was agreed that although some components of MTFC-P and KEEP could be suitable for a number of adoptive families the context of adoption was recognisably different and therefore warranted a separate and unique programme. MTFC and KEEP have a strong evidence base of their effectiveness.

5.11.2. Delivery

AdOpt groups are delivered by two trained facilitators, at least one of whom is either an adoptive parent or has substantial experience in the adoption field, and one other, who has experience in social care and in social learning theory approaches. Sessions are 90 minutes long and run weekly for 16 weeks. It is a manualised programme. Sessions are videoed and recordings are used by the trainers in weekly individual telephone calls with parents, to discuss their child's current behaviour.

5.11.3. Training

AdOpt group facilitators and their in-house supervisor attend the five consecutive days training together. Three sites (nine people) can be trained at the same time. The training is practical and experiential with participants taking turns to act as facilitators while their colleagues role-play adoptive parents based on specific child pen pictures.

The AdOpt manual is carefully walked through session by session. By the end of the week, they are ready to start their first group under consultation from the National Implementation Service. The videoing of sessions and the weekly consultation calls all help to keep the facilitators on track with the model. The consultants keep in regular contact with one of the co-developers based in the USA, Professor Phil Fisher.

5.11.4. Evaluation

The evaluation begin in September 2015 and is due to report by the end of 2016. The evaluation involved 90 adoptive families and a control group of adopters receiving other support services.

5.11.5. Publications

Harold, G. T., & Hampden-Thompson, G. (2015). An evaluation of the AdOpt parenting programme. *National Implementation Service (NIS) and Department for Education*

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Deutsches Jugendinstitut
Nockherstr.2
81541 München
Telefon +49(0)89 62306-0
Fax +49(0)89 62306-162
www.dji.de