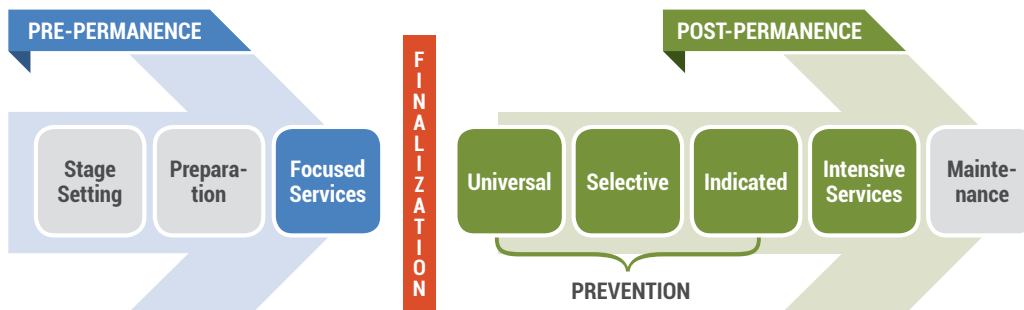


# SELECTIVE

## POST-PERMANENCE INTERVAL

### QUALITY IMPROVEMENT CENTER FOR ADOPTION & GUARDIANSHIP SUPPORT AND PRESERVATION

The QIC-AG has developed a Permanency Continuum Framework that is separated into eight intervals. This is one in a series of papers that describes the intervals along the continuum. Information on the other intervals can be found at [www.qic-ag.org](http://www.qic-ag.org)



# INTRODUCTION

## SELECTIVE INTERVAL

“

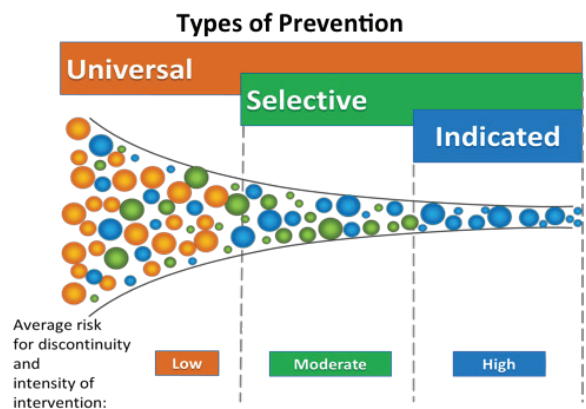
*We adopted two sons from a residential facility. Crisis was often just around the corner. Having somebody proactively check in with us and offer services and supports could have eliminated some of our anxiety and made us feel like we were not in this endeavor on our own.*

”

*Adoptive Parent*

The QIC-AG continuum framework contains aspects of the Institute of Medicine’s (IOM) continuum of care model for mental health. The IOM model categorizes prevention efforts into three intervals—universal, selective, and indicated—each of which covers a different level of risk. Selective is the second of the three prevention intervals. The differences between these three intervals are based on the degree of average risk and the intensity of the intervention. As shown in the figure to the right, the target population of each interval narrows as the continuum moves from universal to selective to indicated. In addition, as the extent of risk for post-permanency discontinuity increases, the intensity of the intervention also increases. According to Springer and Phillips, *selection prevention efforts* are programs and practices that target subgroups based on identified risk factors. For the purposes of the QIC-AG, selective prevention efforts target subgroups identified at the time of finalization as having elevated risks for post-permanency discontinuity. Selective prevention efforts aim to be proactive by engaging in outreach to families.

Some children and families targeted for outreach may never manifest the problematic relationships that indicate high risk. Overall, selective prevention strives to forestall the escalation of moderate risk into high risk by enhancing and/or increasing knowledge, attitudes, and skills of families in caring for children they have adopted or taken under their guardianship.





# POPULATION

Selective interventions are designed for the sector of the post-permanency population with a moderate level of risk for discontinuity. Interventions in this interval target children and families whose individual behaviors or family characteristics have been suggested by research as putting these families at elevated risk for post-permanency discontinuity compared to the universe of families who have adopted or assumed guardianship. The assessment of risk factors is based on what is known at the time of an adoption or guardianship is finalized. The summaries below describe some of the risk factors that are useful and appropriate for identifying children and families for selective interventions.

## EXAMPLES OF RISK FACTORS ASSOCIATED WITH CHILD CHARACTERISTICS

**Child Age.** A child's teen years are well known as a challenging time for most families. Further, research has documented that the teen years can be a particularly difficult period for children who exited foster care through adoption or guardianship. Given the traumatic life experiences that many children in foster care have endured, it can be anticipated that these children might have ongoing identity and role adjustment issues that can intensify as they enter adolescence. Research has shown that the older a child is at adoption, the greater the

challenges with his or her behavioral issues and the family's functioning after adoption.

**Number of Previous Placements.** A vast amount of literature exists regarding the harmful effects placement instability has on foster children's social and emotional well-being. Literature also exists which links post-permanency behavioral issues, family functioning, and discontinuity risks to multiple foster placements prior to permanence.

**Placement History.** Elevated risk has been shown to be associated with not only a child's number of placements while in foster care but also the types of placement while in foster care. For example, research has found elevated risk factors associated with children placed in congregate care. Placements indicative of challenges that make it difficult for children to adjust to a family setting include residential facilities, group homes, and mental health facilities. As such, these placements suggest that children have exhibited more intensive needs in the past, which could lead to greater challenges after adoption or guardianship is finalized. A survey of parents, all of whom had adopted children with special needs, found that children who had a group home or psychiatric placement prior to adoption were associated with poor post-adoption outcomes (e.g., greater frequency or severity of behavioral issues, worse school performance, or a negative impact on the family).

**Severity and Complexity of Special Needs.** Many children in the U.S. child welfare system have endured some level of trauma, which can lead to emotional, mental health, or behavioral problems. Research has shown increased levels of risk factors occur not only among children who have more severe issues in one of these areas but also among children who have needs that accumulate across multiple areas. The number and extent of a child's special needs is one of the most significant predictors of child outcomes and family adjustment to adoption. Studies have found that children who have an identified disability or special needs were more likely to exhibit poor family functioning after adoption. Further, these families were found less likely to have a positive post-adoption adjustment period 18- to 24- months post-adoption.

**Sibling Placement.** Although research has produced mixed findings on the impact of siblings separated from each other due to adoption and guardianship, some studies have shown children's behavior improves when they are placed together with their sibling group. Researchers conducting studies of family functioning in adoptive families have found that as compared with parents who adopted only one sibling, most parents who adopted a sibling group reported fewer problems with externalized child behaviors. Erich and Leung reported that parents who adopted only one of the children who were part of a sibling group were more likely to report behavior problems than parents who adopted a sibling group. These studies suggest that adopting only one child from a sibling group can complicate the child's adjustment to his or her adoptive family.

## EXAMPLES OF RISK FACTORS ASSOCIATED WITH PARENT OR GUARDIAN CHARACTERISTICS

**Family Characteristics.** Factors shown to have a potential impact on family functioning and the level of satisfaction within the family regarding adoption or guardianship include parental characteristics of education level, marital status, parenting style, and income level. In addition, other research studies have found that when families have encountered child behavioral issues, children living with married caregivers were less likely to experience post-permanency discontinuity than children living with caregivers with other marital status (e.g., single or unmarried caregivers). Other characteristics shown to increase risk of discontinuity include caregivers who are distant kin and the caregiver's perception of the adequacy of the adoption/guardianship financial subsidy received.

**Relationship Between Child and Adoptive Parent or Guardian.** Research has consistently found adoption by kin serves as a protective factor in maintaining permanence. In addition, the majority of kin caregivers have reported a positive relationship with the adopted child and expressed a willingness to adopt the child again. However, findings from research conducted with adoptive and guardianship families suggest that longer-lasting permanent homes are more likely to be formed with either kin caregivers who are closely related to the child (e.g., grandparents, aunts and uncles) or unrelated caregivers with a close relationship to the child (e.g., former foster parents) rather than distant kin (e.g., cousins).

**Family Preparation and Supportive Services.** Several research studies have examined the impact of preparation and supportive services provided before and after legal permanence. Some research found that providing adoptive parents with up-to-date background information about the child and both pre- and post-adoption services helped adoptive parents successfully adapt to ongoing concerns post-permanence. Another study found that parents' satisfaction with adoption preparation services had a positive impact on the emotional and behavioral outcomes of their adoptive children. Other studies have found other factors important to the overall well-being of adoptive families included parents' knowledge of adoption-related issues, parents' receipt of child-specific information, and workers' responses to issues or questions raised by adoptive parents.

to a family's privacy and is not perceived as intrusive. Barriers can exist in finding current phone numbers and addresses for families. As child welfare systems move to direct deposit, addresses and phone numbers for families are not always actively maintained, making outreach difficult. Once contacted, many families will welcome post-permanency outreach by child welfare staff but some will find such outreach intrusive and unwelcomed. In a study of adoptive parents and guardians conducted in conjunction with the Illinois public child welfare system, interviewers were unable to contact more than one-quarter (27.3%) of caregivers eligible for the study, even though these caregivers were currently receiving a guardianship or adoption subsidy from the state. Further, some of the parents who were contacted stated that their children were not aware that they had been adopted and, therefore, the parents did not want outreach by the child welfare system.

Numerous risk factors can be used to identify the subgroups of children and families that a child welfare system would want to focus on as the target for selective prevention outreach. These subgroups will likely vary based on the unique demographics and needs within each child welfare system. Capturing the risk factors can prove to be challenging. Not all risk factors are easily captured through administrative data records. Some of risk factors used as examples above are typically maintained in administrative data records (e.g., the number of placement moves in foster care, child's age) while other information is not routinely gathered in such records.

Once the children and families have been identified based on the risk factors, the system must develop a process to proactively reach out to families. It is critically important that this outreach remain sensitive



# INTERVENTION

## PRACTICE PRINCIPLES

Interventions in the selective interval are associated with four primary practice principles:

1. Provide selective outreach efforts based on characteristics known at time of adoption or guardianship finalization, which are associated with post-permanency discontinuity.

Selective interventions use a process of research and data analysis to identify the risk factors more likely to result in discontinuity. However, even when these risk factors are prevalent at the time of finalization, their presence does not infer that the children and families are or will have issues with discontinuity. Instead these interventions proactively reach out to an identified subgroup of children and families with moderate risk in order to offer supports, information, and services. Some families will decline the offer, but others will gratefully accept in the hopes of preventing future problems and addressing minor issues to prevent them from “bubbling up above the surface.”

2. Provide increased supports to groups identified as having moderate levels of risk.

The selective interval does not entail intensive interventions. Rather, selective interventions aim to provide children and families with increased awareness, supports, and services designed to enhance their capacity and neutralize any adverse factors that put family continuity at risk.

3. Provide proactive services and supports to children and families before problematic behaviors manifest.

A key aspect of the selective interval is that families *are not* targeted based on current behaviors or needs but are selected as the focus of these efforts based on certain risk factors that are known at the time of finalization. Services are intended to be proactive and preventative in nature.

4. Use data to target families at elevated risk for poor outcomes.

Many fields are using data to identify risk factors that increase the odds of less than optimal outcomes. For example, the medical field uses patient data to identify and intervene with patients who are most likely to have health problems, such as targeting overweight teens who have a family history of diabetes, and engaging these teens in programs that emphasize a lifestyle of activity and

## INTERVENTION

healthy eating. Using patient risk data allows health professionals to proactively identify patients at risk so that they can then proactively touch base with the patients prior to the health problems emerging. Similarly, child welfare workers can use child welfare data and family characteristics to identify risk factors related to the risk of discontinuity.

### EXAMPLES OF INTERVENTIONS

Selective interventions target outreach to families with risk factors for discontinuity, which are known at the time of finalization. The outreach can be done through various modes, including calls, mailings, support groups, training opportunities, and mentoring or coaching for parents. Given that child welfare systems have typically tended to be more reactionary than prevention-oriented, these types of proactive outreach interventions are not yet prevalent in child welfare systems.

#### VERMONT CHECK-IN



In an attempt to identify common risk factors for discontinuity, the State of Vermont reviewed data on adoption cases in which the children were no longer living in the adoptive home. From this review, Vermont found that adolescence was a highly stressful, trying time for adoptive families. To address the need for additional support during

the child's teens years, Vermont implemented a process of first identifying all families with an active subsidy who had children turning 16, and then sending a letter checking-in on these families. The letters asked adoptive parents several questions, including whether the child still lived in their home, whether they still had guardianship and financial responsibility for the child, and whether they had received or would like to receive post-permanency services. Based on the parents' responses, child welfare workers followed-up with families to make connections and offer services.



#### ADOPTION PRESERVATION, ADVOCACY AND LINKAGE

The Adoption Preservation, Advocacy, and Linkage (APAL) intervention was implemented in and around Chicago, Illinois. APAL targeted children who were either 13 or 16 years old and receiving a guardianship or adoption subsidy from the Illinois Department of Children and Family Services (IDCFS). Families were selected for APAL based on the age of the child in their care. Adoptive parents and guardians were sent notices regarding this outreach and then case managers went to their homes of adoptive parents and guardians to conduct an in-home assessment. Depending on the assessment findings, some families were connected to services in the community while others were referred to the Maintaining Adoption Connections (MAC) program.



# OUTPUTS AND OUTCOMES

A key consideration for prevention work is the tracking of outcomes that are both realistic and capable of being evaluated to determine the effectiveness of the effort. Too often prevention efforts are assigned long-term, distal outcomes that are more appropriate to a later stage in the process. Shorter term, more proximal measures of successful selective prevention efforts might include the percentage of the population contacted and the response rates associated with outreach efforts. Ultimately, the underlying hope is that these prevention efforts will translate into improved outcomes, including stronger permanency commitments, increased post-permanency stability, and improved child and family well-being.

For more information visit the QIC-AG website at [www.qic-ag.org](http://www.qic-ag.org)



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