Introductory/At Home Module #1: Adoption History, Law and Process

This at home introductory module is to be completed before the first class. It is one of the 13 modules that must be successfully completed to gain the TAC (Training for Adoption Competency) certification of completion. You must successfully pass an examination after studying this Module. Please anticipate that this module will take between 5 and 6 hours to complete.

Overview of Module
This Module will provide you with:
- Knowledge on adoption history and law and on the different ways that children are placed with adoptive families;
- Opportunities to explore their own personal beliefs about adoption and the myths about adoption that they are likely to encounter in their clinical work with children, youth and families;
- Information on the clinical issues related to the adoption process itself, including the court process; and
- Information on the legal mandates regarding confidentiality and mandatory reporting of child maltreatment within the context of adoption.

Learning Objectives:
Upon completing this material, you will be able to:

1. Describe at least three key developments in the history of adoption in the United States.
2. Identify one law that governs international adoption and one law that governs the adoption of children in foster care.
3. List the steps in the adoption process.
4. Identify three common myths about adoption and describe the reality associated with each myth.
5. Describe ways that you can help clients re-frame their own beliefs and understanding about adoption.
6. Describe ways that you can assist clients in understanding the impact of the adoption process on the therapeutic process.
7. Describe ways that you can assist adoptive and/or birth parents in working through the impact of court processes on themselves.
8. Describe what is required of therapists with regard to confidentiality and mandatory child maltreatment reporting when working with adoptive and birth families.

Module Outline and Pages

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Welcome to the TAC (Training for Adoption Competency), a training program specifically designed to provide clinicians with the knowledge and skills needed to work effectively with adopted persons – children, youth and adults; adoptive parents and members of the extended adoptive family; kin who adopt their relative children; and birth families – birth mothers, birth fathers, and members of the extended birth family.

This certificate program is organized into 13 modules. We will talk about more about these modules in the first classroom Module but for now, here are the 13 modules and the general content of each:

**The TAC (Training in Adoption Competency)**

**Module #1: Introduction/At Home Module: Adoption History, Law and Process**

You must complete this Module before beginning the classroom-based modules. As noted earlier, this module covers:

- Adoption history and law
- The different ways that children are placed with adoptive families
- Personal beliefs about adoption and the myths about adoption that clinicians may encounter in clinical work with children, youth and families.
- Skills in assisting clients with clinical issues related to the adoption process itself, including the court process
- Legal mandates regarding confidentiality and mandatory reporting of child maltreatment within the context of adoption

**The Class-Room Modules**

**Module #2. Introduction to Adoption Competent Mental Health Practice**

- The definition of “adoption competency” for mental health professionals
- The principles that comprise the theoretical and philosophical framework for the provision of adoption competent mental health services.
- Application of principles in building therapeutic relationships with adopted persons, adoptive families and kinship families and birth families.
• Role of race/ethnicity, class, gender/sexual orientation and birth family culture in adoption
• How biases and beliefs regarding adoption that may impact on clinical practice with adopted persons, adoptive families, and birth families

**Module #3. Clinical and Ethical Issues in Planning, Preparing for and Supporting Adoption**
- The differences between adoption and being in one’s family origin and between adopting and giving birth to a child.
- Family dynamics as a result of these differences
- Clinical skills in working with adoptive families on these issues
- The impact of community perceptions of adoption on the adoptive family
- The planning process for adoption.
- Issues that may arise in preparing children and youth, prospective adoptive parents, kinship families and birth families for adoption
- Specific modalities that clinicians can use in this preparation process and practice the use of these modalities
- Ethical issues in the client-therapist relationship in the context of planning, preparing for, and supporting adoptions

**Module #4. Clinical Issues in Providing Therapeutic Services: Grief, Loss, Separation and Identity**
- The qualities of an adoption competent assessment and how to conduct such an assessment
- The developmental stages of the adopted child
- Loss, grief and separation
- Identity formation.
- Grief and separation from the perspective of the adopted person, adoptive families and birth families.
- Use of a grief model to develop/strengthen skills in working with adopted children, youth, and adults; birth parents in relation to voluntary relinquishment and involuntarily termination of parental rights; and adoptive parents
- Evidence-informed clinical interventions that address these clinical issues
- Ethical dilemmas that arise in working with adoption/kinship network members

**Module #5. Trauma and Brain Neurobiology**
- The impact of trauma on adopted children
- Tools and techniques to support children’s recovery from trauma
- Research on early brain development
• The neuro-developmental impact of abuse, neglect and trauma in early childhood and the positive and negative implications of brain neurobiology on child and youth developments
• Clinical skills in intervening in response to the neuro-developmental impact of abuse and neglect in childhood
• Childhood anxiety disorders

Module #6. Clinical Issues: Attachment
• Attachment: healthy attachment styles, sibling separation, the match or mismatch in attachment styles of child and parent and the impact of foster care and institutional placement on attachment
• Evidence based practices to assess attachment and promote recovery
• The impact of genetics and past experience on developmental outcomes and the range of environmental, relational, and organic stresses that can impact well being
• Clinical skills to assist parents to understand the impact of early adversity on the child and how to promote recovery

Module #7. Adoptive and Birth Families
• Different types of adoptive families and the clinical issues that different types of adoptive families may experience
• Clinicians’ own views and beliefs about different types of adoptive families and how they may impact clinical work with those families
• Clinical skills to work effectively with different types of adoptive families
• The needs of birth family members
• The clinical issues that birth family members – birth mothers and birth fathers and extended birth family members -- may present
• Clinical skills to address these issues
• Clinicians’ own views and beliefs that may affect our effectiveness in working with birth families

Module #8. Adoptive Family Formation, Integration, and Developmental Stages
• The phases of adoptive family development and the normative challenges in adoptive family development
• Clinical issues that impact adoptive family formation and integration
• Clinical skills in working with adoptive families on these issues
• The developmental stages for the adopted person
• Factors that contribute to adoption instability
• Clinical skills in working with adoptive families to prevent disruption/dissolution, support adoptive parents in their parenting roles, help adoptive families cope with stress and promote healthy family development
• Clinical skills to assist families when out of home placement or adoption dissolution occurs


• The behavioral challenges, learning disorders, and other special needs of adopted children that defy traditional parenting techniques
• A framework for understanding significant behavioral problems and relationship difficulties in special-needs adoptions
• Practical ways for mental health providers to consult with adoptive and foster parents on classic problems such as food issues/eating disorders, lying, stealing, bedwetting, encopresis, sleep problems, anger outbursts, fire setting, and parentified behavior
• Understanding behavior problems in the context of the child’s history of past exposure to maltreatment and to dysfunctional family roles
• The impact of genetics and past experience on developmental outcomes and the range of environmental, relational, and organic stresses that can impact well being

Module #10.  Openness in Adoption and Birth Family Culture

• Children’s connections to the past and to their birth families
• The impact of secrecy
• The benefits of openness in adoption
• The continuum of openness and the clinical issues along this continuum
• Clinical skills to help children integrate their histories
• Clinical skills in assisting adoptive parents in exploring connections with birth family, opening a closed adoption, and closing an open adoption
• Clinical issues in search and reunion, including skills in working with families post-reunion
• The impact of birth family culture on adopted persons, adoptive families and birth families and identify
• Clinical skills in assisting adoptive families in understanding and integrating birth family (and birth country) culture into their family life

Module #11.  Race and Ethnicity

• How race structures the lives of children and families, looking specifically at families when the child is minority and the parents are white
• Clinical skills in recognizing and talking about race in the clinical setting
• The impact of discrimination, prejudice, and racism on families, particularly transracial families
• Racial socialization and the factors that support healthy racial and ethnic identity
• Clinical skills in helping adopted persons develop a healthy racial, cultural and ethnic identity, supporting parents in developing or strengthening their ability to provide their minority children with survival skills and helping parents preserve their child’s racial and cultural heritage

Module #12. Adjunct Therapies and Cross Systems and Community Practice
• Potential adjunct therapeutic interventions
• Assessment skills regarding appropriate adjunct therapies
• Effective cross systems and community collaboration on behalf of adoptive families
• The range of formal and informal resources that may be important for adoptive and kinship families
• Building a collaborative network of helpers for adoptive families
• Clinicians’ own potential biases we might have about different service systems that might undermine our ability to work effectively with them

Module #13. Integrating Knowledge, Values and Skills
• Bringing together all that has been learned: knowledge, skills, and values

Each Module, other than this introductory Module requires that you:

• Complete pre-Module reading and assignments

• Attend the classroom-based Module

• Complete evaluations after each Module

Your instructor will talk with you more about the requirements when you meet for Module #2.

Now, to begin this introductory Module . . .
Adoption History

An understanding of adoption history is essential as we work with adopted persons, prospective adoptive parents, adoptive families, birth families and kinship families. An excellent resource is The Adoption History Project (http://darkwing.uoregon.edu/~adoption/index.html). Go to this website and read the following materials about the history of adoption:

1. Adoption History in Brief: http://darkwing.uoregon.edu/~adoption/topics/adoptionhistbrief.htm
2. Orphan Trains: http://darkwing.uoregon.edu/~adoption/topics/orphan.html
3. Baby Farming: http://darkwing.uoregon.edu/~adoption/topics/babyfarming.html
4. Placing Out: http://darkwing.uoregon.edu/~adoption/topics/placingout.html
5. First Specialized Adoption Agencies: http://darkwing.uoregon.edu/~adoption/topics/firstspecial.html
6. Matching: http://darkwing.uoregon.edu/~adoption/topics/matching.html

Was this information in any way new to you? Many TAC students report that they learned for the first time about the orphan trains, baby farming and the early roots of the adoption process. The reality is that many of these historical roots of adoption continue to influence adoption today. For example:

*Baby farming:* This is an early example of the commercial aspect of adoption that came to be subjected to more legal regulation. It foreshadows other commercially oriented aspects of adoption today.

*Orphan trains:* This effort reflects assumptions about the capability of poor and immigrant families to properly raise their children safely. It reflects the biases about birth families that continue to be expressed to this day.
Placing out: The tension between the institutional care of children and placing children with families has not entirely resolved. Today, many children – both in the US and in other countries – are placed in residential care environments. There continues to be concern that too many children are raised in these congregate care settings and that more children are not being placed with families.

Specialized adoption agencies: The views of different private agencies in the early history epitomize the ongoing debate regarding family preservation and adoption.

Let’s look more specifically at four aspects of adoption from a historical perspective:

- African American Adoption
- Indian Adoption Project
- International Adoption
- Fostering and Foster Care

African American Adoption

- For most of the 20th century, African American children were generally not considered for adoption. Most African American children were informally adopted within their communities. To the extent that adoptive families were sought for African American children, matching was used to “match” the race of the child and family.

- After WWII, attention began to be given to finding families for African American children. This attention is considered a part of the focus on special needs adoptions. Adoption resource exchanges were used to find families for African American children.

- In the 1950s, the National Urban League Foster Care and Adoptions Project and Adopt-A-Child advanced the adoption of African American children. These and other adoption programs focused on African American children were located in cities with significant African-American and immigrant populations. None promoted transracial adoption but they received inquiries from white couples.

- Only tiny numbers of African-American children were ever adopted by white parents, but these adoptions reached their peak around 1970, when perhaps 2,500 such adoptions took place.
Food For Thought: How might this history of African American adoption impact the adoption of children of color today?

The Indian Adoption Project

- The Indian Adoption Project lasted from 1958 through 1967 and was administered by the Child Welfare League of American under a federal contract. The project placed 395 Native American children from 16 western states with white families across the country.

- The Indian Adoption Project was perhaps the single most important exception to race-matching which was an almost universal policy at the time. The goal was to systematically place an entire child population across lines of nation, culture, and race.

- David Fanshel evaluated the Indian Adoption Project, studying the motivations of parents and the outcomes for children in approximately one-quarter of all the adoptions arranged through the Indian Adoption Project. In Far from the Reservation, Fanshel concluded that the vast majority of children and families had adjusted extremely well, but he also anticipated criticism.

- In the late 1960s and early 1970s, Native American activists and their allies challenged the idea that the Indian Adoption Project was a triumph for civil rights and equality and described it as an example of a genocidal policy toward native communities and cultures. Tribal advocates worked hard for the passage of the Indian Child Welfare Act, which reacted against the Indian Adoption Project by making it extremely difficult for Native American children to be adopted by non-native parents.

Food for Thought: How do you think that the Indian Adoption Project is viewed today?

International Adoption
• International adoption came into its own after World War II and during the early Cold War. The early focus was on children fathered by soldiers and sailors sent to Europe during the war, Germany and Japan after 1945, and eventually Korea, Vietnam, and elsewhere in Asia. These mixed-race children often were stigmatized in their countries of origin.

• Many organizations that took the lead in international adoption were religiously-based.

• During the 1950s, proxy adoptions, which allowed U.S. citizens to adopt in foreign courts without being physically present, were the most widely publicized means of international adoption. They gained ground after 1955, when an evangelical couple from rural Oregon, Bertha and Harry Holt, adopted eight Korean War orphans. The Holts later arranged for the adoptions of many more Korean children by US families.

• International adoptions were quite different during this period compared to domestic adoptions — domestic adoptions were arranged on the basis of matching while international adoptions often resulted in transracial adoptive families.

• In the history of international adoption, it is important to recognize issues that have continued to be a part of our discussions of adoption: the need for cultural sensitivity to such issues as language and national heritage and the role of love and belonging.

Food for Thought: Does the history of international adoption in relation to transracial families have relevance today?

Fostering and Foster Care

• “Fostering” originally referred to arrangements in which children were cared for in family homes other than their own as distinguished from institutional care. Charles Loring Brace played a key role in advocating for placing children with families rather than placing them in orphanages, a belief that lay at the heart of the orphan trains that he arranged.

• In the early 1900s, other advocates such as Henry Chapin who was convinced that “a poor home is often better than a good institution” influenced the thinking of child welfare and public health professionals though the road from orphanages to foster families was a long one.
• During the early twentieth century, the term “foster care” referred to a variety of arrangements: people who took others’ children into their homes temporarily and permanently, informally and formally; children who earned their keep by working; children whose board was paid by agencies; and even children who were legally adopted.

• Progressive-era social workers aimed to keep children with their own families, even if they were illegitimate, out of respect for the importance of blood ties. But even in this era, advocates knew that some children could not or should not live with their birth parents and that adoption was preferable. Research on attachment and loss and studies of maternal deprivation in infancy ushered in a more pro-adoption climate after the 1940s.

• In the early 1960s, after the expansion of the Aid to Families with Dependent Children program, a growing number of children were placed in foster care. Foster care came to refer to government funded services for children removed from the custody of their parents.

• Foster care and adoption have been shaped by a range of federal and state laws.

Food for Thought: How does the historical connection of foster care and adoption square with our current practices?

Let’s conclude this historical overview with . . .

A Brief History of Adoption

1851 Massachusetts passed the first modern adoption law, recognizing adoption as a social and legal process based on child welfare rather than adult interests. Historians consider the Adoption of Children Act an important turning point because it directed judges to ensure that adoption decrees were “fit and proper.”

1854 The orphan trains were launched.

1868 The Massachusetts Board of State Charities began paying for children to board in private family homes: in 1869, an agent was appointed to visit children in their homes. This was the beginning of “placing-out,” a movement to care for children in families rather than institutions.
1909 The First White House Conference on the Care of Dependent Children declared that poverty alone should not be grounds for removing children from families. When children required placement for other reasons, however, they were to be placed in family homes, “the highest and finest product of civilization.”

1916 Lewis Terman’s revision of the Binet scale popularized the intelligence quotient, or I.Q. Worries about the “feeble-minded” mentality of children available for adoption, and trends toward measuring their mental potential as one part of the adoption process, usually with mental tests, grew out of the eugenics movement in the early part of the century.

1934 The state of Iowa began administering mental tests to all children placed for adoption in hopes of preventing the unwitting adoption of retarded children (called “feeble-minded” at the time). This policy inspired nature-nurture studies at the Iowa Child Welfare Station that eventually served to challenge hereditarian orthodoxies and promote policies of early family placement.

1939 Valentine P. Wasson published The Chosen Baby, a landmark in the literature on telling children about their adopted status.


1953-1958 The first nationally coordinated effort to locate adoptive homes for African American children, the National Urban League Foster Care and Adoptions Project was implemented.

1955 The Child Welfare League of America hosted a national conference on adoption in Chicago and announced that the era of special needs adoption had arrived; Bertha and Harry Holt adopted eight Korean War orphans after a special act of Congress allowed them to do so; Adopt-A-Child founded by the National Urban League and fourteen New York agencies to promote African-American adoptions.

1957 The International Conference on Intercountry Adoptions issued report on problems of international adoptions.


1960 Psychiatrist Marshall Schechter published a study claiming that adopted children were 100 times more likely than their non-adopted counterparts to show up in clinical populations. His
work sparked a vigorous debate about whether adoption was itself a risk factor for mental disturbance and illness and inspired a new round of studies into the psychopathology of adoption.

1961 The Immigration and Nationality Act incorporated, for the first time, provisions for the international adoption of foreign-born children by U.S. citizens.

1964 H. David Kirk published *Shared Fate: A Theory of Adoption and Mental Health*, the first book to make adoption a serious issue in the sociological literature on family life and mental health.

1965 The Los Angeles County Bureau of Adoptions launched the first organized program of single parent adoptions in order to locate homes for hard-to-place children with special needs.

1971 Florence Fisher founded the Adoptees Liberty Movement Association “to abolish the existing practice of sealed records” and advocate for “opening of records to any adopted person over eighteen who wants, for any reason, to see them.”

1972 The National Association of Black Social Workers opposed transracial adoptions; *Stanley v. Illinois* substantially increased the rights of unwed fathers in adoption by requiring informed consent and proof of parental unfitness prior to termination of parental rights.

1973 *Beyond the Best Interests of the Child* articulated the influential concept of “psychological parent,” which prioritized continuity of nurture and speedy and permanent decisions in legal proceedings related to child placement and adoption.

1978 The federal Indian Child Welfare Act passed by Congress.

1980 The federal Adoption Assistance and Child Welfare Act offered significant funding to states that supported subsidy programs for special needs adoptions and devoted resources to family preservation, reunification, and the prevention of abuse, neglect, and child removal.


1994 The federal Multiethnic Placement Act was enacted. It the first federal law to concern itself with race in adoption. It prohibited agencies receiving federal funds from denying transracial adoptions on the sole basis of race, but permitted the use of race as one factor, among others, in foster and adoptive placements. A 1996 revision to this law, the Inter-Ethnic Adoption Amendment, made it impermissible to employ race at all except in very limited circumstances.

1997 The federal Adoption and Safe Families Act stressed permanency planning for children and represented a policy shift away from family reunification and toward adoption.
1998 Oregon voters passed Ballot Measure 58, allowing adult adoptees access to original birth certificates. This legal blow to confidentiality and sealed records was stalled by legal challenges to the measure’s constitutionality, which eventually failed. The measure has been in effect in Oregon since June 2000. Since that time, other states have enacted legislation to provide adult adoptees with access to their original birth certificates.

2000 The federal Child Citizenship Act of 2000 allowed foreign-born adoptees to become automatic American citizens when they entered the United States, eliminating the legal burden of naturalization for international adoptions; the Census 2000 included “adopted son/daughter” as a kinship category for the first time in U.S. history.

2008 The US ratified the Hague Convention on Intercountry Adoption. The federal Fostering Connections to Success and Increasing Adoptions Act was enacted to further strengthen adoption as an option for children in foster care.

2008 Congress passed the Fostering Connections to Success and Increasing Adoptions Act to help ensure that more children in foster care left to permanent families.
Adoption Law

Adoption is governed by international, federal and state law. It is important that as clinicians, we have a general understanding of these laws and what they require. This information can help inform our work with prospective adoptive parents, birth parents, adoptive families, adopted persons, and kinship families.

A Brief Review of International Law

Intercountry adoptions by US citizens are governed by the *Hague Convention on Intercountry Adoption* and the *Intercountry Adoption Act of 2000*. The law in this area has three parts:

1. **What is the Hague Convention on Intercountry Adoption?**

   The Hague Convention on Intercountry Adoption is a treaty designed to apply to all international adoptions between countries that ratify it. In May 1993, 66 countries, including the United States, reached an agreement establishing a cooperative framework between the countries of origin of children in need of adoption and their receiving countries to ensure that the child’s best interests are safeguarded. The Convention’s
objective was to prevent abuses such as the abduction or sale of, or the trafficking in, children or any other improper financial gains. It also sought to ensure proper consent to the adoption, allowed for the child’s transfer, and established the adopted child’s status in the receiving country. The Convention set minimum international standards and procedures for adoptions that occur between countries which have implemented the Convention. In the case of adoptions taking place between countries that have implemented it, the Convention ensures greater protection from exploitation for children, birth parents and adoptive parents alike. Not every signatory country has yet implemented the agreement.

2. What are the goals of the Hague Convention?
The goals of the Hague Convention are to:
- To establish safeguards to ensure that intercountry adoptions take place in the best interests of the child and with respect for his or her fundamental rights as recognized in international law
- To establish a system of co-operation among countries that sign the Convention to ensure that those safeguards are respected and thereby prevent the abduction, the sale of, or traffic in children
- To secure the recognition of intercountry adoptions by states that sign the Convention.

3. What are the responsibilities of the child’s country of origin under the Hague Convention?
The child’s country of origin:
- Determines that the child is adoptable
- Determines that an intercountry adoption is in the child’s best interests
- Ensures that the consent necessary for adoption has been appropriately given
- Ensures that the consent of the mother, where required, has been given only after the birth of the child
- Ensures that the child, based on his/her age and degree of maturity of the child:
  1. Has been counseled and duly informed of the effects of the adoption and of his or her consent to the adoption, where such consent is required
  2. Has freely given consent to the adoption

4. What are the responsibilities of the country where the prospective adoptive family lives under the Hague Convention?
The country where the prospective adoptive family lives:
o Determines that the prospective adoptive parents are eligible and suited to adopt
o Ensures that the prospective adoptive parents have been counseled as may be necessary
o Determines that the child is or will be authorized to enter and reside permanently in the country

5. Has the United States signed the Hague Convention on Intercountry Adoption? Yes. As of November 2010, 80 countries had signed the Hague Convention. A list of these countries can be found at: http://adoption.state.gov/hague/overview/countries.html


For the Hague Convention to take effect in the United States, Congress had to enact “enabling legislation: The Intercountry Adoption Act of 2000.

1. What is the Intercountry Adoption Act of 2000?
The Intercountry Adoption Act of 2000 (IAA), enacted on October 6, 2000, provides the implementing legislation that was needed for the Hague Convention. The United States needed to enact this legislation to come into compliance with the requirements of the Hague Convention.

2. When did it take effect?
The IAA took effect in 2008 when the United States implemented the Convention. The Department of State published implementing regulations in the Federal Register and the United States has deposited the instruments of ratification with the Permanent Bureau of the Hague Conference.

3. What is the effect of the IAA?
Under the Convention, each country that is party to the Convention must designate a central authority to monitor requests for intercountry adoption. The IAA designates the Department of State as the U.S. Central Authority for intercountry adoptions. The U.S. Central Authority coordinates adoption matters between the Federal government and the central authorities of other countries.
4. *How does the IAA change the Immigration and Nationality Act (the Act)?*

The IAA makes two changes to the Immigration and Nationality Act. The IAA amends the Act to provide that an adoption certificate issued by the central authority is conclusive evidence of the relationship between the adopted child and the adoptive parent(s). The IAA also expands the definition of “child” beyond its previous definition in the Act (see Question #8).

5. *Are US citizens limited to adopting a child only from a country which has implemented the Convention?*

No. United States citizens may still adopt a child from any country which allows intercountry adoption. However, a child adopted from a country which has not implemented the Convention must qualify as an adopted child or an orphan under existing U.S. immigration law.

6. *What children may be adopted from Hague countries?*

The IAA amends the Act to add section 101(b)(1)(G). This section defines a child as under the age of sixteen at the time an immigrant petition (Form I-600) is filed on the child’s behalf. The child must be adopted in a foreign state that is a party to the Convention. Alternatively, the child must be emigrating from such a foreign state to be adopted in the United States. In either instance, the prospective adoptive parent(s) must be a United States citizen and spouse jointly, or an unmarried United States citizen at least twenty-five years of age.

In order for a petition to be approved, the Attorney General must be satisfied that proper care will be furnished the child if admitted to the United States. The child’s natural parents (or parent, in the case of a child who has one sole or surviving parent because of the death or disappearance of, abandonment or desertion by, the other parent), or other persons or institutions that retain legal custody of the child, must have freely given their written irrevocable consent to the termination of their legal relationship with the child, and to the child’s emigration and adoption.

In the case of a child having two living natural parents, the natural parents must be incapable of providing proper care for the child. Also, the Attorney General must be satisfied that the purpose of the adoption is to form a bona fide parent-child
relationship, and the parent-child relationship of the child and the biological parents has been terminated.

7. What is the adoption certificate issued by the Department of State?

The Convention provides that adoptions between Hague countries may not be completed unless both the sending country and the receiving country have certified that the child will be allowed to immigrate to the country of his or her adoptive parent(s). To ensure this, the IAA requires that no immigrant petition may be approved on behalf of a child being adopted between two Hague countries unless the Secretary of State has certified that the central authority of the child’s country of origin has notified the U. S. Central Authority that a United States citizen habitually resident in the United States has effected final adoption of the child, or has been granted custody of the child for the purpose of emigration and adoption.

8. Is it possible that a family could adopt a child from a Hague country and later learn that the child is not eligible to immigrate to the United States?

This should not be possible. Adoption in the sending country should not be permitted to take place before the adoption certificate issued by the Department of State establishes the child’s eligibility to immigrate to the United States.

Implementing Regulations

With the Intercountry Adoption Act in effect, the State Department then needed to issue regulations that address exactly how the Act is to be implemented. Here are some of the key areas that the regulations address:

1. Adoption Fees

Before providing any adoption services to a prospective adoptive family, an adoption service provider must itemize and disclose in writing the following categories of fees and estimated expenses:

• The home study fee
• Adoption expenses in the United States
• Foreign country program expenses
• Expenses incurred in care of the child
• Translation and document expenses
• Contributions to child welfare service programs in the child’s country of origin
• Fees for post-placement and post-adoption reports
• Third-party fees
• Travel and accommodation expenses

2. **Training of Prospective Adoptive Parents**

The primary adoption agency must offer at least ten hours of training (independent of the home study) to prospective adoptive parents before they travel to the country of origin to adopt the child, or before the child is placed with the family for adoption. The mandatory training addresses a wide range of topics, including the intercountry adoption process, developmental risk factors associated with children from the expected country of origin, and attachment disorders.

3. **The Child’s Medical Records**

Adoption service providers are responsible for providing prospective adoptive families with an English language translation of the child’s medical records, no later than two weeks before the adoption or two weeks before the date when the prospective adoptive family travels to the country of origin to complete the adoption (whichever is earlier). Adoption service providers make reasonable efforts to obtain available information, including the following:

- The date that the Convention country or other child welfare authority assumed custody of the child and the child’s condition at that time
- History of any significant illnesses, hospitalizations, special needs, and changes in the child’s condition since the child came into custody
- Growth data, including prenatal and birth history
- Specific information on the known health risks in the specific region or country of origin
- If a medical examination of the child is arranged, the date of the examination, and the name, contact information, and credentials of the physician who examined the child
- Information detailing all tests performed on the child
- Current health data
- Information about the child’s birth family, cultural, racial, religious, ethnic, and linguistic background
- Information about the child’s past placements prior to adoption
Food for Thought: What has been your experience (if any) with respect to families adopting internationally? What is your impression of the impact of the Convention, federal law and federal regulations in protecting the rights and interests of children, their birth families, and/or prospective adoptive parents?

Here are some key points to consider about international adoption law:

- The law (the Convention and federal law and regulations) are designed to better protect the rights of individuals touched by international adoption.

- With the Department of State serving in the role of Central Authority, there has been more activity with respect to international adoptions with countries that are not “playing by the rules.”

- Some applaud this oversight – which at times involves the suspension of international adoptions from certain countries.

- Others object to this oversight, believing that it is diminishing the opportunities for children to have adoptive families and for families in the US to adopt internationally.

- With the implementation of the Hague Convention in the US, a number of private adoption agencies (which are required to be accredited) have closed. Also, the number of international adoption has declined.

  If you interested in reading more about the controversies around international adoption:

  National Council for Adoption. A Case For Ethical Intercountry Adoption.
  https://www.adoptioncouncil.org/publications/adoption-advocate-no11.html The authors strongly support intercountry adoption.

  UNICEF takes a far more critical stance on international adoption. See its report at:
Foster Care and Adoption Law in the United States

The adoptions of children in foster care are governed by both federal law and state law.

Federal Law

There are many federal laws that impact the adoption of children and youth in foster care. Here is a list of some of the main laws:

✓ The Indian Child Welfare Act of 1978
✓ The Promoting Safe and Stable Families Program (PSSF) (Title IV-B, Subpart 2 of the Social Security Act)
✓ The Multi-Ethnic Placement Act of 1994 and the Interethnic Placement Act Amendments (MEPA/IEP)
✓ The Fostering Connections to Success and Increasing Adoptions Act of 2008

Let’s look at each one!

The Indian Child Welfare Act of 1978 (ICWA)

- Which children are covered by ICWA? ICWA applies to American Indian and Alaskan Native children who are unmarried and under the age of 18 (or under the age of 21, who entered foster care prior to the child’s 18th birthday who remains in foster care) and who:
  - is a member of an Indian nation/tribe; or
• is eligible for membership in an Indian nation/tribe; or
• is the biological child of a member of an Indian nation/tribe and is residing on, or
  is domiciled within, an Indian reservation.

Example #1: A child, living in an urban area, is considered by the Cherokee Tribe to
be a member of the tribe. The child comes into foster care and adoption becomes
the plan for the child. The child is covered by ICWA.

Example #2: A child’s father is a member of the Apache Tribe. His mother is an
Anglo. Under the tribal membership rules:

  All persons of at least one-sixteenth (1/16) degree Fort Sill Apache blood born on
  or after April 9, 1977, who file applications for enrollment and who have at least
  one natural parent who is a member of the Fort Sill Apache Tribe of
  Oklahoma.

The child comes into foster care and adoption becomes the plan for the child. The
child is covered under ICWA.

Example #3: A couple lives on the reservation. They leave the reservation shortly
before she gives birth, has the baby in a city approximately 75 miles away from the
reservation and place the child for adoption. The baby is covered by ICWA.

• Tribal Jurisdiction. Tribes have exclusive jurisdiction in cases involving Indian children
who live on Indian reservations and/or when the child has been made a ward of the
tribal court. These types of proceedings must be adjudicated through the tribal court of
the relevant tribe. A tribal court and a state court may have concurrent jurisdiction if the
Indian child lives off the reservation or is domiciled off the reservation.

Example #1: A child lives on the reservation and the child comes into foster
care. The tribe has the authority to make decisions about the safety,
permanency and well being of the child.

Example #2: A child who is a member of the tribe lives with his parents off the
reservation. The child comes into foster care. Both the tribal court and the state
court may have the authority to make decisions about the safety, permanency
and well being of the child.

• “Active Effort” Requirement. When an Indian child’s case remains in state court and an
involuntary foster care placement of an Indian child is sought, the state must show that
an active effort was made to provide remedial and rehabilitative services to the child’s family and that it was unsuccessful, and that continued custody by the parent(s) or Indian custodian likely will result in serious emotional or physical damage to the child.

**Example:** An Indian child comes into foster care. In this case, the state court has the authority to make the decisions about the child’s safety, permanency and well-being. The state child welfare agency has to show the court that:

- It made “active efforts” to keep the child at home. For example, the agency provided the Indian parents with transportation to services, helped them find a safe and affordable home, referred the father to substance abuse counseling, and provide the mother with an aide to help her manage the household.

- Those “active efforts” were not successful. For example, the parents refused to move to a safer home; the father only attended two Modules but did not return for counseling; the mother refused the services of the in-home aide after one visit.

- The child will experience emotional or physical harm if he remains at home with his parents. For example, the child, age 4 has been physically harmed in the past when his father became violent after drinking heavily. Because the father is not willing to attend substance abuse counseling, he is at serious risk of harm if he remains at home.

- **Termination of Parental Rights.** Active efforts must be made to reunite American Indian/Alaskan Native children with their parents. The rights of American Indian and Alaskan Native parents can be terminated only on the basis of evidence that shows beyond a reasonable doubt that the child will face serious emotional or physical harm if parental rights are not terminated, and that active efforts to provide remedial and rehabilitative services have been unsuccessful. The findings must be supported by the testimony of a qualified expert witness, one who is versed in the ways of traditional Indian child-rearing practices.

**Example:** An Indian child has been in foster care for 15 months and the state child welfare agency files a petition to terminate his parents’ rights. The court will grant that petition only if the agency provides “beyond a reasonable doubt” (this is same standard used in criminal cases to convict a person of a criminal offense) that:
• The child will be seriously harmed emotionally or physically if his parents’ rights are not terminated (for example, the child would be physically harmed and emotionally traumatized by a return home)

• Active efforts to help the parents resolve the problems that brought the child into foster care have been unsuccessful (for example, continued failure by the parents to resolve substance abuse problems)

In addition, an expert who understands Indian child rearing practices must testify that the parents’ rights should be terminated. For example, a counselor who works with Indian families in crisis testifies that the father’s substance abuse issues pose a serious danger to the child and the father is not motivated to make the necessary changes in his behavior.

• Adoption Placement Hierarchy. An agency providing adoption services to an Indian child is required, in the absence of good cause to the contrary, to place the child with:
  o First, a member of the child’s extended family;
  o Second, other members of the child’s Indian nation/tribe; or
  o Third, other Indian families.

The nation/tribe may establish a different order of preference by tribal resolution.

Example: An Indian child in foster care is freed for adoption. Several people have stepped forward to adopt him. In order of preference, he would be adopted by:

• His aunt who has helped raise him since he was an infant

• A neighbor on the reservation whose children attended pre-school with him

• A couple who are members of a different tribe
So, what exactly is “permanency”? A broadly accepted definition of permanency is having an enduring family relationship that:

- Is safe and meant to last a lifetime
- Offers the legal rights and social status of full family membership
- Provides for physical, emotional, social, cognitive and spiritual well-being; and
- Assures lifelong connections to extended family, siblings, other significant adults, family history and traditions, race and ethnic heritage, culture, religion, and language.

Source: Casey Family Services.

- Agencies must make “reasonable efforts” to: 1) prevent unnecessary placements; 2) reunify children in foster care with their parents/primary caregiver; and 3) find permanence for children and youth who cannot return to the parents/primary caregiver.

“Reasonable efforts” are broadly defined. Generally, these efforts consist of accessible, available, and culturally appropriate services that are designed to improve the capacity of families to provide safe and stable homes for their children. These services may include family therapy, parenting classes, drug and alcohol abuse treatment, respite care, parent support groups, and home visiting programs. Some commonly used terms associated with reasonable efforts include "family reunification," "family preservation," "family support," and "preventive services."
• Agencies are encouraged to use concurrent planning to achieve permanency for children in foster care.

• Agencies are not required to make “reasonable efforts” to reunify children when certain aggravated circumstances exist and a court orders that reasonable efforts are not to be made.

So, what is concurrent planning? Here is one description of this practice:

Concurrent planning initially developed as a type of permanency planning in which reunification services were provided to the family of a child in out-of-home care at the same time that an alternative permanency plan was made for the child, in case reunification efforts failed. To be effective, concurrent planning requires not only the identification of an alternative plan, but also the implementation of active efforts toward both plans simultaneously, with the full knowledge of all case participants. Compared to more traditional sequential planning for permanency, in which one permanency plan is ruled out before an alternative is developed, concurrent planning may provide earlier permanency for the child.

As an example, a child in foster care may have a primary goal of reunification with her parents. The concurrent goal might be adoption by her foster parents.

For more information on concurrent planning, see the Child Welfare Information Gateway at:
http://www.childwelfare.gov/systemwide/laws_policies/statutes/concurrent.cfm

• When a child has been in foster care for 15 of the most recent 22 months, an agency must file a petition to terminate parental rights unless (1) the parents have not received the services that have been identified as necessary to support reunification; (2) the child is placed with a relatives; or (3) there is a compelling reason that termination of parental rights is not in a child’s best interest.
So what does this mean? The state child welfare agency is required to file a petition to terminate parental rights when a child has been in foster care for 15 of the most recent 22 months— for example:

A child enters foster care in January 2011 and remains in care as of April 2012. He has been in care for 15 months and the law requires that the agency file a petition to terminate parental rights unless an exception applies (more about that in a minute).

A child enters foster care in January 2011 and leaves foster care after months (September 2011). In December, she returns to foster care and remains in care as of July 2012. She has been in foster care for a full 15 months over the most recent 22 months.

The law does provide exceptions to this requirement of filing a petition to terminate parental right:

The parents have not received the services identified as necessary to support reunification. For example, the service plan states that the parents are to receive family therapy. The agency does not make the referral for therapy for 4 months and then the family is placed on a waiting list for 6 months.

The child is placed with relatives. For example, the child, upon entering foster care, is placed with her grandmother or aunt.

There is a compelling reason that termination of parental rights is not in a child’s best interest. For example, a 15-year-old, despite extensive counseling, refuses to allow himself to be adopted. State law requires that youth age 14 or older consent to their adoptions.
The Promoting Safe and Stable Families Program (PSSF)
(Title IV-B, Subpart 2 of the Social Security Act)

- Provides federal funding to states for four areas of services: family support, family preservation, time limited reunification services, and adoption promotion and support services

What does each of these four categories of services include?

*Family support services* are intended to help families provide safe and nurturing environments for their children. These services are aimed at improving parenting, strengthening parental relationships, promoting healthy marriages, and enhancing child development.

*Family preservation services* are targeted to families in crisis and include placement prevention services, post-reunification services, respite care, parenting skills training, and infant safe haven programs.

*Time-limited family reunification services* help families that are seeking to address the conditions that led to removal of a child. These services include counseling, substance abuse treatment, mental health services, domestic violence services, crisis nurseries, and transportation.

*Adoption promotion and support services* help families that are preparing to adopt or that have adopted a child from foster care.

- Provides funding to states for services to certain groups of parents: incarcerated parents and parents affected by methamphetamines and other substances
The Multi-Ethnic Placement Act of 1994 and the Interethnic Placement Act Amendments (MEPA/IEP)

This federal law says that states may not delay or deny the foster care or adoptive placement of a child based on the child’s or the prospective foster or adoptive parent’s race, color or national origin. States are expected to diligently recruit foster and adoptive families who represent the racial and ethnic backgrounds of children in foster care.

Let’s stop for a moment and consider the context for this law and the history of transracial adoption in this country. Some highlights:

- Prior to the 1950s, African American children, if placed at all by adoption agencies, were placed with African American families.

- During the 1950s, there were efforts to promote African-American adoptions and white couples began to inquire about transracial adoption. A few agencies began cautiously placing mixed-race and African-American children with white families.

- The debate about transracial adoption changed course in 1972, when the National Association of Black Social Workers issued a statement that took “a vehement stand against the placements of black children in white homes for any reason, calling transracial adoption “unnatural,” “artificial,” “unnecessary,” and proof that African-Americans continued to be assigned to “chattel status.” This opposition slowed black-white adoptions to a trickle.
• A meeting at Harlem-Dowling Children’s Service, staffed entirely by African-Americans. The agency was by founded in 1972 by opponents of transracial adoption whose goal was to locate black homes for black children. Harlem-Dowling was the brainchild of African-American administrators at Spence Chapin Adoption Service.

• Many people in the child welfare and mental health fields know about the 1972 NABSW statement. Many are not as familiar with the NABSW’s later document in 1994 called Preserving African American Families. This report stressed:

  o The importance of stopping unnecessary out-of-home placements
  o The reunification of children with parents
  o The importance of placing children of African ancestry with relatives or unrelated families of the same face and culture for adoption
  o The need to address the barriers that prevent or discourage persons of African ancestry from adopting
  o The importance of promoting culturally relevant agency practices
  o The position that transracial adoptions of African American children should only be considered after documented evidence of unsuccessful same race placements has been reviewed and supported by appropriate representatives of the African American community
As this last bullet makes clear, the NASWB acknowledged that for some African American children, transracial adoption may be an appropriate option.

- In 1994, the Multiethnic Placement Act (MEPA) was enacted amid spirited and at times contentious debate about transracial adoption and same-race placement policies. This law had several provisions, some of which were changed by amendments in 1996.
  
  o The law prohibited State agencies and other entities that receive Federal funding and were involved in foster care or adoption placements from delaying, denying or otherwise discriminating when making a foster care or adoption placement decision on the basis of the parent or child's race, color or national origin. THIS REMAINS THE LAW TODAY.

  o The law prohibited State agencies and other entities that received Federal funds and were involved in foster care or adoption placements from categorically denying any person the opportunity become a foster or adoptive parent solely on the basis of race, color or national origin of the parent or the child. THIS REMAINS THE LAW TODAY.

  o The law required States to develop plans for recruitment of foster and adoptive families that reflect the ethnic and racial diversity of children in the State for whom families are needed. THIS REMAINS THE LAW TODAY.

  o The law allowed an agency or entity to consider the cultural, ethnic, or racial background of a child and the capacity of an adoptive or foster parent to meet the needs of a child with that background when making a placement. THIS WAS CHANGED BY THE 1996 AMENDMENTS. Under current law, states and other entities may not use race (with few exception) in making decisions about adoptive placements for children in foster care.

The Fostering Connections to Success and Increasing Adoptions Act of 2008

This is most recent federal child welfare law. It:

- Establishes New Family Connection Grants that increase resources for Kinship Navigator programs, Family Group Decision-Making meetings, Intensive Family Finding activities, and Residential Family-Based Substance Abuse Treatment. These programs can help achieve permanency for children in foster care more quickly.

- Preserves the sibling bond for children by requiring states to make reasonable efforts to place siblings together when they must be removed from their parents’ home, provided it is in the children’s best interests. In the case of siblings not placed together, states must make reasonable efforts to provide for frequent visitation or other ongoing interaction, unless such interaction would be harmful to any of the siblings.

- Provides direct access to federal support for Indian tribes and offers, for the first time, many American Indian and Alaska Native children federal assistance and protections through the federal foster care and adoption assistance programs; requires the US Department of Health and Human Services to provide technical assistance and implementation services dedicated to improving services and permanency outcomes for Indian children and their families.

- Makes more children eligible for federal adoption assistance, monthly payments made on behalf of children with “special needs” to their adoptive families. Children eligible for federal adoption assistance are also eligible for Medicaid, the federally funded health care coverage program.
Let’s consider a few key ideas that we will cover in more detail throughout the TAC.

- There has been a growing emphasis on ensuring that children in foster care have permanent families. When children cannot be safely reunited with their birth families, adoption is the next option to be considered.

- Many child welfare systems now license families to be “resource families” – families who provide foster care and who stand ready, if reunification cannot be achieved, to be the adoptive families for the children for whom they are caring. By using this approach, the time for children to have permanent families is shortened.

- Even with the emphasis on permanency and adoption in particular, many children continue to remain in foster care for extended periods of time and many of these children experience many different placement throughout their stays in foster care.
• When families adopt – whether they have been the child’s resource family or a family recruited as an adoptive family for the child, it is essential that the child’s background information be shared with the family. This issue is one that we will discuss in a future Module.

• In many cases, it takes a long period of time to actually finalize the adoption, creating uncertainty for children and their prospective adoptive parents.

• In some cases, there is concern that if a youth is adopted, he or she will lose benefits available to youth who age out of foster care – such as free college tuition at state universities. This problem is being addressed in both federal and state laws so that youth are not “penalized” when they are adopted.
Post adoption services are increasingly recognized for families who adopt children from foster care – subsidies which provide families with monthly financial support when their children have “special needs” (as have almost all children in foster care) and services and supports. Nonetheless, many families still struggle to find the right post adoption services and supports, particularly mental health services.

Despite efforts to support adoptions, some children experience:

*Adoption disruption*: the ending of their adoptive placements with families before the adoption is finalized

OR

*Adoption dissolution*: the ending of the adoption after it has been legally finalized
State Law

State law governs the adoption of infants in this country and many aspects of the adoption of children from foster care and children adopted from other countries.

There are two key types of state statutes that govern adoption: compacts and statutes.

1. **Compacts.** These are state laws that reflect agreements with other states.

There are two key compacts that are important in adoption:

**Interstate Compact on the Placement of Children.** This Compact applies when private adoptions occur across state lines. It also applies to private parent placements of children in residential treatment facilities, group homes, and other licensed facilities. State agencies and courts must also comply with Compact law when placing children in foster care in treatment facilities, with foster families, with adoptive families or with the child’s relatives who live in another state. The Compact requires a state where a child is living (State A) to obtain the permission of the state where the family is living or the facility is located (State B) to place the child in State B before a placement is made.

**Interstate Compact on Adoption and Medical Assistance.** This Compact is an agreement between and among states that enables states to coordinate the provision of medical benefits and services to children receiving adoption assistance in interstate cases.
2. **State statutes.** These are state laws that govern adoption in the state.

There are many state statutes that govern adoption and the content of these statutes differ from state to state. Here are some key issues that state statutes address:

An issue that has been the subject of great debate is the adult adopted persons’ access to their original birth certificates. When an adoption is finalized, a new birth certificate for the child is customarily issued to the adoptive parents. The original birth certificate is then sealed and kept confidential by the State registrar of vital records. In the past, nearly all States required a court order for adopted persons to gain access to their original birth certificates. In approximately 29 States and the District of Columbia, a court order is still required to gain access to the original birth certificate.

However, in many States, the laws are changing to allow easier access to these records. Some of the methods now available include:

- Available through court order when all parties have consented
- Available upon request to the adult adopted person
- Available upon request to the adopted person unless the birth parent has filed an affidavit denying release of confidential records
- Available to persons who have established their eligibility to receive identifying information through a State adoption registry
- Available when consents to the release of identifying information from the birth parents are on file
Consent to adoption. Consent refers to the agreement by a parent, or a person or agency acting in place of a parent, to relinquish a child for adoption and release all rights and duties with respect to that child. States differ in the way they regulate consent. In most States, the consent must be in writing and either witnessed and notarized or executed before a judge or other designated official. In all states, the birth mother and the birth father (if he has properly established paternity) hold the primary right of consent to adoption of their child. In most cases, the waiver cannot be signed until the baby has actually been born. No state imposes a deadline on the birth mother to sign the waiver, so the process can sometimes take a long while, depending on how certain the birth mother is that she wishes to go forward with the adoption. Some states require that the voluntary waiver form be signed in front of notary or in court in front of a judge, while others will only require that an adoption agency representative or lawyer/facilitator be present. In addition, some states specify a period after the form has been signed during which the birth mother can still revoke her consent.

State law also often addresses the consent of the child to adoption. The statute typically states that a child of a certain age must give consent to the adoption before the adoption can go forward.

Most states with laws addressing this issue require that a child age 14 or older give consent to his or her adoption unless the court, based on the best interest of the child, dispenses with the child’s consent. Find out your state’s law on this issue at: http://www.childwelfare.gov/systemwide/laws
Adoption expenses in infant adoptions. In private placement or independent adoptions, the adoptive parents may pay some of the birth mother's expenses, particularly in the case of a pregnant woman planning to place her infant for adoption. Approximately 45 States have statutes that specify the type of birth parent expenses a prospective adoptive family is allowed to pay. The actual dollar amount is usually limited by the standard "reasonable and customary."

The types of expenses most commonly allowed by statute include:

- Maternity-related medical and hospital costs
- Temporary living expenses of the mother during pregnancy
- Counseling fees
- Attorney and legal fees and guardian ad litem fees
- Travel costs, meals, and lodging when necessary for court appearances or accessing services
- Foster care for the child, when necessary

Approximately seven States explicitly prohibit adoptive parents from paying certain types of expenses. Costs such as educational expenses, vehicles, vacations, permanent housing, or any other payment for the monetary gain of the birth parent often are excluded. In a number of states, the statutes do not exclude specific types of expenses, but do indicate that any expense not expressly permitted by law or considered by the court to be unreasonable cannot be paid by the adoptive parents.

Some states specify time limits for the payment of the birth mother's living expenses or psychological counseling. The time limits set for these payments can range from as little as 30 days to as long as 6 months after the child's birth or placement. In six States, the payment of expenses may not exceed a set dollar amount, unless the court grants an exception.
Quiz: Check yourself about what you know about adoption law after reading this information. Try to answer the questions without looking at the answers!!!

1. A child in foster care lives in Maryland and a family in Indiana is interested in adopting her. Under the law:
   a. The Maryland child welfare agency can send the child to Indiana if the family pays for the child’s travel.
   b. The Maryland child welfare agency cannot send the child to Indiana. A Maryland family has to adopt a Maryland child.
   c. The Maryland child welfare agency can ask the Indiana family to come pick up the child.
   d. The Maryland child welfare agency has to get the okay from the state of Indiana to place the child with an Indiana family.

   Answer: d. The Interstate Compact for the Placement of Children requires that states work together on interstate adoption placement. Indiana and Maryland would have to agree on the placement.

2. A private adoption agency has matched Emily who is 6 months pregnant with a prospective adoptive couple. The couple can:
   a. Pay for only those expenses allowed by state law
   b. Pay for all of Emily’s expenses for the remainder of her pregnancy
   c. Not pay for any of Emily’s expenses during her pregnancy
   d. Pay for Emily’s expenses and pay for a great vacation for her after the baby is born and has been placed with them

   Answer: a. The couple can pay only for those expenses that state law allows.
3. An adopted person, age 22, wants his original birth certificate. Will he get it?
   a. Yes, adopted persons are entitled to their original birth certificates.
   b. Never. Original birth certificates are sealed.
   c. It depends on state law.
   d. It depends on the adoption agency’s policy.

   Answer: c. Whether an adopted adult can obtain his original birth certificate depends on state law.

4. If a child in foster care cannot return safely return home to her parents, what is the next option that federal law says should be considered?
   a. Remaining with her foster parents
   b. Placement with a relative
   c. Adoption
   d. Emancipation from foster care

   Answer: c. Adoption. Reunification is the first permanency option to be considered. When reunification cannot be achieved, adoption is the next option to be considered because it provides both legal and social permanence.

5. Can a public child welfare agency wait to place a child in foster care with an adoptive family in order to match the child and family by race?
   a. Yes
   b. No

   Answer: b. No. The agency cannot delay a child’s placement on the basis of race.

6. An adoptive family wants to adopt a child from another country. Which federal agency must approve the adoption?
   a. US Department of Health and Human Services
   b. US Department of Justice
   c. US Department of Education
   d. US Department of State
Answer: d. US Department of State. The Intercountry Adoption Act of 2000 designated the Department of State as the Central Authority for the US.

7. Under the US regulations implementing the Hague Convention, adoptive parents must receive how many hours of training before the adoption?
   a. 10 hours
   b. 15 hours
   c. 20 hours
   d. No training is required

Answer: 10 hours

8. A pregnant mom wants to place her child for adoption. When can she sign the papers for adoption?
   a. Any time before she gives birth
   b. Up to three days before giving birth
   c. Not until after she gives birth
   d. She must wait at least 6 months after giving birth to sign the papers.

Answer: c. Not until she gives birth

9. True or False: Adoptive parents have the same parental rights as the parents to whom a child is born.

Answer: True

10. True or False: In the international adoption of a child by a US family, the US decides if the family is suitable to adopt and if the child is free for adoption.

Answer: False. The US decides if the family is suitable to adopt; the child’s country of origin decides if the child is free for adoption.
How did you do?
The Adoption Process

Woven into adoption law is the adoption process itself. The law dictates in many ways how the process will occur. Let’s look at the key steps in adoption process.

STEP I

STEP ONE: Birth parents’ rights to their child end and the child is freed for adoption.

In infant adoption, birth parents receive counseling and voluntary relinquish their rights to their child.

In foster care adoption, some parents (probably the minority) are counseled and voluntarily relinquish their rights to their child. More often, parents do not do this and the court involuntarily terminates their parental rights.

In international adoption, the child’s country of origin determines whether a child is free for adoption. Some of the circumstances that the country of origin may use are:

- Abandonment by parents (example: one child policy in China)
- Determination that child has been abused or neglected
- Death of both parents

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Birth parents may be in their teens, 20s, 30s or 40s. **Why might birth parents voluntarily make an adoption plan for their child?**

Here is what we know from the research on the reasons that birth parents choose to make an adoption plan for their child.

- Personal stresses associated with mental health challenges
- Personal stresses associated with financial instability and few if any resources and supports
- Not feeling ready to take on the responsibilities of parenting at that stage of their lives
- Birth parents already have children and do not believe that they can raise an additional child
- Family/social pressure, especially related to the birth parents’ cultural background
- Emotional trauma related to the conception of the child
- Death of one parent that leaves remaining parent unable to cope or care for the child

In foster care adoption, adoption is determined to be the goal for the child through the permanency planning process.
Take a look at the process by which a child comes to the attention of a public child welfare agency and plans are made for the child:

**Entry into Foster Care and The Permanency Planning Process**

- **Report of child abuse/neglect**
  - Investigation/assessment of report
  - Report is not found to be valid
    - Child remains at home
    - *Services provided
    - *No services needed
  - Report is found to be valid
    - Child is placed in foster care (with relatives, unrelated foster family, other placement)

**Permanency Planning**

- Concurrent Planning: Reunification (Plan A) and Other Permanency Option (Plan B – usually adoption)

**Outcomes of Permanency Planning**

1. **Reunification** with parents/caregivers
2. **Adoption**: Birth parents relinquish the child or their rights are involuntarily terminated by the court
3. **Guardianship**: The child is placed with a guardian – usually a relative – who has legal custody and the power to make decisions for the child based on a court order of guardianship.
4. **Living with relatives**: The child is placed with a relative without a guardianship arrangement.
Let’s consider a couple of key points:

**Voluntary relinquishment:** State laws vary as to the procedures that must be followed for taking a voluntary relinquishment: who may take it; whether witnesses are required. Voluntary relinquishments must be in writing and follow state law regarding the content of the document.

**Concurrent planning for children in foster care:** This is a process in which the caseworker, other child welfare staff members and family work toward the primary goal of family reunification (Plan A), while at the same time, they are also developing an alternative permanency plan for the child (Plan B). Plan B often is adoption as the major alternative to family reunification. If the family reunification efforts fail, then the alternate plan will already be in place and well on its way to completion. Concurrent planning is intended to reduce the total period of time a child will remain in foster care before being permanently placed with a family.

**Termination of parental rights:** The involuntary severing of a parent’s legal rights to his/her child by a court. Why might the rights of birth parents to their children in foster care be involuntarily terminated?

Generally, parents’ rights are involuntarily terminated when (1) the parent is found to be unfit and (2) termination of parental rights is in the best interest of the child.

- Parents have been found to be unable to care for the child – that is, that the parent is unfit. Each state’s law set out the grounds for termination of parental rights. Some of most common grounds are:
  - Severe or chronic abuse or neglect
  - Abuse or neglect of other children in the household
  - Abandonment
  - Long-term mental illness or deficiency of the parent(s)
  - Long-term alcohol- or drug-induced incapacity of the parent(s)
  - Failure to support or maintain contact with the child
  - Involuntary termination of the rights of the parent to another child
• A felony conviction of the parent(s) for a crime of violence against the child or another family member, or a conviction for any felony when the term of incarceration is so long as to have a negative impact on the child

• The court determines that the termination of parental rights is in the child’s best interest. Many state laws state that the best interest of the child is the primary and determining consideration of the court.

**STEP 2. An adoptive family is found for the child.**

In general, this step involves the following:

1. *A prospective adoptive family comes forward*

Prospective adoptive families are identified in a variety of ways. Prospective adoptive parents may:

• On their own, contact a private adoption agency that arranges infant adoption or international adoption or contact a public child welfare agency about adopting a child in foster care
• Learn about adoption through adoption agency outreach/recruitment
• Be a relative of a child who needs an adoptive parent
• Already be caring for a child in foster care as an unrelated foster parent
• Already be caring for a child in foster care as a relative

*Why might adults make the decision to adopt?*

Here are some reasons that individuals choose to adopt:
• Infertility
• Presence of serious genetically-based conditions/hereditary disease that could be passed to a child by birth
• Desire not to go through pregnancy and labor
• Desire to add more children to the family
• Religious or ethical reasons that lead to a desire to bring a child into their family through adoption
• Desire to “save” a child
• Lack an appropriate partner with whom to have a child by birth
• Marriage and step-parenting
• For relatives: To provide children in their families with permanent, legal parents and safety and maintain family and cultural connections

2. The home study process

The laws of every State and the District of Columbia require all prospective adoptive parents (no matter how they intend to adopt) to participate in a home study. This process has three purposes:

1. To educate and prepare the adoptive family for adoption
2. To gather information about the prospective parents that will help a social worker match the family with a child whose needs they can meet
3. To evaluate the fitness of the adoptive family

Specific home study requirements and processes vary greatly from agency to agency, state to state, and in the case of intercountry adoption, by the child's country of origin.

There is no nationally recognized format that adoption agencies use to conduct home studies. Some states, however, use a standard format for home studies throughout their states. Many agencies include the following components in their home study process, although the specific details and order will vary.

Training of prospective adoptive parents

Interviews with the adoptive family
Home visits to ensure that the home meets state licensing standards

Health statements regarding the prospective adoptive parents

Income statements

Background checks – both criminal and child abuse record clearances for all adoptive and foster parent applicants.

Autobiographical statement

References: 3 or 4 individuals

The Home Study Report

In general, home study reports include the health and income statements, background checks, and references, as well as the following types of information:

Information on the prospective adoptive parents’ family background.

The applicant’s education and employment and their satisfaction with these aspects of their lives.

Relationships. If the applicants are a couple, the report may cover their history together as well as their current relationship. If applicants are single, there will be information about their social life and how they anticipate integrating a child into it, as well as information about their network of relatives and friends.

Daily routines.

Applicants’ past experiences with children (e.g., their own, relatives' children, neighbors, volunteer work, babysitting, teaching, or coaching) and their plans regarding discipline and other parenting issues.

Description of the applicants’ neighborhood, including safety and proximity to community resources.

Information about the applicants’ religion, level of religious practice, and what kind of religious upbringing (if any) they plan to provide for the child.
Especially important are the applicants’ feelings about their readiness for adoption. What might be addressed:

- Why the applicants want to adopt
- Feelings about infertility (if this is an issue),
- What kind of child they might best parent and why
- How they plan to talk to their children about adoption-related issues.
- How the applicants feel about birth families and how much openness with the birth family might work best.

**Approval/recommendation.** The home study report concludes with a summary and the social worker's recommendation. This often includes the age range and number of children for which the family is recommended.

3. **The family is approved/certified to adopt (the approval/recommendation)**

4. **The child and family are “matched.”**

A child and family may be matched in different ways. Many agencies that arrange the adoption of infants involve the birth parents in selecting the adoptive parents. In other agencies, the agency reviews the information on children and families and makes a decision regarding the right “match.”

**STEP 3. Pre-placement activities**

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The pre-placement process differs depending on whether the child is adopted domestically or internationally.

**Domestically, pre-placement activities typically include:**
- Personal introduction of child and family
- Preparation of the child for adoption (which will be covered in the next Module)
- Preparation of the family for adoption (also covered in the next Module)
- Trial home visits – including overnight visits

With international adoptions, the pre-placement process differs depending on the child’s country of origin. In international adoptions, most countries require one or both of the adoptive parents to travel to the birth country and personally transport the child back to the United States. Multiple trips may be required, one or more of which is mandated to last for an extended period of several days or weeks. Other countries allow the adoptive parents to hire someone to act as their proxy for bringing the child home.

**STEP 4. Placement of child with family**

The final stage of the adoption process occurs when a child is placed with the adoptive parents to create a new or expand an existing family. The placement process will differ, depending on whether the adoption is domestic or international.

**Domestic Adoptions**

In a domestic infant adoption, the phone call announcing the availability of the child comes when that child is born. If the adoption is open in nature, the adoptive family may even be at the hospital with the birth parents at the time of birth. With a domestic adoption, the child will
usually be temporarily placed with the adoptive parents immediately upon discharge from the hospital, after they have signed a placement agreement in which they consent to adopt that particular child. The actual placement process varies from agency to agency and with the state that governs the agency.

In foster care adoptions, the agency places a child in foster care with the family as a “pre-adoptive placement.”

After the placement of either an infant or a child in foster care, there is a supervised period of two to six months during which the newly formed family receives several follow-up visits by the social worker assigned to their case to determine how things are going. During this supervision period, the adoption is not final and it is possible for either the birth parents (when the child is placed through a voluntary relinquishment) or the adoptive parents to change their minds.

*International Adoptions*

The child returns with the adoptive parents (or the designated proxy) from the child’s country of origin.

An important aspect of adoption law is the judicial process that leads to the finalization of the adoption. Finalization of an adoption is the process in a court of law by which an adoption is decreed to be permanent and binding by a judge. After this point, it is extremely difficult to overturn an adoption unless fraud, duress, baby-selling or other allegations can be proven.
Domestic Adoptions

In domestic adoptions, the last legal step to be taken is a court appearance to finalize the adoption. This is a very short court Module, usually taking about 15 minutes. No more time is needed because all the hard work and paperwork have already been done. The judge, lawyer, and adoptive parents will be present; sometimes the social worker who has worked with the family will make an appearance depending on state requirements. The adoptive parents will be required to take the stand and state the date of their marriage (if applicable), the child’s birth date, and the date of placement. The judge will ask a number of questions to verify that the parents understand the legal implications of accepting the child for adoption. After all the questions and answers are completed, the judge will formally sign the adoption decree, finalizing the adoption. Within several weeks, the court will issue a "Delayed Certificate of Birth," which documents the child's new legal name and adoptive parents.

International Adoptions

In some cases, the child’s adoption is finalized in the United States. "Finalization" is necessary when the child is coming to the U.S. for purposes of adoption and there has been no adoption proceeding abroad, the adoption was not completed abroad, or the adoption is not considered final by the foreign country. This is often seen in adoptions of children from Korea or India in which only a guardianship or custodial relationship between the child and the agency or the child and the parents is established.

In many other cases, the child’s adoption is finalized by a court in the child’s country of origin. Many states grant the same recognition and effect to final decrees of adoption when issued pursuant to due process in a foreign country as to decrees of adoption issued in that State or territory.

A number of states allow a child adopted in the child’s country of origin to be re-adopted in state court, when the adoption petition is accompanied by proof of adoption in a foreign court. The term "readoption" generally refers to a process by which a U.S. state court in the state of the parents' or sole parent's residence reviews the details of the adoption abroad along with additional information as it deems necessary, and issues a new adoption decree, independent from the foreign decree, stating that the child has been adopted in conformity with the adoption law of the applicable state. The required documentation and the procedures involved in a readoption vary by state. Within each state, the rules and procedures may vary by county.
or by the local state equivalent. Readoption may be required in some states where the state does not give the same recognition and effect to a final decree of adoption issued by a foreign country as to a decree of adoption issued in that state.

**Effect of Final Adoption Decree:** The adoptive parents have full rights and responsibilities as the child’s parents.
STEP 6. Post-adoption services and supports

Families who adopt domestically or internationally often need services and supports following the adoption. Let’s take this quiz together and see how much we know about post-adoption services and supports.

Quiz: Check yourself on your knowledge of post adoption services. Try to answer the following questions without first looking at the answers that follow each question!

True or False

_____ 1. Adoptive families generally need post adoption services only immediately after the child is placed with them.

Answer: False. Studies show that families need services and supports over time, with many families seeking post adoption services more than 5 years after their children have been placed with them.
____ 2. Most adoptive families who need post adoption services have one adopted child.

Answer: False. Studies show that many families have adopted more than one child and also have non-adopted children.

____ 3. Adoptive families virtually always seek post adoption services because of difficult child behaviors.

Answer: False. Research shows that families seek post adoption services because of difficult child behaviors AND relationship issues. Among the common reasons that families seek services and supports are: children's relationships to others, child self-image, grief related to loss of birth families, school problems, and child behavior.

____ 4. Adoptive families, when seeking post adoption services, are often looking for support in a crisis, help negotiating the service system, and practical assistance with children's needs.

Answer: True. Families report that post adoption services and supports benefit them in all three areas.

Myths and Realities About Adoption

A number of myths and unfounded beliefs about adoption have developed over time – and some have been hard to “debunk”.

Here are some myths that we may hear:

“Birth parents are pathological. They are extremely troubled people.”

Reality: Birth parents face stresses that lead them to consider and make an adoption plan. They are as varied as any other group of people.
“Birth parents move on and forget about the adoption.”

**Reality:** Practice experience and research confirm that the vast majority of birth parents do not “move on” nor do they forget the children they placed for adoption. Studies suggest that most birth parents welcome information about and/or contact with their children when the child reaches adulthood.

“Adopted children are ‘bad seeds’.”

**Reality:** Adopted children may have a range of challenges. Children differ on whether they have psychological challenges – some children do and some do not. Some challenges may be associated with genetically related conditions, but not all.

“Adopted children will be confused if they know too much about the circumstances that led to their adoptions.”

**Reality:** Studies show that adopted children need to know their histories and are not confused by knowing that they have parents by birth as well as the parents who are raising them.

“Adoptive parents are ‘saints’ for ‘taking in’ children.”

**Reality:** Adoptive parents adopt because they want to parent.

“Adoptive parents are perfect”.

**Reality:** Adoptive parents are just like any parents – they have strengths and challenges.
Personal Exercise: Take about 10 minutes and complete the following. This exercise is designed to help you consider your own beliefs and experiences related to adoption and that of others. You will have an opportunity to talk more about these issues in your first class.

1. What are my personal beliefs about adoption?

2. How might those beliefs impact my therapeutic work with adopted persons, adoptive families and birth families?

3. Are there personal beliefs that mental health professionals might have that can:
   - Strengthen their work with adopted persons, adoptive/kinship families and birth families?
   - Compromise the effectiveness of their work with adopted persons, adoptive/kinship families and birth families?
Let’s consider some of the beliefs that can strengthen clinicians’ work with adopted persons, adoptive/kinship families and birth families:

- Belief in the strengths of adoptive and birth families
- Belief in the importance of open, honest communication
- Belief in adoptive parents as the experts on their families
- Belief in the value that birth families bring to adopted children and youth and their adoptive families

And here are some beliefs that can compromise the effectiveness of clinical work:

- Belief that adoptive parents are the cause of their children’s problems
- Belief that adoption is, in and of itself, fraught with pathology
- Belief that a child’s relationship with his/her birth parents is inherently harmful
- Belief that secrecy best protects the parties to an adoption

Just as clinicians may have certain beliefs about adoption, clients might have certain beliefs about adoption based on myths. Let’s look at some brief case scenarios. Think about the beliefs of the individuals involved and how you as a clinician might work with the individuals around these beliefs.

**CASE #1**: Mary is the single adoptive parent of Baby Jane, age 5 months, whom she adopted from a private adoption agency. She has not met the birth mother and father. The agency has told her that the parents are young and thought that adoption was the best option. Mary says she understands and wants them to move on with their lives. She is happy that they will put the adoption experience behind them.

What beliefs of Mary’s would you focus upon and how?
Some Ideas:

Mary believes that birth parents (especially young parents) want to and will simply move past the adoption and not think about it further.

Potential approaches:

- Discussion of the birth parents’ possible feelings about placing Baby Jane for adoption; exploration of possible mixed feelings and/or painful feelings.

- Discussion of the impact of difficult decisions in one’s life. Ask Mary about difficult decisions she has made -- even when she thought it “best” -- and how she has dealt with those decision over time.

- Discussion of how the “adoption story” regarding Jane’s birth family may impact Jane in the future.

CASE #2: Dan and Myra adopted a three-year-old from Russia. Their friends at church are constantly telling that they are doing “the Lord’s work.” This makes them uncomfortable but they do not know how to respond.

*How would you work with Dan and Myra around these issues?*

Some Ideas:

Dan and Myra struggle when they are perceived by their church community as adopting out of altruism.

Potential approaches:

- Discussion of the thoughts/feelings behind church members’ views of the couple as altruistic.
Discussion of possible responses to comments about their doing “the Lord’s work” – exploration of how the couple can convey their true reasons for adopting

CASE #3: Wanda and Raoul adopted six-year-old Juan from foster care. Juan was in the care of the same foster family for five years. They think it is important for Juan to remain in touch with this foster family but see no reason for him to be exposed in any way with his birth family – he has never known them.

*What beliefs would you focus upon and how?*

Some Ideas:

Wanda and Raoul believe that if a child has not known his birth family, it is not important to incorporate them in any way in their child’s life.

Potential approaches:

- Discussion of why they believe that it is important for their child to remain in touch with his former foster parents; building on those reasons, an exploration of why connection with birth family might be important
- Discussion of what Juan may think and feel about his birth family in the future
- Discussion of how they might start to think now about how they will respond to Juan’s thoughts and feelings in the future
The Impact of the Adoption Process on the Therapeutic Process

The adoption process itself can have an impact on the therapeutic process.

First, here are potential impacts on adopted persons:

- Inadequate preparation for adoption
- Failure to share non-identifying information leaving the adopted person with little to no understanding of his/her history
- Secrecy around birth parent identifying information which the adopted person wants to have
- Separation of the adopted person from his/her siblings/loss of contact

Food for Thought: In your own clinical practice, have you seen any of these issues impact the therapeutic process when working with an adopted person?

Next, here are potential impacts on birth families:

- Inadequate counseling about making the adoption decision
- Lack of involvement of the birth father in adoption planning/notice of adoption plan
- Birth parent sense of pressure in making the adoption decision
- Failure to share information about the adoptive family (strengths and challenges) with the birth parents
• Failure to appropriately involve extended family members as supports for birth parents
• For parents whose rights are involuntarily terminated: Feelings of unfairness and disrespect

Food for Thought: In your own clinical practice, have you seen any of these issues impact the therapeutic process when working with a birth mother or birth father? If not, how might you imagine one of these issues affecting the therapeutic process?

Now, here are some potential impacts on adoptive families:
• Inadequate preparation for adoption
• Home study ignored unresolved issues such as loss and grief regarding infertility or miscarriages
• Failed adoption attempts before this adoption
• Sense of being disrespected by the adoption agency
• Sense that too much money was charged or that money issues were not handled fairly
• Failure to provide adoptive families with complete and/or accurate information about the child’s background/history

Food for Thought: In your own clinical practice, have you seen any of these issues impact the therapeutic process when working with adoptive parents?
Applying these Ideas

Let’s look at two scenarios that illustrate how the adoption process can affect the therapeutic process. Consider each scenario and the questions that follow. Jot down your thoughts. Following each scenario are some ideas that might be included in or added to your thoughts.

Scenario #1: Don and Luanne adopted Meg, age 8, from foster care after many delays and after receiving misinformation from the child welfare agency on everything from Meg’s health history to her subsidy. Now, Meg is saying that she never wanted to be adopted. They are frustrated that after all their grueling work to adopt her, she doesn’t want to be in their family.

1. How did the adoption process impact these clients?

2. What might be some of the implications of the adoption process for the therapeutic process?
Some Ideas:

1. How did the adoption process impact the client?
   - Spilling over of frustration from the adoption process with its delays and misinformation to the adoption itself
   - Sense of lack of appreciation/understanding for the hard work involved in adopting
   - Fear that Meg really means that she doesn’t want to be in their family
   - Fear that the adoption, in the end, was not worth it

2. What might be some of the implications of the adoption process for the therapeutic process?
   - Separating feelings about the adoption process from feelings about Meg’s current behavior
   - Exploring their fears and concerns about Meg’s statements
   - Placing Meg’s behavior in a development perspective (both in relation to child development and the developmental stages of adoption)
Scenario #2: LaTrice contacted a private adoption agency to place her son, Matt, age one year, for adoption. LaTrice made an adoption plan, selecting an adoptive family for Matt based on photographs and the family’s letters. She did not meet them. After Matt was adopted by the family, LaTrice learned from a newspaper article that included a photo, that Matt’s adoptive father had been arrested for indecent exposure in the community. LaTrice believes that the agency knew about the man’s problems and withheld this information from her.

1. How did the adoption process impact these clients?

2. What might be some of the implications of the adoption process for the therapeutic process?
Some Ideas:

1. How did the adoption process impact these clients?
   - Fear that her son may be in danger
   - Anger that the agency did not give her full information on the adoptive family
   - Worry that despite best efforts to make the best plan for her child, she failed

2. What might be some of the implications of the adoption process for the therapeutic process?
   - Focusing on current concerns about Matt’s safety
   - Exploring options for ensuring Matt’s safety
   - Recognizing anger about not previously knowing about the adoptive father’s problems
   - Exploring possible scenarios about the agency’s knowledge/lack of knowledge

The Adoption Court Process

The adoption court process may also affect the therapeutic process. We have already talked about how the court is involved in terminating parental rights (and in some states, accepting voluntary relinquishments) and in finalizing adoptions. Please review the following regarding the impact of the adoption court process on members of the adoption kinship network.

Potential Impacts on Birth Parents

Voluntary Relinquishments
   - Belief that the relinquishment process was not well enough explained
   - Belief that pressure was exerted to “make” the parent sign the relinquishment
   - Belief that the relinquishment process was too rushed – not enough time to make a good decision

Involuntary Termination of Parental Rights
   - Sense of unfairness in the legal process
   - Sense of disrespect in the legal process
• Belief that the agency did not really help the parent with services that should have been provided
• Belief that the agency lied to the court about the parent
• Belief that the parent’s attorney did not do a good job representing the parent
• Belief that the judge was “against” the parent

Potential Impacts on the Adopted Child
• Uncertainty about exactly what happened in court
• Anger that the court did not hear his/her voice
• When the child was heard by the judge, belief that the court did not really care what the child said
• Anger that the court did not help his/her siblings

Potential Impacts on Prospective Adoptive Parents/Adoptive Parents

Court Processes Involving Termination of Parental Rights
• Concerns about birth parents’ reactions when their rights were involuntarily terminated
• Concerns about the child’s reactions to the court process

Adoption Finalization Court Processes
• Belief that the court process (and making the adoption legally final) will magically make family life wonderful

Let’s look at a case example in which a therapist is working with a prospective adoptive parent who is dealing with feelings related to the termination of parental rights hearing. At different places in the script, there are questions, WHAT WOULD YOU SAY? At each point in the script, write what you would say to the client.

Scenario:
Maydell Smith is Charlene’s grandmother. Maydell’s daughter-in-law, Latricia, has long had a substance abuse problem, frequently combining alcohol and street drugs. When Charlene was 5, a neighbor reported Latricia to child protective services because she believed that Latricia had left Charlene alone in their apartment. The child protective services investigator found that Latricia often left Charlene alone, not returning for 2 to 3 days at a time when Latricia was using alcohol and drugs. Maydell’s son, Hector,
disappeared from the family’s life more than 2 years ago. No one – including Maydell – knows where he is. When it was determined that Charlene would enter foster care, the agency contacted Maydell who agreed to care for Charlene. After a year in care, the plan for Charlene was changed to adoption and Maydell stated that she wanted to adopt her. Latricia’s and Hector’s parental rights were terminated. Maydell testified at one part of the trial about Charlene’s needs. When she left the court room, Latricia hissed at her, saying, “I am goin’ to hurt you good.” Charlene’s adoption will be finalized in two weeks. Maydell is meeting with the therapist, Sue. She has already shared with Sue what happened in court.

Sue: Hi, Maydell. How are you doing today?

Maydell: Sue, I am just not feeling so great. I should be excited that Charlene will be finally and legally mine but I am having bad dreams about Latricia and just can’t shake a feeling that she is going to do something bad.

Sue: Would you tell me about this feeling?

Maydell: It is like someone is creeping up behind me and ready to pounce. I keep thinking that I am going to suddenly be faced with Latricia. I feel scared.

Sue: What do you imagine might happen if you were to see Latricia?

Maydell: I think she would do just what she said – hurt me. When she is drinking and using drugs she is crazy. [Begins to escalate] So crazy that no one should be around her. So crazy that someone should lock her up. So crazy that somebody should do something to make her stop. [Begins to cry]

Sue: WHAT WOULD YOU SAY? ____________________________________________

Maydell: [Still crying] I don’t know what to do. I can’t protect Charlene and me from her. [Again begins escalating] What if she decides to break into our house? What if she stops us in our car? What if she pulls a knife?
Sue: Let’s look at what Latricia has done since the court hearing when her rights were terminated. Have you seen her since the hearing?

Maydell: No, but that doesn’t mean anything! I know she knows that the adoption is coming up and now will be the time that she will make her move to do something bad. [Raises her voice] I don’t know what to do!

Sue: WHAT WOULD YOU SAY? ______________________________________

Maydell: Look, I know that she doesn’t like me being the one to adopt Charlene. She is mad at Hector for taking off and leaving her to take care of Charlene and she is mad at me for taking Charlene away from her.

Sue: You believe that she is mad at you now?

Maydell: Absolutely!

Sue: Is it possible that she might have different feelings about the plans for Charlene than she had at court that day?

Maydell: You don’t know her! She is a mean woman who carries a grudge!

Sue: WHAT WOULD YOU SAY? ______________________________________

Maydell: I just don’t feel safe.

Sue: What would it take for you to feel safe?

Maydell: I just don’t know. Maybe I should postpone the adoption until I can figure this out.

Sue: WHAT WOULD YOU SAY? ______________________________________

Maydell: [Wrings hands] I just don’t know what to do.
Take a few minutes and answer the following questions:

1. What are the clinical issues that Maydell raised in this Module?

2. What are the primary clinical issues on which Sue should focus at this point in her work with Maydell?

3. How might Sue help Maydell in addressing her fears – about her safety and about the adoption finalization?
Confidentiality and Mandatory Child Maltreatment Reporting

As you know, confidentiality is a key ethical principle in psychotherapeutic relationships. When working with children and families, special issues may arise.

Advising Families

Review the following information that has been prepared by a clinician for use in her work with children and families:

What You Should Know about Confidentiality in Therapy

“I will treat what you tell me with great care. My professional ethics (that is, my profession’s rules about moral matters) and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about—in other words, the “confidentiality” of therapy. But I cannot promise that everything you tell me will never be revealed to someone else. There are some times when the law requires me to tell things to others. There are also some other limits on our confidentiality. We need to discuss these, because I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules now, so that you don’t tell me something as a “secret” that I cannot keep secret. These are very important issues, so please read these pages carefully and keep this copy. At our next meeting, we can discuss any questions you might have.

1. **When you or other persons are in physical danger,** the law requires me to tell others about it. Specifically:

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a. If I come to believe that you are threatening serious harm to another person, I am required to try to protect that person. I may have to tell the person and the police, or perhaps try to have you put in a hospital.

b. If you seriously threaten or act in a way that is very likely to harm yourself, I may have to seek a hospital for you, or to call on your family members or others who can help protect you. If such a situation does come up, I will fully discuss the situation with you before I do anything, unless there is a very strong reason not to.

c. In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect your life. I will try to get your permission first, and I will discuss this with you as soon as possible afterwards.

d. If I believe or suspect that you are abusing a child, an elderly person, or a disabled person I must file a report with a state agency. To “abuse” means to neglect, hurt, or sexually molest another person. I do not have any legal power to investigate the situation to find out all the facts. The state agency will investigate. If this might be your situation, we should discuss the legal aspects in detail before you tell me anything about these topics. You may also want to talk to your lawyer.

In any of these situations, I would reveal only the information that is needed to protect you or the other person. I would not tell everything you have told me.

2. In general, **if you become involved in a court case or proceeding**, you can prevent me from testifying in court about what you have told me. This is called “privilege,” and it is your choice to prevent me from testifying or to allow me to do so. However, there are some situations where a judge or court may require me to testify:

   a. In child custody or adoption proceedings, where your fitness as a parent is questioned or in doubt.

   b. In cases where your emotional or mental condition is important information for a court’s decision.

   c. During a malpractice case or an investigation of me or another therapist by a professional group.

   d. In a civil commitment hearing to decide if you will be admitted to or continued in a psychiatric hospital.

   e. When you are seeing me for court-ordered evaluations or treatment. In this case we need to discuss confidentiality fully, because you don’t have to tell me what you don’t want the court to find out through my report.
3. There are a few other things you must know about confidentiality and your treatment:

   a. I may sometimes consult (talk) with another professional about your treatment. This other person is also required by professional ethics to keep your information confidential. Likewise, when I am out of town or unavailable, another therapist will be available to help my clients. I must give him or her some information about my clients, like you.

   b. I am required to keep records of your treatment, such as the notes I take when we meet. You have a right to review these records with me. If something in the record might seriously upset you, I may leave it out, but I will fully explain my reasons to you.

4. Here is what you need to know about confidentiality in regard to insurance and money matters:

   ...  

5. Children and families create some special confidentiality questions.

   a. When I treat children under the age of about 12, I must tell their parents or guardians whatever they ask me. As children grow more able to understand and choose, they assume legal rights. For those between the ages of 12 and 18, most of the details in things they tell me will be treated as confidential. However, parents or guardians do have the right to general information, including how therapy is going. They need to be able to make well-informed decisions about therapy. I may also have to tell parents or guardians some information about other family members that I am told. This is especially true if these others’ actions put them or others in any danger.

   b. In cases where I treat several members of a family (parents and children or other relatives), the confidentiality situation can become very complicated. I may have different duties toward different family members. At the start of our treatment, we must all have a clear understanding of our purposes and my role. Then we can be clear about any limits on confidentiality that may exist.

   c. If you tell me something your spouse does not know, and not knowing this could harm him or her, I cannot promise to keep it confidential. I will work with you to decide on the best long-term way to handle situations like this.
Now, let’s look at a case example:

Gabrielle, age 14, was adopted at age 12. After several Modules with you, he discloses to the therapist that before he was adopted, he was sexually abuse by his uncle. His uncle’s abuse began when Gabrielle was 6 and continued until he entered foster care at age 8. He has had no contact with his uncle since he entered foster care. His uncle might still be living where he lived when Gabrielle came into care, but Gabrielle does not know for certain.

Would you report the sexual abuse?

___ Yes

___ No

Why or why not?

As the materials you just read make clear, the issue of past abuse can be a gray area. Let’s briefly review the points that can help with this type of issue:

First, review the state’s mandatory reporting statute, which is probably available online, to see whether it contains time limits.

Second, many state child protective agencies provide consultation concerning whether a report is required.

Third, share the anxiety.

Fourth, be mindful that mandatory reporting laws protect clinicians who make reports in good faith.

Fifth, don’t be harsh on yourself for not knowing the answer.
We have reached the conclusion of this Module. How do you answer these questions about what you have learned?

1. Can I describe three key developments in the history of adoption in the United States?
2. Can I identify one law that governs international adoption and one law that governs the adoption of children in foster care?
3. Can I list the steps in the adoption process?
4. Can I identify three common myths about adoption and describe the reality associated with each myth?
5. Am I able to demonstrate at least one skill in helping clients in re-framing their own beliefs and understanding about adoption?
6. Am I able to demonstrate at least one skill in assisting clients in understanding the impact of the adoption process on the therapeutic process?
7. Am I able to demonstrate at least one skill in assisting adoptive and/or birth parents in working through the impact of court processes on themselves?
8. Can I describe what is required of therapists with regard to confidentiality and mandatory child maltreatment reporting when working with adoptive and birth families?

As a result of this Module, you should be able to answer “yes” to each of these questions.
And the formal quiz. Please go to www.adoptionsupport.org and take the quiz on this Module. You must pass this quiz to receive credit for this Module.

**Reading List for Module #1:**


The Adoption History Project. (2008). *Topics in Adoption History.* Available at: [http://darkwing.uoregon.edu/~adoption/topics/index.html](http://darkwing.uoregon.edu/~adoption/topics/index.html)


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