ADOPTION FACTBOOK V

The most comprehensive source for adoption statistics nationwide

National Council For Adoption

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Adoption is such an interesting and, in many ways, unique phenomenon—an institution that exists to bring together children and families, while serving those who might not be able or ready to parent. The world of adoption is so interesting and unique as well. On the one hand, it feels like such a self-contained world. Adoptive families, when recognizing each other, talk in a language of homestudies and referrals and birthparents that others may not easily understand. Policymakers and attorneys speak in the acronyms of AFSA and TPR. And researchers use the variables of age of adoption, length of institutionalization, openness with birthparents; variables that are not common to researchers from other fields.

And yet, at the same time, families, policymakers, and researchers touched by adoption are not in a special club at all. Adoptive families, in so many ways—so many ways that matter—are very common and no different from any other families. Adoption-related legislation can pass or fail in much the way as other legislation. Researchers specializing in adoption have the same funding frustrations as all of their colleagues. As the culture of adoption becomes increasingly more entrenched in our society with each passing year, it may also become more difficult to find stories, facts, and research that are specific to adoption and that help define the “world” of adoption.

Adoption Factbook V was designed, not to set adoption apart, but to highlight, define, and explore the world of adoption; a world that isn’t necessarily immediately apparent at first glance. And so, for me, it has been a joy to explore the multiple components of the “universe of adoption.”

First, from a numbers perspective, we are so proud to present Dr. Placek’s study on national adoption data, which is the only national source for statistics on infant domestic adoption. In our first section, we try to paint a complete picture of the universe of adoption “by the numbers”, including information on special focus groups, such as families who adopt children with special needs and families formed via interracial adoption. In our second section, we provide information for adoptive parents, ranging from help with deciding what type of adoption to embark upon to the nuts and bolts of the adoption tax credit. Our third section focuses on foster care, providing data on the benefits of adopting from foster care, the costs of letting children age out of foster care, and specific recommendations for how foster care can be improved, as well as examples of strategies that are already working. Intercountry adoption is addressed in the fourth section, as we strive to paint an accurate picture of the current state of international adoption, ranging from the impact of the Hague Convention to the way the community was impacted by the return of one child to Russia last year. In the fifth section, directed at birthmothers, we combine personal accounts with hands-on decision-making tools for birthmothers, as well as an example of a program that is working to provide support to birthmothers. Section Six highlights issues that are currently at the forefront of discussions in the policy and legislative arenas, and Section Seven addresses medical issues related to adoption. Section Eight presents up-to-the-minute research on outcomes for adopted children and their families, and Section Nine presents an overview of the state of putative father registries across the country.
We at the National Council For Adoption (NCFA) are also so proud of the ways in which this Factbook furthers NCFA’s core mission:

- A commitment to infant adoption, adoption out of foster care, and intercountry adoption
- A commitment to the belief that every child deserves a nurturing, permanent family
- A commitment to serving children, birthparents, adoptive families, adoption agencies, U.S. and foreign governments, policymakers, the media, and the generally public
- A commitment to promoting the culture of adoption through education, research, and legislative action

As with previous Adoption Factbooks, it is our hope at NCFA that this book will educate, inspire, and help celebrate the positive option of adoption. And, most of all, we hope it will illuminate current knowledge and help pave the way for future knowledge in the universe of adoption.

Elisa Rosman,
Director of Research and Publications

National Council For Adoption
Acknowledgments

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Thanks to all of our authors who contributed their time and energy to this Factbook, responding to editorial questions with cheer and goodwill.

Thanks to all adoptive families, our own included, who remind us every single day why the work NCFA does is so important.
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Ira J. Chasnoff, M.D., is President of the Children’s Research Triangle and a Professor of Clinical Pediatrics at the University of Illinois College of Medicine in Chicago. He is one of the nation’s leading researchers in the field of child development and the effects of maternal alcohol and drug use on the newborn infant and child. In November 2008, Dr. Chasnoff was appointed to the U.S. Department of Health and Human Services’ Interagency Coordinating Council on FASD, the federal committee tasked with the coordination of national efforts to address prenatal alcohol exposure and its health and fiscal impact on the U.S. population. Dr. Chasnoff has authored nine books, the most recent of which, The Mystery of Risk, explores the biological and environmental factors that impact the ultimate development of alcohol- and drug-exposed children and presents practical strategies for helping children reach their full potential at home and in the classroom. The recipient of several awards for his work with high risk women, children, and families, Dr. Chasnoff for the past twelve years has been selected by a poll of physicians across the nation for listing in America’s Best Doctors. Dr. Chasnoff has been active in establishing comprehensive intervention programs for children in Australia, Denmark, Portugal, Vietnam, the former Soviet Union, and across the United States and has lectured on this topic around the world.

Mark E. Courtney, Ph.D., is Professor of Social Service Administration at the University of Chicago. He is a faculty affiliate of Chapin Hall at the University of Chicago, where he
served as Director from 2001 to 2006. He has also served on the faculties of the University of Washington (2007-2010) and the University of Wisconsin (1992-2000). Much of Dr. Courtney’s research has focused on child welfare services and policy. His current work includes studies of the adult functioning of former foster children, experimental evaluation of independent living services for foster youth, reunification of foster children with their families, and evaluation of Solution-Based Casework as a child welfare practice model.

Heidi Bruegel Cox, J.D., is the Executive Vice President and General Counsel for the Gladney Center in Fort Worth, Texas, and has worked as an attorney in the field of adoption for over 20 years. Heidi is a member of the American Academy of Adoption Attorneys, has written numerous articles, has appeared on several television programs highlighting adoption, and serves on many committees focused on family law and child welfare. Heidi currently serves as a gubernatorial appointee to the Texas Adoption Reform Committee which is examining the child welfare system and seeking solutions to remove barriers to adoption for children in foster care. In the international arena, Heidi has worked with officials from Rwanda as they begin to set up a system of adoption in compliance with the Hague Treaty. As a child advocate, Heidi is active in promoting legislative initiatives to protect children and support positive adoption practices. She is also involved with adoption at the national level, serving as a board member and secretary for the National Council For Adoption. Heidi is experienced with intercountry adoptions, assisting with agency placements from Asia, Eastern Europe, Africa and Latin America. A frequent speaker, Heidi has been presenting adoption programs and papers to professionals and the community since 1990.

David Cross, Ph.D., is the Associate Director of the Institute of Child Development, where his primary responsibilities are to assist the Director, Dr. Karyn Purvis, and to supervise the research activities of the Institute. He is also Director of the Developmental Research Laboratory and a Professor in the Psychology Department, where he teaches courses such as Principles of Behavior, Child Psychology, Developmental Psychology, Graduate Developmental Psychology, and Multivariate Analysis. David earned his B.S. from California State University Fresno with a major in Psychology, and then attended The University of Michigan in Ann Arbor for graduate study, beginning in 1980. He earned an M.A. Psychology and an M.A. in Statistics, and then earned a Ph.D. in Education and Psychology. In 1985, he accepted a position as Assistant Professor in TCU’s Department of Psychology.

The Dave Thomas Foundation for Adoption is a national nonprofit public charity dedicated to dramatically increasing the adoptions of the more than 150,000 children waiting in North America’s foster care systems. Created by Wendy’s® founder, Dave Thomas, who was adopted, the Foundation implements results-driven national signature programs, foster care adoption awareness initiatives and research-based advocacy efforts.

Alan J. Dettlaff, Ph.D., M.S.W., is Assistant Professor in the Jane Addams College of Social Work, University of Illinois at Chicago. His practice experience includes several years as a practitioner and administrator in public child welfare, where he specialized in investigations of physical and sexual abuse. Dr. Dettlaff’s research interests focus on improving outcomes for children of color in the child welfare system through the elimination of disproportionality and disparities. Specifically, Dr. Dettlaff is actively involved in research examining the needs and experiences of immigrant Latino families who come to the attention of the child welfare system and addressing the disproportionate overrepresentation of African American children in this system. Dr. Dettlaff is also Principal Investigator of the Jane Addams Child Welfare Traineeship Project, which provides advanced training and financial assistance to students pursuing careers in child welfare.
Cathy Crenshaw Doheny, B.A., is an award-winning freelance writer and journalist. Her work has been featured by many national and local publications, including Adoption Today Magazine, Liver Health Today, and Faith and Family Magazine. She is currently a contributing writer for Asian Fortune News and The Charlotte Observer's University City Magazine. Her creative nonfiction pieces have been published in numerous anthologies, including A Cup of Comfort for Mothers, Pets Across America 2, and Root Exposure—New Voices in Literature. Cathy is the Famous Operas contributing writer for The Daily Book of Classical Music recently released by Walter Foster Publishing. Cathy and her husband Kevin are the proud parents of a five-year-old daughter, Jade Chun'an, whom they adopted through the China Waiting Child Program.

Amy Dworsky, Ph.D., is a Senior Researcher at Chapin Hall. Her research interests include youth aging out of foster care, homeless youth, pregnant and parenting foster youth, and teenage pregnancy prevention. Dr. Dworsky is a Co-Investigator for the Midwest Evaluation of the Adult Functioning of Former Foster Youth, a longitudinal study of young people making the transition from foster care to adulthood in Iowa, Wisconsin and Illinois. She has been the Principal Investigator for several studies including an evaluation of campus support programs which help foster youth attend and graduate from college, an evaluation of an employment training and job placement program for foster youth in Cook County, and a comprehensive review of policies and programs designed to support youth transitioning out of foster care across the 50 states and the District of Columbia.

Victor Eugene Flango, Ph.D., is the Executive Director, Program Resource Development, at the National Center for State Courts. In this position he generates support for National Center research, education and technical assistance projects. Before assuming that position in April 2005, Dr. Flango was the Vice President of the National Center’s Research and Technology Division for ten years. In that role, he led approximately 40 Research and Technology staff members in developing and managing the national scope, multi-jurisdictional, revenue-generating projects and programs conducted each year. He is the author of over a hundred publications, including seven monographs, 17 articles, and one website dealing with child welfare issues. He has delivered over one hundred presentations and served on numerous panels at national, regional, state, and local events to professional and academic audiences. Some of the issues addressed include child protection, data exchange, performance measurement, adoption, appellate courts, criminal justice, and a variety of other justice issues. Before joining the National Center for State courts in 1977, Dr. Flango was a professor of Political Science at Northern Illinois University and director of the Master of Arts in Public Affairs' degree program in judicial administration. His Ph.D. degree is from the University of Hawaii (1970) and he is a Fellow of the Institute for Court Management.

Karen J. Foli, Ph.D., R.N., is an assistant professor at the Purdue University School of Nursing in West Lafayette, Indiana. She is the coauthor of The Post-Adoption Blues: Overcoming the Unforeseen Challenges of Adoption (Rodale, 2004) and conducts research surrounding depression in adoptive parents and nursing care of the adoption triad. Her mid-range theory of post-adoption depression appeared in the Western Journal of Nursing Research (2010). Dr. Foli is a frequent presenter at local, regional, and national adoption conferences, and has been interviewed by journalists from national and international media, including, The New York Times, The Philadelphia Inquirer, and O! The Oprah Magazine for articles discussing post-adoption “blues.”

John R. Gallagher, M.S.W., L.S.W., L.C.D.C., is a case manager for the Tarrant County (Fort Worth), Texas Drug Court. He is a Licensed Social Worker and Licensed Chemical Dependency Counselor and has practiced in the areas of chemical dependency and mental health treatment for 10 years. Additionally, Mr. Gallagher
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**Karen Greenberg**, J.D., is an experienced and accomplished attorney, having concentrated in family law matters for more than twenty years. She regularly represents adoption agencies, adoptive families and birthparents in all aspects of adoption law and most often in contested matters. Karen also represents many individuals in disputed family law matters. She helps her clients make their way through difficult and heavily-contested matters, such as divorce, child-related issues of custody, visitation and support, property division, alimony, retirement benefits and paternity. A frequent lecturer and author on adoption related issues, she recently collaborated in the redrafting of the Massachusetts adoption statutes. As a founding member of the American Academy of Adoption Attorneys, she was elected to its Board of Directors in 2004 and became President of the Academy in May 2007. The Academy works to promote the reform of adoption laws and disseminates information on ethical adoption practices. Karen is a graduate of Boston University and holds a master’s degree from Wheelock College. She graduated cum laude from Suffolk University Law School in 1983 and formed Konowitz & Greenberg, P.C. in 1988.

**Andrew M. Herbert**, Ph.D., graduated with a B.Sc. in Biology from McGill University in Montreal, then completed an M.A. and Ph.D. at the University of Western Ontario in Psychology with Keith Humphrey. He completed his post-doctoral training in Psychology and Vision Science at Glasgow Caledonian University in Scotland and then studied with Jocelyn Faubert at the University of Montreal. Andrew spent three years at the University of North Texas, running the Cognitive Neuroscience Lab in the Department of Psychology. He has been at RIT since 2002 and has served as Chair of the Department of Psychology since December, 2008. Andrew has examined different visual illusions, spent a lot of time trying to understand the perception of structure in the world (focusing on bilateral symmetry detection), and he is interested in the timing and locus of different perceptual and cognitive processes. In the past few years he has been doing research on the perception of faces and facial expressions. In collaboration with Dr. Jeff Pelz in the Multidisciplinary Vision Research Lab (MVR Lab) housed in the Carlson Center for Imaging Science at RIT, he is examining eye movements during change detection and responses to emotional faces, among other things.

**Sandra H. Jee**, M.D., M.P.H., is an Associate Professor of Pediatrics at the University of Rochester Medical Center. Dr. Jee received her B.A. in English at Yale University and her M.D. with Distinction in Research at the University of Rochester. She completed her first two years of pediatrics residency at New York University/Bellevue Hospital. She completed her senior year of pediatrics residency at the University of Michigan, where she did a fellowship in Pediatric Health Services Research and received her M.P.H. in Health Management and Policy at the University of Michigan School of Public Health. She was selected to complete a one year post-doctoral position as a Kellogg Scholar in Health Disparities. She recently completed a career development award from the Robert Wood Johnson Foundation as a Physician Faculty Scholar, and her research interests include

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resilience for children in the child welfare system, mental health needs for children in foster care, and fetal alcohol syndrome. She maintains her clinical practice teaching resident and medical students in both the university-based pediatric practice and in the foster care clinic. This clinical work serves as the foundation for her research ideas.

Larry S. Jenkins, J.D., manages the adoption practice at Wood Jenkins LLC in Salt Lake City, Utah. He is admitted to practice in Utah, several Federal courts and the United States Supreme Court. His firm is involved in many adoption matters, including contested cases, interstate cases and ICWA matters, among others. Wood Jenkins represents adoption agencies, adoptive families, and birthparents. Larry participated in a symposium at BYU Law School in 2007 on Adoption Law and published an article in the fall 2007 edition of Children’s Legal Rights Journal at Loyola Chicago School of Law on the new proposed Interstate Compact on the Placement of Children (ICPC). Larry chairs the standards and practices committee of the Utah Adoption Council. In 2005, Larry was nominated by Senator Orrin Hatch to be an Angel in Adoption. In 2009, Larry received the Professional Service Award from the Utah Adoption Council. Larry has had several adoption decisions issued by the Utah Supreme Court and Utah Court of Appeals. He is a fellow of the American Academy of Adoption Attorneys where he is currently a member of the Board of Trustees and ICPC Committee.

Charles “Chuck” Johnson, M.A., is the president and CEO of the National Council For Adoption (NCFA) and the Director of the IAAT Program. He is the primary editor of NCFA's highly rated Consider the Possibilities curriculum and of the Adoption Advocate, a monthly publication of NCFA. He is also the project manager and editor/writer of the Intercountry Adoption Journey: Hague-Compliant Training from NCFA, a Web-based training for prospective adoptive parents that promotes the learning objectives required by the Hague Convention on Intercountry Adoption. Prior to joining NCFA, Mr. Johnson served 17 years with a licensed child-placing agency, including eight years as its executive director. He was a consultant and on-camera participant to Hallmark Entertainment's A Family for Li. His recent citations include CNN, CNN International, Fox News, USA Today, Time, Newsweek, the New York Times, and Family News in Focus. Mr. Johnson is a graduate of Auburn University with a degree in Social Work and holds a Masters degree from Birmingham Theological Seminary. He has been a licensed practicing social worker since 1986. He is a father by adoption and lives with his wife and three children in Maryland.

Hal Kaufman, M.B.A., is an adoptive father, open adoption advocate, frequent speaker on the topic of adoption, and founder of My Adoption Advisor (www.MyAdoptionAdvisor.com). My Adoption Advisor offers training and hands-on coaching services to help families pursuing domestic adoption better understand the adoption process, anticipate bumps in the road, and adopt more quickly.

Lauren Kelley is a senior at Duke University where she will graduate with a degree in public policy. She plans to pursue a Master's in Social Work beginning in the fall of 2011. This article in this book was authored while Lauren was interning in the Legal Department at the Gladney Center for Adoption during the summer of 2010.

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Megan Lindsey, J.D., is Manager of National Council For Adoption's Infant Adoption Training Initiative. An attorney in Texas and Michigan, she graduated from Regent University's School of Law, specializing in Public Interest Law with a special interest in child advocacy and human rights. Megan holds a B.A. in Public Law and Government from Eastern Michigan University.

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David Martin, M.A., is a doctoral student at the University of Minnesota’s Institute of Child Development. He contributed to the Early Growth and Development Study (EGDS), a study of adopted children and their adoptive and birthparents, by coordinating the efforts of adoption agencies and study personnel while at the University of California, Davis, and at the University of Minnesota, Twin Cities. His research interests focus on social and biological factors influencing healthy family relationships and individual development. Using the EGDS data set, he is currently examining changes in the openness of adoption kinship networks over time and how these changes affect each member of the network.

Patrick Mason, M.D., Ph.D., is the Director and founder of the International Adoption Center. He received both his M.D. and Ph.D. from the Medical College of Virginia in Richmond, VA. He then went on to complete his Pediatric Residency and fellowship in Pediatric Endocrinology at Emory University in Atlanta. He has been working with internationally adopted children for many years and is now on the Executive Committee of the American Academy of Pediatrics’ Section on Adoption and Foster Care. Dr. Mason has faculty appointments at the University of Virginia School of Medicine, Virginia Commonwealth University School of Medicine and as a Voluntary Faculty at the National Institute of Health. Dr. Mason’s ongoing research project is examining the effects of early life experiences in international orphanages on the child’s stress response and its impact on growth and puberty. Dr. Mason is also committed to caring for children who are not adopted. He has
led medical mission trips throughout the world caring for children in orphanages. Trips have included care for children in Honduras, Romania and Russia. Dr. Mason is the Board President of HOMBRE, an organization committed to providing care in Honduras as well as training medical students and residents in the care of children around the world. He also serves on the Board of Directors for the Golden Phoenix, a foundation developed to help with these relief efforts.

**Mark L. Melson**, M.B.A., is Executive Vice President and Chief Development Officer for the Gladney Center for Adoption in Fort Worth, Texas. In his role Mark is responsible for a development effort that supports initiatives in this country and around the world. In addition Mark oversees the marketing and outreach teams responsible for promoting the option of adoption. Mark has traveled extensively throughout the world helping to create initiatives which support less fortunate children as they age out of orphanages. He has been designated as a Certified Specialist in Planned Giving (CSPG) from California State University, Long Beach, and is a Certified Fund Raising Executive (CFRE). Mark recently served as the treasurer on the board of directors of the National Committee on Planned Giving and has a BBA and MBA from the University of North Texas. Mark has over 17 years experience in charitable gift planning.

**Laurie C. Miller**, M.D., Professor of Pediatrics at Tufts University School of Medicine, founded the International Adoption Clinic at Tufts Medical Center in 1988, the second such clinic in the U.S. She has served as a pediatric consultant in China, Egypt, Pakistan, Afghanistan, Bosnia, Nepal, Romania, Russia, Guatemala, Ukraine, Rwanda, and Kazakhstan. In the Murmansk region of Russia, she oversaw an NIH-funded program to improve outcomes for orphanage residents for many years. She established “Big Sisters” projects in Baby Homes in Murmansk, Ukraine, and India. Dr. Miller serves on the Board of Directors of Romanian Children’s Relief, the national Board of FRUA (Families for Russian and Ukrainian Adoption), and the NIH Study Section for Brain Disorders in the Developing World. She currently is the Principal Investigator of a longitudinal project to monitor and improve the health and nutritional status of impoverished children in Nepal. She has published over 80 peer-reviewed articles and 30 chapters related to pediatrics and international adoption, as well as two books (Handbook of International Adoption Medicine, Oxford University Press, and Encyclopedia of Adoption [with C. Adamec], Facts on File). She also is a board-certified pediatric rheumatologist and directs the pediatric rheumatology training program at Tufts Medical Center.

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**Shanna Mittie**, M.L.A., M.S. and Ph.D., designs and conducts research studies at the TCU Institute of Child Development. She earned her B.S. from Missouri Western State University in St. Joseph, Mo. She went on to earn an M.L.A., M.S. & Ph.D. (Experimental Psychology, 2009) from TCU. Her main emphasis
is analyzing data, making critical observations of analyses, identifying patterns in the data and maintaining quality control. She has extensive knowledge of the scientific process, research principles and protocols. Dr. Mittie serves as the Institute’s liaison between the University, local and state government agencies, and other participating agencies by providing consulting assistance to various organizations. She helps coordinate development, implementation, and maintenance of community research studies and projects. She also serves as a member of Cook Children’s Institutional Review Board (IRB) and helps facilitate the grant application process from initial application to final award determination. Finally, Dr. Mittie supervises both undergraduate and graduate students in the TCU Department of Psychology as well as research assistants by assigning and reviewing research-related tasks, overseeing and organizing Independent Study students into research groups.

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**Jenae Neiderhiser**, Ph.D., is a Liberal Arts Research Professor of Psychology at the Pennsylvania State University. Her work has focused on understanding gene-environment interplay with a particular interest in understanding how children and their families influence each other. She has used twin, sibling and adoption designs and novel combinations of these designs to tease apart genetic and environmental influences on family relations and the adjustment of family members. She is currently directing the Early Growth and Development Study–Phase 2. This study, together with the Early Growth and Development Study–Phase 1, longitudinally assesses 561 sets of adopted children, their adoptive families and birthparents longitudinally and includes information on prenatal environment, extensive assessment of the environment within the household, interpersonal relationships, adult and child adjustment, temperament and personality and other related measures.

**Herbie Newell**, M.A., is the Executive Director/President of Lifeline Children’s Services, Inc. of Birmingham, Alabama. Founded in 1981, Lifeline provides birthparent services, domestic adoption, intercountry adoption and residential maternity care. Herbie holds a Master’s in Accounting from Samford University in Birmingham, Alabama and currently serves as the Vice-Chairman of the National Christian Adoption Fellowship.

**Kimberly Newman**, J.D., has served for several years on the governing board, and now the emeritus board, of the National Council For Adoption. She is the mother of two children adopted from Russia. After practicing law at a major law firm in Washington, DC for nearly 20 years, she now works for Wal-Mart and resides in Bentonville, Arkansas.

**James B. Outman**, J.D., is an adoptive parent and a counselor at law practicing in Atlanta, Georgia. He received his Bachelor of Science degree in Industrial Management from the Georgia Institute of Technology, in Atlanta, and his Juris Doctor degree from the Georgetown University Law Center, in Washington, DC. He has been the principal author of every major piece of legislation involving adoption in Georgia since 1975, including the Adoption Act of 1990 which was the recodification of the entire adoption code, and the addition of the use of the Georgia putative father registry in 1998. He is the primary author of the chapter on Adoption in *Georgia Domestic Relations Forms*, published by LexisNexis Matthew Bender. He has appeared on public broadcasting and CNN to discuss adoption issues, and frequently
lectures on adoption topics. He has chaired and spoken at 21 Adoption Law & Practice seminars sponsored by the Institute of Continuing Legal Education in Georgia since 1993. He has also addressed the Superior Court Judges of the State of Georgia seven times since 1990 at conferences sponsored by the Institute of Continuing Judicial Education in Georgia. He has represented adoptive parents in the finalization of all types of adoptions and helped shape Georgia’s law through appearances, either as counsel of record or amicus, in 14 reported decisions by Georgia’s appellate courts. In 2003 he was recognized as an Angel in Adoption by the Congressional Coalition on Adoption Institute. He is a Fellow in the American Academy of Adoption Attorneys and a Fellow in the Georgia Council of Adoption Lawyers.

Sheri Parris, M.Ed., is a research associate with the TCU Institute of Child Development. She has a B.B.A. from Texas Wesleyan University, M.Ed. from Texas Christian University, and is completing her Ph.D. in Reading Education at the University of North Texas. Sheri has taught at the middle school, high school, and college levels. She was appointed by the Texas Commissioner of Education to serve on the Texas Textbook Review Panel in 2009 and has co-authored many journal articles and two books in the field of education. She has been a presenter at both national and international educational conferences, and served on national and international committees for educational organizations.

Paul Placek, Ph.D., has worked on all five National Council For Adoption (NCFA) national surveys of adoption over the past 25 years. He wrote many of the chapters in earlier Adoption Factbooks, and he conducted all of the data collection, processing, and analysis for NCFA’s most recent national adoption survey. Dr. Placek is retired from the Centers for Disease Control and Prevention as a Senior Statistician in the Office of the Director, National Center for Health Statistics. As a Senior Statistician working in the WHO Collaborating Center for the Family of International Classifications housed at NCHS, he worked for 12 years on revision, promotion, and application of the International Classification of Functioning, Disability and Health (WHO, Geneva, 2001). He designed many ICF research projects and as Project Officer he worked with contractors on ICF Videos and ICF web-based training. He chaired DISTAB, a group of statisticians from six countries who produced internationally-comparative data with their respective national disability surveys. His group produced DISability TABulations which were back coded to the ICF in order to standardize the presentation of data. For 11 years, he co-chaired the Interagency Subcommittee on Disability Statistics (ISDS), which has monthly disability presentations at eight interactive video sites plus worldwide call-in, and he emailed minutes to 1,000 persons monthly. Dr. Placek also wrote monthly messages for the NACC Clearinghouse on ICF, which has 600 subscribers interested in key summaries of ICF activities in the U.S. and Canada. He co-authored (with Gerry Hendershot) a book entitled Predicting Fertility. Dr. Placek has over 100 publications in refereed journals.

Karyn Purvis, Ph.D., the Director of the Institute of Child Development at Texas Christian University, developed and directs the Hope Connection, a research and intervention summer day camp for adopted children. She and her colleague, Dr. David Cross, have co-authored a feature book for McGraw-Hill, The Connected Child: Bringing Hope and Healing to your Adoptive Family, which was released Spring 2007. During 2008, Dr. Purvis was awarded the T. Berry Brazelton, M.D. Infant Mental Health Advocacy Award, was given the title of Distinguished Fellow in Adoption and Child Development by the National Council For Adoption and was appointed Presiding Officer of the Texas Department of Family and Protective Services Committee on Licensing Standards by Governor Rick Perry.
Melissa Raap is a graduate student in the School of Social Work at the University of Washington.

Elisa Rosman, Ph.D., is the Director of Research at the National Council for Adoption (NCFA). Her research interests include children at risk and their families and the policies that affect them. She has conducted projects ranging from a study of low-income women who have children with disabilities to a review of best practices on the part of pediatric primary care providers. Dr. Rosman holds a Ph.D. from NYU and a B.A. from Yale University. Organizations that she has worked for include Docs for Tots, the Georgetown University Center for Child and Human Development, the National Research Council, and the United Way of Massachusetts Bay and Merrimack Valley. Dr. Rosman is mom to four (including three children from China).

Joan R. Rycraft, Ph.D., is an Associate Professor at the University of Texas at Arlington, School of Social Work, and former Associate Dean and Director of the Ph.D. Program. She is a Faculty Associate of the UTA-SSW Center for Child Welfare and has also been named a Distinguished Fellow in Adoption and Child Welfare by the National Council for Adoption. Dr. Rycraft teaches courses in child and youth policy, advanced administration, and research methods and evaluation. Over the past 10 years, Dr. Rycraft has been awarded over 12.5 million dollars in external funding to train child welfare managers to use data for improved decision-making, train caseworkers and supervisors on effective practices with Latino children and families, develop one of five national Child Welfare Implementation Centers to provide intensive technical assistance to state and tribal child welfare agencies, and to conduct field evaluations of the National Council For Adoption’s Infant Adoption Awareness Training program. Her areas of research cover policy and administrative issues in child welfare and services to youth. She has presented at several national and international conferences and published widely in these areas.

Paula St. John, M.S.W., is a Licensed Clinical Social Worker and the Vice President of Family Services at the Gladney Center for Adoption. She has worked with at-risk children and families for 20 years. Paula obtained a Bachelor of Social Work from Texas Tech University and a Masters in Social Work from the University of Texas in Arlington. Paula supervises the development of training and education programs for adoptive families, in particular working with families adopting at-risk children. She has presented numerous adoption topics to various groups across the United States. Paula centers her work on the holistic view of treating the whole child and working toward permanency for all children in need of loving homes around the world.

Jayne Schooler, M.B.S., has been passionate for over 25 years about the training and education of adoption and foster care professionals and families. She has been a featured speaker at numerous state, national and international conferences. Her most recent work has taken her to Ukraine, Kyrgyzstan, Poland and New Zealand. She trains regularly for the Ohio Child Welfare Training Program. She is the author/co-author of six books in the adoption field and numerous training curricula. She and her husband, David are the parents of two children, Ray, 44, who joined their family as a teenager at 16 and Kristy, 34, their birth daughter, who is also involved in adoption work.

Rita Soronen, B.A., President and CEO of the Dave Thomas Foundation for Adoption, has served as Executive Director of the Dave Thomas Foundation for Adoption since 2001, working to find loving adoptive families for each of the 150,000 waiting children in the United States and Canada’s foster care systems. Under Rita’s leadership, the Foundation has significantly increased its grant-making and awareness commitments, while developing signature initiatives that underscore and act on the urgency of the issue. In 2009, the Foundation dedicated more than $12 million to grants and award-winning national awareness activities, including
Wendy’s Wonderful Kids, Adoption-Friendly Workplace, National Adoption Day, national foster care adoption attitudes research, *A Child is Waiting: A Step-by-Step Guide to Adoption*, national foster care adoption poster campaign, PSAs and educational videos. In four years, the Wendy’s Wonderful Kids program has grown from seven pilot site grants to 122 active sites in all fifty states, the District of Columbia and five provinces in Canada dedicated to aggressively and effectively moving children from foster care to permanent families. More than 1,700 children have been adopted as a direct result of Wendy’s Wonderful Kids. Rita serves on the Board of Directors of the Congressional Coalition on Adoption Institute, the Ohio CASA/GAL Association, the Public Education Committee of the National CASA Association and is a fellow of the Jefferson Fellowship for Executive Leadership. She is a requested national speaker on the topic of children and the child welfare system.

**Kelsey Stewart** is a birth mother of three children. She placed her first child, a daughter, for adoption in the late 80's and then two years later placed her twin sons for adoption as well. Her experiences in open adoption have been incredibly positive because of the communication that she has continued to have throughout her children’s lives. Always the communicator, Kelsey searched for two decades to find a children’s book that would explain to her children why she chose adoption for them. She eventually wrote *The Best For You*, which started as a personal project for her children, but soon was published as an honest portrayal of what one mother was thinking when faced with the decision to place her children for adoption and has been well received by all sides of the adoption triad. Kelsey has written articles for *The Open Adoption Examiner, Adoptions From The Heart, The National Council For Adoption*, and she composed an eBooklet that was published by Tapestry Books titled *Guilt, Grief and Pride*. She is also the author of the blog A Birth Mother Voice that chronicles her life as a mother over the last 20 years with an incredibly positive outlook. Her background includes a career as a graphic designer, however she left the work force to stay at home with her two sons that she is raising with her husband of eleven years. Kelsey is also a very active volunteer for everything from Scouting to Little League.

**Kathleen Strottman, J.D.,** is the Executive Director of the Congressional Coalition on Adoption Institute (CCAI), having previously served for nearly eight years as a trusted advisor to Senator Mary L. Landrieu (D-LA). As the Senator’s Legislative Director, Kathleen worked to pass legislation such as the No Child Left Behind Act, The Medicare Modernization Act, The Inter-Country Adoption Act, The Child Citizenship Act of 2000, The Adoption Tax Credit and the Family Court Act. Together with the Senator, Kathleen worked to increase the opportunity for positive dialogue and the exchange of best practices between the United States and sending countries such as China, Romania, Russia, Guatemala, Honduras, El Salvador and India. Prior to joining the Senator’s staff, Kathleen attended Whittier Law School's Center for Children's Rights were she graduated with honors and received a state certified specialty in juvenile advocacy. A member of the Whittier Law Review, Ms. Strottman published an article entitled *Creating a Downward Spiral: Transfer Statutes as Answers to Juvenile Delinquency*. Kathleen received her bachelor’s degree in political science from the College of the Holy Cross and went on to serve as a Jesuit Volunteer. She and her husband, Matt, are the proud parents of three children, Grace, Noah and Liam.

**Tony X. Tan, Ph.D.,** is an associate professor of Educational Psychology at the Department of Psychological and Social Foundation in the College of Education, University of South Florida, Tampa, Florida. He earned his doctorate in Human Development and Psychology from Harvard University Graduate School of Education in 2004. In addition, he also earned a Master’s degree in Education from Harvard University in 2000, and a Bachelor of Law degree in Diplomacy from Foreign Affairs College (Beijing, China)
in 1998, and a B.A. in English and Medical Science from Xi'an Jiaotong University (Xi'an, China) in 1996. Since 2001, he has been studying adopted Chinese children’s post-adoption development. Large-scale longitudinal data from his study showed that the adopted children had favorable outcomes in language development, social-emotional development, and academic performance. Currently, Dr. Tan is studying how the adopted Chinese children’s genotypes, as well as those of their adoptive parents, might help understand the development of anxiety and depression in adopted children.

Tiffany Terry, B.S., received her Bachelors of Science in psychology in 2001 from the University of North Texas in Denton where she also was a research assistant in the Cognitive Psychology Lab. She is currently studying in the Masters of Community and Regional Planning program at the University of New Mexico in Albuquerque, New Mexico.

Linda Grey Tirella, O.T.D., M.H.A., OTR/L, is a licensed occupational therapist with over 30 years of experience including: adoptive medicine, the school system for all ages and disabilities, with a concentration on children diagnosed with Autism/Pervasive Developmental Delays as well as neurodevelopmental delays. Dr. Tirella has worked at the Center for Adoptive Families at Floating Hospital, Tufts Medical Center in Boston for over 10 years. She is certified in Sensory Integration Therapy and Video Feedback Intervention for Positive Parenting. She has established collaborative partnerships with local universities in an effort to design new models of augmentative communication and mobility. She has given lectures and in-service seminars on Sensory Integration for both professionals and parents, and guest lectures at Boston College in the areas of childhood development and oral motor/feeding issues. She has presented both locally and nationally on her research on outcomes of internationally adopted children.

Sharon Vandivere, M.P.P., has studied child well-being for over 12 years at Child Trends, where she is a research scientist in the child welfare area. Her interests include adoption and foster care, poverty, and risk and resiliency factors. She has extensive experience analyzing nationally representative data, including data from surveys with complex sampling methodologies, as well as administrative data.

Rebecca Weichhand, J.D., is the Director of Policy at the Congressional Coalition on Adoption Institute (CCAI). She has a J.D. from Regent Law, and has singularly focused her life work on orphan relief, foster care and adoption policy since she was in high school. During college and law school, Rebecca traveled coast to coast to work with several of the U.S.’s premier child welfare law firms and policy organizations, including the Alliance for Children’s Rights and National Council For Adoption. She also frequently travels internationally to study and work with orphan care programs in other countries. For years, she has aspired to reduce the bureaucratic impediments that prevent children from joining loving families – consequently, Rebecca is thrilled to join CCAI in serving and educating Members of Congress and their staff on the issues about which she is the most passionate.

Kate Welti, M.P.P., is a senior research analyst at Child Trends. She performs quantitative analyses for projects related to adoption, reproductive health, non-marital childbearing, family structure, and early care and education. Prior to joining Child Trends, Ms. Welti was a Graduate Research Fellow at the Center for Research on Children in the United States at Georgetown University.

Kathleen L. Whitten, Ph.D., is a faculty member in psychology at Georgia State University, a developmental psychologist, and adoptive mother. A former lecturer in psychology at the University of Virginia, she was also a research faculty member at the Child-Parent Attachment Clinic, Department of Psychiatric Medicine, University of Virginia, and an evaluator for Virginia’s Quality Improvement Center for Adoption. Dr. Whitten’s book, Labor of the Heart: A Parent’s Guide to the Decisions and Emotions in Adoption, was published in 2008 by M. Evans (Rowman & Littlefield). She has published articles on adoption in Adoption Quarterly, Parenthood in America (ABC-CLIO), The Encyclopedia of Primary Prevention (Kluwer), The New Book of Knowledge (Grolier/Scholastic) and the Virginia Journal of Social Policy and Law. She has presented research on the psychology of adoption at national and international psychology conferences. Her work has been covered by CNN and the Associated Press.

Kathy Widenhouse, M.A., is a development copywriter who works with nonprofits to get their message out and increase their reach. She specializes in helping faith-based organizations. Kathy has also written five books. Find her online at www.kathywidenhouse.com

Ellen Wilson, C.P.A., is the Senior Vice President, Chief Financial Officer for the Gladney Center for Adoption. Ellen left public accounting to join The Gladney Fund at its inception in 1992, serving as the Vice President of Finance until 1999. After spending a few years in private practice, Ellen rejoined the Gladney Center for Adoption in 2006. Ellen received a BBA in Accounting from the University of Texas in Arlington.

Marc Zappala was formerly the Assistant Director of Research at the National Council For Adoption (NCFA). He is currently a law student at Washington and Lee University School of Law.

Nicholas Zill, Ph.D., is a Washington-based psychologist. He was the founding Director of Child Trends and, prior to his retirement in 2008, the head of the Child and Family Study Area at Westat. He has written extensively on the effects of divorce on children as well as on the development and well-being of adoptive children and children in stepfamilies. He has given invited testimony on trends in American family life to several Congressional committees and national commissions.
Section 1

By the Numbers: Adoption Statistics
National Adoption Data Assembled by the National Council For Adoption

Paul J. Placek

Introduction

Six kinds of national data were assembled by the National Council For Adoption (NCFA) to construct the 17 statistical tables (plus figures and charts) described in this report. The data include:

1) A 2007 NCFA survey of state-by-state adoption statistics, combined into national estimates

2) Annual data on total and nonmarital live births, collected by the National Center for Health Statistics, Centers for Disease Control and Prevention

3) A national survey of abortions collected by the Alan Guttmacher Institute (with notes on why incomplete Centers for Disease Control and Prevention data were not used)

4) Annual data on intercountry adoptions (or immigrant orphans) collected by the Department of Homeland Security (formerly the U.S. Immigration and Naturalization Service)

5) Annual data on adoptions based on immediate relative visas issued by the U.S. Department of State

6) Annual data on adoptions of children with public child welfare agency involvement, collected by the Administration for Children & Families

Live births, nonmarital live births, adoptions with public child welfare agency involvement, intercountry adoptions, and relative visas data systems are maintained and regularly collected on a national basis by the federal bureaucracy. The federal statistics are accurate and their methodologies are well described in their reports.

However, most of the national data on ten adoption items as collected in the 2007 NCFA surveys are not routinely collected by any federal bureaucracy. Due to this vacuum on adoption data, NCFA has collected it, and the data are now described here.

By mail, e-mail, fax, and telephone, NCFA’s statistical consultant Dr. Paul Placek contacted health, welfare, and vital statistics offices within each state to gather 2007 data on the following:

- total adoptions
- related domestic adoptions (legal adoptions in which at least one of the adoptive parents or guardians is related to the child by blood or marriage to the child’s biological parent)
- unrelated domestic adoptions by public agencies (those child-placing agencies that are supported by public funds and administered by public officials and their personnel)
- unrelated domestic adoptions by private agencies (voluntary agencies which are supported by private funds as well as some public funds for certain programs under purchase of services agreements with public agencies)
- unrelated domestic adoptions by private individuals (independent placements made without agency involvement that are sometimes referred to as “private” adoptions)
unrelated adoptions of infants (infants under two years of age adopted by persons not related to the infant by blood or marriage)

unrelated domestic adoptions of children with special needs (those children who may be difficult to place due to ethnic background, age, membership in a minority or a sibling group, or the presence of physical, emotional, or mental handicaps)

Interstate Compact on the Placement of Children (ICPC) adoptions

Appendix 2 consists of the questionnaire used in the 2007 NCFA survey. The most recent base year for which it was feasible for NCFA to collect these data was 2007, due to time lags for state data processing.

NCFA conducted its 2007 survey for the same reasons it conducted its 1982, 1986, 1992, 1996, and 2002 surveys. There is still a desperate need for more current adoption data to be made available to policymakers, adoption agencies, social workers, attorneys, health professionals, researchers, adopted persons, biological parents, and potential adoptive parents. Federal efforts to collect comprehensive national adoption data are limited, periodic, and/or for a single purpose. NCFA’s surveys demonstrate that it is feasible to collect these data. We hope that new federal data systems on adoption will soon be improved and made more comprehensive, complete, and timely. We also hope that standardized definitions will be developed to improve the comparability of the data.

Overview of Adoptions in 2007

Table 1 indicates that, in 2007, there were 133,737 domestic adoptions. Of these, 57,248 were related domestic adoptions, and 76,489 were unrelated domestic adoptions. Public agencies handled the largest number of unrelated domestic adoptions (42,978). The rest were handled by private agencies (20,254), or else were independent adoptions handled by private individuals, usually attorneys (13,257). In 2007, infants comprised almost one-fourth (18,078) of unrelated domestic adoptions, and children with special needs (some of whom may have been infants) comprised two-fifths (32,402) of unrelated domestic adoptions.

There were 6,336 “entered state for adoption” ICPC adoptions in 2007, and 8,111 “left state for adoption” ICPC adoptions in 2007. Finally, there were 19,442 intercountry adoptions in 2007, as reported by the Department of Homeland Security.

Because the NCFA surveys in earlier years were similar to the 2007 survey in design and content, certain trends can be shown. Figure 1 shows an increase in unrelated domestic adoptions in 2007, when compared with four periods in the 1980s and 1990s. However, the 2007 figure is almost identical with the one from 2002.

Figure 2 shows a decline in domestic infant adoptions in 2007, as compared with 1992 and 1996 NCFA survey data. However, the 18,078 domestic infant adoptions observed in 2007 is almost the same as the 17,602 observed in NCFA’s first national survey in 1982.
Figure 2. Unrelated domestic adoptions of infants, NCFA surveys

Figure 3 shows the recent decline in adoptions of children with special needs—32,402 in 2007, as compared with 45,584 in 2002.

Figure 4. Public agency adoptions, NCFA surveys

Table 2 shows that, of the 76,489 unrelated domestic adoptions in 2007, 56.2 percent were handled by public agencies, 26.5 percent by private agencies, and 17.3 percent by private individuals. In 2007, state adoption experts reported that, due to state law, there were no independent adoptions by private individuals in eight states (Massachusetts, Connecticut, North Dakota, Delaware, Minnesota, the District of Columbia, Colorado, and Nevada).

Figure 4 shows that public agency domestic adoptions rose steadily from the 1980s to the 1990s, and rose again dramatically in 2002, stabilizing at 42,978 in 2007. Figure 5 shows a steady rise in private agency adoptions since 1982. Figure 6 shows that private individual adoptions have fallen to 13,257, from 16,058 in 2002.
Adoptions of Children with Special Needs—2007

Unrelated special needs adoptions are usually defined as adoptions of children with physical or emotional disabilities, sibling groups, older children, or children of minority or ethnic backgrounds. In 2007, 42.4 percent of unrelated domestic adoptions were special needs (Table 4). Adoptions of children with special needs comprised just over one-fourth of all unrelated domestic adoptions both in 1982 (27.6 percent) and in 1986 (26.5 percent) (NCFA, Adoption Factbook I and Adoption Factbook II). The rise in the number of adoptions of children with special needs was attributed in Adoption Factbook III to increased public funding for assisting children with disabilities and other special needs.

Ratios of Adoptions, Live Births, Nonmarital Live Births, and Abortions—2007

Ratios are useful devices for standardizing data and indicating the relative sizes of two quantities to be compared. It is helpful to standardize “per 1,000” as in Table 5 so that the relative magnitude of adoptions, births, and abortions to each other can be compared. The ratio of abortions per 1,000 live births, also called the “abortion ratio” in demographic studies, represents an indication of abortions in relation to the frequency of live births occurring to residents of each state. Therefore, in 2007, there were 279.4 abortions for every 1,000 live births, or about 28 abortions per 100 live births in the United States in 2007. The magnitude of the ratios is affected by the distribution of both live births and abortions in relation to characteristics of the female population such as marital status, state policy on Minnesota, and Virginia), intercountry adoptions comprised over one-third of total unrelated adoptions in 2007. In four states (Oklahoma, Arkansas, Wyoming, and Nevada), intercountry adoptions accounted for less than one-tenth of total unrelated adoptions.

Unrelated Domestic and Unrelated Adoptions—2007

When 76,489 unrelated domestic and 19,442 intercountry adoptions are totaled, it is found that 95,931 unrelated adoptions occurred in the U.S. in 2007 (Table 3). Intercountry adoptions comprised 20.3 percent of unrelated adoptions in 2007, up from 10.5 percent since 1992 (Table 5, Adoption Factbook III). In three states (Connecticut,
public funding of family planning and abortion, availability of services (family planning, maternity homes) for pregnant women, prevalence of certain religious groups from state-to-state, and proximity to other states with certain services and facilities.

In *Adoption Factbook II*, NCFA had devised three new types of ratios based on the standard demographic technique described above. The ratio of infant adoptions per 1,000 abortions represents an indication of infant adoptions in relation to the frequency of abortions. There were only 15.0 infant adoptions per 1,000 abortions in 2007 (Table 5). NCFA takes no position on abortion, except to suggest that many women might not choose abortion if there were better counseling, better social services, more maternity assistance programs, and increased adoption awareness and counseling available. If women knew that there are many families hoping to adopt for every one adoptable infant, and that adoption is beneficial to most adopted persons and birth mothers who make an adoption plan, there might be more adoptions.

The ratio of infant adoptions per 1,000 live births represents an indicator of infant adoptions in relation to the frequency of live births. Therefore, there were only 4.2 domestic infant adoptions per 1,000 live births in America in 2007. Fewer than one-half of one percent of live births are children relinquished for adoption as infants.

The ratio of infant adoptions per 1,000 nonmarital live births is a better yardstick, because unmarried women are more likely to choose adoption for their babies, and this ratio indicates infant adoptions in relation to the frequency of nonmarital live births. There were 10.3 adoptions per 1,000 nonmarital live births in 2007, down from 18.7 in 1996 (Table 8, *Adoption Factbook III*), indicating that about one percent of unmarried mothers chose adoption for their infants, and over 99 percent parented the baby.

Note in Table 5 the states with higher ratios of infant adoptions per 1,000 nonmarital live births in 2007. All of these states have ratios ranging from of 20.2 to 51.0—much higher than the national average of 10.3. These states, therefore, have at least twice the relative success as the national average in offering the adoption option to unmarried women who would otherwise parent the baby. These same states also have high ratios of infant adoptions per 1,000 abortions. This means that these states (New Hampshire, Vermont, Iowa, Idaho, Wyoming, Colorado, and Utah) may have much more relative success in offering the adoption option to women who would otherwise choose abortion.

**Unrelated Adoptions of Infants—2007**

Table 6 focuses on unrelated domestic adoptions of infants, which comprised almost half (47.9 percent) of all unrelated domestic adoptions in 1992, 43.2 percent in 1996, but only 23.8 percent in 2007. In 2007, infants comprised over half of unrelated domestic adoptions in Georgia, Wyoming, Utah, and Nevada. In 2007, domestic adoptions of infants comprised only 0.4 percent of 2007 live births, and 1.3 percent of births to unmarried women. Unmarried women are by far the most likely to consider relinquishing their infants for adoption, yet these statistics show that 98.7 percent of unmarried women who gave birth in 2007 elected to parent the child.

**Adoption Option Index™ from the National Council For Adoption**

A useful index has been created which indicates the number of infant adoptions per 1,000 nonmarital live births and abortions combined. This index, created by NCFA, is called the Adoption Option Index and was first published in *Adoption Factbook II*. Based on statistical data from NCFA’s survey on domestic infant adoption, counts of births to unmarried women from U.S. vital statistics, and abortion counts reported by the Alan Guttmacher Institute (all shown in Table 5), NCFA has constructed this index, which shows the relative frequency of infant adoptions per 1,000 abortions and births to unmarried women.
Domestic Infant Adoptions
Abortsions + Births to Unmarried Women
\[ \times 1,000 = \text{NCFA's Adoption Option Index} \]

The United States Adoption Option Index is calculated as follows for 2007:

\[
\frac{18,078}{1,206,240 + 1,757,013} \times 1,000 = 6.1
\]

In 1996, the Adoption Option Index was 9.5 (Adoption Factbook III). By 2007, it had fallen to 6.1.

This is the first index ever constructed to indicate the relative frequency of infant adoptions to that group of pregnancy outcomes which could potentially yield adoptions. The index has both strengths and limitations.

Its strengths are:
1) It is an objective index based on counts of actual events.
2) It is a ratio, which standardizes events “per 1,000,” so large states and small states alike can be compared with regard to adoption activity in relation to the pool of pregnancies which potentially could yield adoptable infants.
3) It allows statistically standardized comparisons of trends for all time periods and locations for which the three data items of infant adoptions, abortions, and births to unmarried women are available.
4) It is a summary measure which reflects the types of adoption choices made by adoptive couples, unmarried pregnant women who choose to terminate their pregnancies, and unmarried pregnant women who carry their pregnancies to term and deliver. It also reflects the varied levels of adoption facilities, counseling, and regulations in a given geographic area.

Its limitations are:
1) The index will vary with a substantial change in any one of the three data components.
2) Social factors, attitudes, and legislation can affect any of the three data components.
3) It applies to domestic infant adoptions, and excludes foreign adoptions.
4) For Tables 5 and 7, 2005 abortion data had to be used, since complete U.S. abortion counts for 2007 were not available at press time.
5) Preliminary live births data were used since final data were not available for 2007 at press time.

Table 7 ranks all states with respect to the Adoption Option Index in 2007. The index is 6.1 for the U.S. as a whole, and indicates that there were about six domestic infant adoptions for every 1,000 abortions and births to unmarried women. If converted to a base of 100, it means that there is less than one adoption for every 100 abortions plus births to unmarried women.

In 2007, two states—Wyoming and Utah—stood out with Adoption Option Indexes about six times higher than the national average. In these states, there were three to four adoptions for every 100 abortions plus births to unmarried women. Among other possible factors, these states can be argued to have better counseling, services, and facilities to orient pregnant women towards adoption.

On the other hand, five states had indexes which are one-half the national average, indicating a much lower level of adoption activity than the national average. NCFA does not wish to “point a finger” at these states, because there are many fine agencies in these areas struggling to do excellent work with very limited resources. Hopefully, NCFA's Adoption Option Index will become an objective measure used henceforth to gauge the level of services and obtain more resources to make the adoption option a choice selected more often.
NCFA takes neither a “pro-choice” nor a “pro-life” position on abortion, but stresses the importance for open dialogue between those of different persuasions. NCFA also recognizes that some aborted fetuses, if allowed to gestate to term, would not have resulted in live births. Also, some abortions are to married women, who would most likely not relinquish for adoption if their pregnancies were carried to term. NCFA does not suggest that all unmarried women should choose adoption for their babies, and it is a fact that about 99 percent of unmarried women now choose to parent their babies.

However, as options are considered, it is all too often forgotten that adoption is one of those options, and that it could have major benefits for all concerned. Pregnant women who choose to abort may not have access to adequate counseling, pregnancy resources such as maternity homes in their communities, or the social, financial, and medical support available to carry their pregnancies to term and then make an adoption plan. Women who now deliver unwanted babies without a supportive male partner may not know that hundreds of thousands of families are now available to adopt the babies that they may attempt to raise with great difficulty. The fact that NCFA’s Adoption Option Index varies so greatly across different geographic areas indicates that adoption choices may largely depend upon the support services available. The Adoption Option Index therefore shows how much room for improvement there is in certain areas, indicating those places in which service and activity levels in the field of pregnancy counseling and services for pregnant women should be closely examined.

National Trends in Related and Unrelated Adoptions—1951-2007

U.S. adoption data are available from 1951 to 1975 (collected by the federal government), and, with NCFA’s surveys, for 1982, 1986, 1992, 1996, 2002, and 2007 as well (Table 8). Total adoptions rose from 72,000 in 1951 to a peak of 175,000 in 1970, declined to 108,463 in 1996, and rose to 133,737 in 2007. However, unrelated adoptions rose from 33,800 in 1951 to a peak of 89,200 in 1970, fell substantially in the mid-1970s through the mid-1990s, and rose again to 76,489 in 2007. Unrelated adoptions as a percentage of total adoptions have comprised half or less than half of all adoptions since 1971, but rose to 57 percent in 2007. The substantial increase in unrelated adoptions may reflect a larger U.S. population, greater acceptance of the adoption message, more childless couples, and/or other factors.


Table 9 shows the long-term trend in agency and independent adoptions. In the 1950s, public agencies handled about 20 percent of unrelated adoptions, and this rose steadily to 56 percent in 2007. Private agency adoptions have fallen from 40 percent of the total in the early 1960s to 26 percent in 2007. Independent adoptions comprised half of unrelated adoptions in the 1950s, dropped steadily through the 1970s to nearly one-third of unrelated adoptions in 1982 and 1986, and in 2007 fell to an all-time low of 17 percent of unrelated adoptions.


The data presented in Table 10 show the states of destination for immigrant orphans for 2007. The first column of Table 10 is the same information as shown in Table 1, but the gender and age columns in Table 10 represent new information. In 2007, immigrant orphans tended to be female (11,846 of the 19,471 total), and less than half (7,789) were under one year of age. Note, however, that 1,375 were over 9 years old. States with larger populations absorbed more immigrant orphans because the demand for adoption is numerically greater. Some of these states scored below the U.S. average on NCFA’s Adoption Option Index.
for domestic adoption. This suggests that in states in which domestic infants are less available, the demand for immigrant orphan adoptions will be higher. In areas where the Adoption Option Index is low due to fewer domestic adoptions, it is possible that couples alternatively pursue the international adoption option. Table 11 shows 2008 data for immigrant orphans by intended state of residence. The total count for 2008 (17,229) is lower than for 2007 (19,471). In 2008, the larger number of immigrant orphan girls (10,008) than boys (7,221) is still evident. Table 12 shows a dramatic drop in immigrant orphan adoptions in 2009, with a total of only 12,782.

**Trends in Countries of Origin for International Adoptions**

Table 13 shows Department of State adoption data on the top 20 countries for adoption to the United States from FY 2005 to FY 20010. China, Guatemala, and Russia predominated in the 2005-2008 years. Figure 7 shows the 1973-2010 trends in international adoptions to the United States, also based on Department of State data. The all-time high was 22,990 in 2004, but fell steadily to a low of 11,058 in 2010.

As this chart demonstrates, the 2003 count of 21,320 international adoptions represents the largest OIS/DHS number in the past 36 years. The 2009 count of 12,753 represents the lowest number in the past 12 years.

**Adoptions of Children with Public Child Welfare Agency Involvement**

The Administration for Children & Families supports state public child welfare agencies’ efforts to document adoptions handled by state agencies. These counts do not typically include private agency or private individual adoptions. However, there is little standardization in state data adoption practices. From years 2000 to 2009, this count has hovered around 50,000 adoptions, up from nearly 26,000 when the system began in 1995. There has been an increase in years 2007 to 2009.
## Table 1. Related and unrelated domestic adoptions and intercountry adoptions: United States, 2007 National Council For Adoption Survey

<table>
<thead>
<tr>
<th>Geographic division and state</th>
<th>1 Related and unrelated domestic adoptions</th>
<th>2 Related domestic adoptions</th>
<th>3 Unrelated domestic adoptions (subtotal 4+5+6)*</th>
<th>4 Unrelated domestic adoptions by public agencies</th>
<th>5 Unrelated domestic adoptions by private individuals</th>
<th>6 Unrelated domestic adoptions of infants (included in 3)</th>
<th>7 Unrelated domestic adoptions of children with special needs (included in 3)</th>
<th>8 Interstate Compact on the Placement of Children**</th>
<th>9 Entered state for adoption</th>
<th>10 Left state for adoption</th>
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<td>57,248</td>
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*continued*
### Table 1. Related and unrelated domestic adoptions and intercountry adoptions: United States, 2007 National Council For Adoption Survey (continued)

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Table 1. Related and unrelated domestic adoptions and intercountry adoptions: United States, 2007 National Council For Adoption Survey
(continued)

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<th>8 Unrelated domestic adoptions of infants</th>
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NOTES:
*Columns 4+5+6 may not exactly equal this total due to estimates which were rounded to the nearest whole number. The maximum discrepancy is limited to one adoption per state in column 4, 5, or 6. Column 6 includes adoptions handled by attorneys acting on behalf of adoptive parents.
**The number of children entering (6,336) and exiting (8,111) states for adoption are not equal, in large part, because of state record-keeping practices. Refer to Methodology Section for more detail.
Table 2. Number and percentage distribution of types of unrelated domestic adoptions for each state, division, and the United States: 2007 National Council For Adoption Survey

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continued
Table 2. Number and percentage distribution of types of unrelated domestic adoptions for each state, division, and the United States: 2007 National Council For Adoption Survey (continued)

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<tr>
<th>Geographic division and state</th>
<th>Number</th>
<th>Percent</th>
<th>Unrelated adoptions by public agencies</th>
<th>Unrelated adoptions by private agencies</th>
<th>Unrelated adoptions by individuals</th>
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<td>0.8</td>
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</table>

NOTES: Unrelated domestic adoptions category does not include intercountry adoptions. Percentages may not add to 100.0 due to rounding.
### Table 3. Total unrelated (domestic and intercountry) adoptions, and total intercountry adoptions as a percentage of total unrelated adoptions for each state, division, and the United States: 2007  
National Council For Adoption Survey

<table>
<thead>
<tr>
<th>Geographic division and state</th>
<th>2007 Total unrelated adoptions (Unrelated domestic adoptions plus intercountry adoptions)</th>
<th>2007 Intercountry adoptions as a percentage of total unrelated adoptions</th>
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<tr>
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</tr>
<tr>
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<td>20.3</td>
</tr>
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</tr>
<tr>
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<td>20.8</td>
</tr>
<tr>
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continued
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<th>Geographic division and state</th>
<th>Total unrelated adoptions (Unrelated domestic adoptions plus intercountry adoptions)</th>
<th>Intercountry adoptions as a percentage of total unrelated adoptions</th>
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</table>
Table 4. Special needs adoptions as a percentage of unrelated domestic adoptions for each state, division, and the United States: 2007 National Council For Adoption Survey

<table>
<thead>
<tr>
<th>Geographic division and state</th>
<th>Unrelated domestic adoptions of children with special needs</th>
<th>Unrelated domestic adoptions</th>
<th>Percent special needs</th>
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<td>Virginia</td>
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<tr>
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<td>3,917</td>
<td>42.4</td>
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</table>

continued
### Table 4. Special needs adoptions as a percentage of unrelated domestic adoptions for each state, division, and the United States: 2007 National Council For Adoption Survey (continued)

<table>
<thead>
<tr>
<th>Geographic division and state</th>
<th>Unrelated domestic adoptions of children with special needs</th>
<th>Unrelated domestic adoptions</th>
<th>Percent special needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>East South Central</strong></td>
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<td></td>
<td></td>
</tr>
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### Table 5. Number of domestic infant adoptions, abortions, live births, and nonmarital live births, and ratios for each state, division, and the United States: 2007

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<th>Number</th>
<th>Ratios</th>
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*continued*
Table 5. Number of domestic infant adoptions, abortions, live births, and nonmarital live births, and ratios for each state, division, and the United States: 2007 (continued)

<table>
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<th>Geographic division and state</th>
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<th>Ratios</th>
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continued
Table 5. Number of domestic infant adoptions, abortions, live births, and nonmarital live births, and ratios for each state, division, and the United States: 2007 (continued)

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<th>Geographic division and state</th>
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<th>Ratios</th>
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SOURCES: Domestic infant adoptions from 2007 National Council For Adoption Survey; Live births are by place of residence from U.S. vital statistics: live births and nonmarital live births from National Vital Statistics Reports. Hamilton, B.E., Martin, J.A. & Ventura, S.J. (2009). Births: Preliminary Data for 2007. vol 57 no 12. Hyattsville, Maryland: National Center for Health Statistics. Final data for 2007 not available at press time. 2005 abortions data are by state of occurrence from Jones, R.K., Zolna, M.R.S., Henshaw, S.B., & Finer, L.B. (2008). Abortion in the United States: Incidence and access to services, 2005. Perspectives on Sexual and Reproductive Health, 40, 6-16. State counts of abortions were collected from abortion facilities and providers, and are therefore more complete than the Centers for Disease Control and Prevention (CDC) data. AGI data are rounded to the nearest 10 and may not add to total. More recent AGI abortion data not available at press time. 2006 CDC Abortion Surveillance data were not used because these data (collected from state health departments) exclude California, Louisiana, and New Hampshire and are therefore incomplete. The CDC total for 2006 abortions is 846,181 as compared with 1,206,240 for AGI data.
Table 6. Number of unrelated domestic adoptions of infants and as a percentage of unrelated domestic adoptions, live births, and births to unmarried women for each state, division, and the United States: 2007

<table>
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<tr>
<th>Geographic division and state</th>
<th>Unrelated domestic adoptions of infants</th>
<th>...as a percentage of unrelated domestic adoptions</th>
<th>...as a percentage of 2007 live U.S. births</th>
<th>...as a percentage of 2007 births to U.S. unmarried women</th>
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<td>0.4</td>
<td>1.4</td>
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<td>42</td>
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<td>0.3</td>
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</table>

continued
Table 6. Number of unrelated domestic adoptions of infants and as a percentage of unrelated domestic adoptions, live births, and births to unmarried women for each state, division, and the United States: 2007 (continued)

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<th>2007</th>
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<td>...as a percentage of 2007 live U.S. births</td>
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<tr>
<td>Tennessee</td>
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<td>24.8</td>
<td>0.5</td>
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<td>Alabama</td>
<td>124</td>
<td>9.6</td>
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<tr>
<td>Mississippi</td>
<td>123</td>
<td>25.8</td>
<td>0.3</td>
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<td>0.3</td>
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<td>0.5</td>
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NOTE: Unrelated domestic adoptions of infants category does not include intercountry adoptions.
Table 7. State rankings using “Adoption Option Index”™ from the National Council For Adoption: 2007

<table>
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<tr>
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<td>Vermont</td>
</tr>
<tr>
<td>5</td>
<td>13.9</td>
<td>Iowa</td>
</tr>
<tr>
<td>6</td>
<td>12.8</td>
<td>Missouri</td>
</tr>
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<td>12.8</td>
<td>Indiana</td>
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<td>Alaska</td>
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*continued*
Table 7. State rankings using “Adoption Option Index”™ from the National Council For Adoption: 2007 (continued)

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<td>District of Columbia</td>
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* NCFAs “Adoption Option Index”™ is a standardized ratio calculated by dividing the number of domestic infant adoptions by the sum of abortions and births to unmarried women, x 1,000. Ties in ranks were broken by carrying the index to three decimals.
### Table 8. National estimates of related and unrelated adoptions: United States 1951 to 2007

<table>
<thead>
<tr>
<th>Year</th>
<th>Total adoptions</th>
<th>Unrelated adoptions</th>
<th>Related adoptions</th>
<th>Percentage unrelated adoptions</th>
<th>Percentage related adoptions</th>
</tr>
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<tbody>
<tr>
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<td>38,200</td>
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<td>48</td>
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<td>42,800</td>
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<td>47</td>
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<tr>
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<td>45,100</td>
<td>50</td>
<td>50</td>
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<td>47,900</td>
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Table 9. National estimates of domestic unrelated adoptions and type of agency making adoptive placement: United States 1951 to 2007

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<th>Public agency</th>
<th>Private agency</th>
<th>Independent</th>
<th>Percentage public agency</th>
<th>Percentage private agency</th>
<th>Percentage independent</th>
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<td>14,000</td>
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### Table 10. Immigrant-orphans adopted by U.S. citizens by state of residence, gender and age: Fiscal year 2007

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<th>State of residence</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>Under 1</th>
<th>1–4</th>
<th>5–9</th>
<th>Over 9</th>
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<tr>
<td>Total</td>
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<td>7,789</td>
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Table 10. Immigrant-orphans adopted by U.S. citizens by state of residence, gender and age: Fiscal year 2007 (continued)

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—  Represents zero.

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Table 11. Immigrant-orphans adopted by U.S. citizens by state or territory of residence, gender and age: Fiscal year 2008 (continued)

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D  Data withheld to limit disclosure.
— Represents zero.

Table 12. Immigrant-orphans adopted by U.S. citizens by state or territory of residence, gender and age: Fiscal year 2009

| State of residence | Total | Gender | | Age in years | |
|-------------------|-------|--------|----------------|----------------|
|                   |       | Male   | Female         | Under 1 | 1–4 | 5–9 | Over 9 |
| Total             | 12,782| 5,561  | 7,221          | 3,208   | 6,580 | 1,761 | 1,233 |
| Alabama           | 154   | 56     | 98             | 20      | 85   | 24   | 25    |
| Alaska            | 39    | 14     | 25             | D       | 24   | 9    | D     |
| Arizona           | 206   | 106    | 100            | 57      | 91   | 32   | 26    |
| Arkansas          | 74    | 37     | 37             | 27      | 37   | D    | D     |
| California        | 1,052 | 453    | 599            | 296     | 518  | 122  | 116   |
| Colorado          | 350   | 164    | 186            | 120     | 151  | 43   | 36    |
| Connecticut       | 158   | 71     | 87             | 37      | 92   | 15   | 14    |
| Delaware          | 38    | 15     | 23             | 10      | 24   | 4    | —     |
| District of Columbia | 48   | 15     | 33             | 10      | 25   | 10   | 3     |
| Florida           | 548   | 220    | 328            | 97      | 309  | 75   | 67    |
| Georgia           | 364   | 151    | 213            | 66      | 184  | 56   | 58    |
| Guam              | 9     | D      | D              | D       | D    | D    | D     |
| Hawaii            | 83    | 39     | 44             | 26      | 33   | 13   | 11    |
| Idaho             | 79    | 30     | 49             | 10      | 37   | 21   | 11    |
| Illinois          | 588   | 272    | 316            | 169     | 295  | 89   | 35    |
| Indiana           | 354   | 155    | 199            | 69      | 181  | 73   | 31    |
| Iowa              | 151   | 75     | 76             | 39      | 75   | 20   | 17    |
| Kansas            | 164   | 76     | 88             | 26      | 93   | 31   | 14    |
| Kentucky          | 259   | 118    | 141            | 75      | 135  | 32   | 17    |
| Louisiana         | 96    | 37     | 59             | 14      | 73   | 6    | 3     |
| Maine             | 55    | 15     | 40             | 17      | 26   | 9    | 3     |
| Maryland          | 310   | 123    | 187            | 87      | 156  | 28   | 39    |
| Massachusetts     | 360   | 163    | 197            | 87      | 207  | 34   | 32    |
| Michigan          | 512   | 242    | 270            | 119     | 279  | 69   | 45    |
| Minnesota         | 454   | 189    | 265            | 153     | 206  | 61   | 34    |
| Mississippi       | 55    | 22     | 33             | 7       | 35   | 6    | 7     |
| Missouri          | 312   | 136    | 176            | 69      | 172  | 45   | 26    |

continued
| State of residence | Total | Gender | |  | Age in years |
|--------------------|-------|--------|---|---|---|---|---|---|
|                     |       | Male | Female | Under 1 | 1–4 | 5–9 | Over 9 |
| Montana             | 66    | 36   | 30     | 11 | 25 | 16 | 14 |
| Nebraska            | 87    | 39   | 48     | 26 | 29 | 15 | 7  |
| Nevada              | 23    | 14   | 9      | 7  | 13 | D  | D  |
| New Hampshire       | 85    | 30   | 55     | 24 | 44 | D  | D  |
| New Jersey          | 401   | 176  | 225    | 127| 201| 36 | 37 |
| New Mexico          | 55    | 25   | 30     | 14 | 19 | 12 | 10 |
| New York            | 738   | 329  | 409    | 204| 348| 95 | 91 |
| North Carolina      | 411   | 165  | 246    | 110| 223| 54 | 24 |
| North Dakota        | 21    | 12   | 9      | 7  | 9  | D  | D  |
| Ohio                | 464   | 192  | 272    | 109| 262| 50 | 43 |
| Oklahoma            | 104   | 49   | 55     | 22 | 52 | 17 | 13 |
| Oregon              | 240   | 102  | 138    | 89 | 108| 30 | 13 |
| Pennsylvania        | 508   | 215  | 293    | 115| 306| 59 | 28 |
| Puerto Rico         | 17    | 6    | 11     | —  | D  | 8  | D  |
| Rhode Island        | 21    | 7    | 14     | D  | 13 | D  | —  |
| South Carolina      | 127   | 58   | 69     | 24 | 82 | 18 | 3  |
| South Dakota        | 57    | 29   | 28     | 14 | 29 | 5  | 9  |
| Tennessee           | 310   | 126  | 184    | 74 | 171| 47 | 18 |
| Texas               | 663   | 291  | 372    | 135| 349| 107| 72 |
| U.S. Armed Services Posts | D | D | D | D | D | | |
| U.S. Possessions    | D     | —    | D      | —  | —  | D  | —  |
| Utah                | 144   | 51   | 93     | 19 | 54 | 29 | 42 |
| Vermont             | 33    | 17   | 16     | 9  | 15 | D  | D  |
| Virginia            | 444   | 195  | 249    | 111| 229| 59 | 45 |
| Washington          | 497   | 205  | 292    | 136| 223| 79 | 59 |
| West Virginia       | 42    | 19   | 23     | D  | 28 | 6  | D  |
| Wisconsin           | 330   | 160  | 170    | 91 | 170| 50 | 19 |
| Wyoming             | 19    | 13   | 6      | D  | 13 | D  | —  |

D  Data withheld to limit disclosure.
— Represents zero.
Table 13: Top 20 countries for adoptions to the United States: FY 2005 to FY 2010

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<td>China–3,911</td>
<td>Guatemala–4,727</td>
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<td>Russia–1,082</td>
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<td>Colombia–287</td>
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**NOTE:** These counts represent IR3 – IH3 – IR4 – IH4 Visa Issuances for FY 2005 to FY 2009. When a foreign adoption or guardianship is granted, adoptive parent(s) apply for an immigrant visa at a U.S. consulate or Embassy abroad. Generally an IR-3 or an IH-3 visa is for a child adopted abroad; an IR-4 or IH-4 visa is for child to be adopted in the United States.

* This does not include children admitted as part of the Special Humanitarian Parole program after the earthquake.


<table>
<thead>
<tr>
<th>Region and country of birth</th>
<th>Total</th>
<th>Gender</th>
<th>Age in years</th>
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</tr>
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<tr>
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<td>11,846</td>
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<td>El Salvador</td>
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<th>Gender</th>
<th>Age in years</th>
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Table 14. Immigrant Orphans Adopted by U.S. Citizens by Gender, Age, and Region and Country of Birth: Fiscal Year 2007 (continued)

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<th>Region and country of birth</th>
<th>Total</th>
<th>Gender</th>
<th>Age in years</th>
<th>Under 1 year</th>
<th>1–4 years</th>
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D  Data withheld to limit disclosure.
— Represents zero.
### Table 15. Immigrant-orphans adopted by U.S. citizens by gender, age, and region and country of birth: Fiscal year 2008

<table>
<thead>
<tr>
<th>Region and country of birth</th>
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<th>Female</th>
<th>Age in years</th>
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</thead>
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<td></td>
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<td>Under 1 year</td>
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</tr>
<tr>
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<td>5,830</td>
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<tr>
<td>Total</td>
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<td>7,221</td>
<td>10,008</td>
<td>5,830</td>
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</table>

*continued*
Table 15. Immigrant-orphans adopted by U.S. citizens by gender, age, and region and country of birth: Fiscal year 2008 (continued)

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<th>Region and country of birth</th>
<th>Total</th>
<th>Gender</th>
<th>Age in years</th>
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</thead>
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continued
Table 15. Immigrant-orphans adopted by U.S. citizens by gender, age, and region and country of birth: Fiscal year 2008 (continued)

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D  Data withheld to limit disclosure.
— Represents zero.
* Korea Includes both North and South Korea
Table 16. Immigrant-orphans adopted by U.S. citizens by gender, age, and region and country of birth: Fiscal year 2009

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*continued*
Table 16. Immigrant-orphans adopted by U.S. citizens by gender, age, and region and country of birth: Fiscal year 2009 (continued)

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Table 16. Immigrant-orphans adopted by U.S. citizens by gender, age, and region and country of birth: Fiscal year 2009 (continued)

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<th>Region and country of birth</th>
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D Data withheld to limit disclosure.
— Represents zero.
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<td>298</td>
<td>287</td>
<td>380</td>
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<td>124</td>
<td>135</td>
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<td>167</td>
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</table>

*continued*
### Table 17. Adoptions of children with public child welfare agency involvement by state FY 2002-FY 2009 (*continued*)

<table>
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<td>289</td>
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<td>3,858</td>
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<td>3,419</td>
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<td>152</td>
<td>150</td>
<td>125</td>
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<td>137</td>
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<td>1,868</td>
<td>1,779</td>
<td>1,638</td>
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<td>1,029</td>
<td>1,142</td>
<td>1,271</td>
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<td>943</td>
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<tr>
<td>Wyoming</td>
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<td>235</td>
<td>236</td>
<td>180</td>
<td>152</td>
<td>202</td>
</tr>
</tbody>
</table>

| TOTAL           | 51,419  | 49,629  | 51,019  | 51,629  | 50,633  | 52,657  | 55,303  | 57,466  |

Sources of Data for Table 1—2007 NCFA Survey

ALABAMA—(11 contact attempts—see Methodological Notes for details).
1. 2,215–Youngpeter, of the Alabama Department of Human Resources (op.cit.) reported 1,871 whereas Woolbright, of the Center for Health Statistics, (op. cit.) reported 2,215. The Woolbright count of amended birth certificates was used.
2. 1,694–Youngpeter reported 1,431 for item 2 and 440 for item 3. These relative proportions were applied to the Woolbright count of 2,215 to generate the numbers which NCFA accepted. Therefore, 76.5% of 2,215 is 1,694 (item 2), and 23.5% of 2,215 is 521.
3. 521—see explanation for item 2 above.
4. 72–Youngpeter reported 61, 134, and 245 for items 4, 5, and 6, respectively. The proportions represented to her 440 total in item 3 are 13.9%, 30.4%, and 55.7% and were applied to the item 3 total of 521, for estimates of 72, 158, and 291, for items 4, 5, and 6, respectively.
5. 158—see explanation for item 4 above.
6. 291—see explanation for item 4 above.
7. Est.
8. Est.
10. 148—Ibid.

ALASKA—(13 contact attempts).
1. 571–The questionnaire was originally mailed to Tracy Spartz Campbell (op. cit.), who referred it to Kari Lee Pietz, Adoption Program Coordinator, Resource Family Section, State of Alaska's Children's Services, P.O. Box 110630, Juneau, Alaska 99811-0630. Pietz provided information for items 1-10. Pietz reported 249 for item 1 (total adoptions), which is a count similar to the public agency count reported to AFCARS/ACF. Refer back to the methodological discussion entitled “Total Adoptions—Item 1”. Therefore, NCFA accepted the 571 count provided by NCS C. Since Pietz provided internally consistent counts for items 1-10, these counts were inflated proportionately by a 2.3 multiplier to the NCSC item 1 count of 571.
2. 238–Pietz, ibid and see item 1.
3. 333–Pietz, ibid and see item 1.
4. 310–Pietz, ibid and see item 1.
5. 7–Pietz, ibid and see item 1.
6. 16–Pietz, ibid and see item 1.
7. 58–Pietz, ibid and see item 1.
8. 329–Pietz, ibid and see item 1.
9. 28–See item 1 above.
10. 9–See item 1 above.

ARIZONA—(18 contact attempts).
1. 2,047–Mark A. Schwartz, Operations Manager, Division of Children, Youth, and Families, Arizona Department of Economic Security, P.O. Box 6123-940A, Phoenix, AZ 85007. Source for items 1-8. Arizona’s “CHILDS” Automated System. NCSC reported 2,047 outgoing and 2,308 incoming adoption caseload for 2006, and the 2,047 outgoing count was used. Arizona Office of Vital Records reported that their office does not track adoption data, and added that their adoption records are sealed after the child is placed. This response is per Tony Miller, Birth Registry Section Manager, Office of Vital Records, 1818 W. Adams, Phoenix, AZ 85007. Ms. Miller responded on behalf of our inquiry to Christopher Mrela, op. cit., who reported 713 for item 2 and 776 for item 3. The proportional distribution of these two items was applied to the NCSC count of 2,047, which yielded 980 for item 2 and 1,067 for item 3.
2. 980–Schwartz, ibid.
3. 1,067–Schwartz, ibid.
4. 776–Schwartz, op. cit.
5. Est.
6. Est.
7. 201–Schwartz, op. cit.
10. 280–O'Donnell, ibid.

ARKANSAS—(9 contact attempts).
1. 1,889–Outgoing adoption caseload for 2006 reported by Victor E. Flango, Ph.D., Executive Director, Program Resource Development, National Center for State Courts, 300 Newport Avenue, Williamsburg, VA 23185.
2. Est.–Estimated by NCFA.
3. Est.–Estimated by NCFA.
5. Est.–Estimated by NCFA.
6. Est.–Estimated by NCFA.
7. Est.–Estimated from the Arkansas Annual Report Card, Produced for the Arkansas Department of Human Services, Division of Children and Family Services, produced under contract by Hornby Zeller Associates, Inc. In SFY2009 (Table 1), we find that 73 children, age 0-1, exited foster care by adoption and 280 children age 2-5 did the same. We estimated that one-fourth of the children age 2-5 were up to age 2, the cut off for infants in NCFA's survey. One-fourth of 280 = 70, so we added 70 to 73 for our estimate of 143 infant adoptions from foster care alone. To this we should add some estimate of infant adoptions from private agencies and independent adoptions.
8. 293–The Arkansas Annual Report Card SFY2009 reported that 273 children with special needs were placed in a pre-adoptive home during SFY2009 (of 368 placed, 74.2% had special needs. This proportion was applied to the ACF figure of 395 public agency adoptions, for a best estimate of 293 with special needs).
9. Est.–Estimated by NCFA.
10. Est.–Estimated by NCFA.

CALIFORNIA—(12 contact attempts).
1. 16,581–Tammy Hackman, Public Records Coordinator, California Department of Public Health, Center for Health Statistics, P.O. Box 997410, MS 5102, Sacramento, CA 95899-7410. Based on Office of Vital Records Customer Request Tracking System.
2. 8,061–Sharon Rego, LCSW, Acting Bureau Chief, California Department of Social Services, Permanency Policy Bureau, Sacramento, CA 95814. Rego was assisted in this request by Michael Carey in her office. For item 1, Rego reported 8,157. For item 2, Rego reported 3,969. For item 3, Rego reported 4,188. She reports as source: AD42R (Private Agency Adoptions) and California’s Child Welfare System/Case Management System (Public Agency Adoptions) and AD42I (Independent Adoptions), FY2007. We applied the item 2 and 3 proportions from Rego to the item 1 total from Hackman, which resulted in an estimate of 8,061 for item 2 and 8,507 for item 3.
3. 8,507–See item 2 explanation above.
4. 3,875–Rego, op. cit.
5. Est.
6. Est.
7. 2,545–Rego reported 1,233 infant adoptions out of 4,188 unrelated adoptions which Rego reported for item 3. This
 proportion (from 1,253 divided by 4,188) was applied to 8,507 estimates for item 3 based on the combination of Hackman and Rego data, as explained in the notes for item 2.
8. 2,675–Rego, op. cit.

COLORADO–(12 contact attempts).
1. 2,138–Mona Olivas, Office of Vital Records, CHEIS, Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South–CHEIS–HS–AI, Denver, CO 80246-1530. NCSC had no information from Colorado. Sharon Ford (op. cit.) reported 1,050, 311, and 739 from the state AFCARS data system, but NCFA believes these counts refer to adoptions handled only by the Colorado public agency, not totals for Colorado. Therefore, the proportions reported by Ford for items 2 (311) and 3 (739) were applied to the item 1 total (2,158) reported by Olivas, and those resulting numbers (639 and 1,519) were accepted as the best estimates of items 2 and 3, respectively.
2. 639–See discussion for item 1, above.
3. 1,519–See discussion for item 1, above.
4. 726–Ford, op. cit.
5. 793–See item 6 discussion below. Sharon Ford (op. cit.) stated: “Private adoptions are only tracked in Colorado’s child welfare statewide automated database if the child receives adoption assistance. These adoptions are otherwise tracked by the Department of Health that issues the new birth certificates.”
6. 0–Ford, op. cit. stated: “Independent adoptions are illegal in Colorado.” Therefore, by subtraction, item 3 (1,519) minus item 4 (726) leads to the best estimate of 793 for item 5.
7. Est.–Ford, op. cit. reported that 171 of her 726 private agency adoptions were of infants. However, there were also 793 private agency adoptions, many of these are likely to be infants. Rather than report the 171 which NCFA believes to be an undercount, NCFA has estimated this number based on proportions observed in States which reported these items.
8. 108–Ford, op. cit., based on AFCARS.
9. Est.
10. Est.

CONNECTICUT–(11 contact attempts).
1. 895–June M. Wiehn, op. cit. She cited the LINK–DCF Computer System for items 1–7 and supplied the programmer’s logic and calculations to support her answers. Her answers for items 1–8 were internally consistent. We therefore chose not to use NCSC data which reported 1,511 incoming adoption caseload but provided no outgoing adoption caseload, the primary statistic of interest for item 1. Note also that Connecticut vital statistics provided no data.
2. 313–Wiehn, op. cit.
3. 582–Wiehn, op. cit.
5. 95–Wiehn, op. cit.
6. 0–Wiehn, op. cit. Both NCFA and Wiehn stated that private individual adoptions are not legal in Connecticut.
7. 117–Wiehn, op. cit.
8. 482–Wiehn, estimate: “Most of public agency adoptions are special needs; maybe 5–10 per year are not.”
9. 190–Wiehn, op. cit. reported private agency 160 and public agency 30, total 190.
10. 52–Wiehn, op. cit., reported private agency 20 and public agency 32, total 52.

DELAWARE–(14 contact attempts).
1. 214–Outgoing adoption caseload data for 2006 provided by Victor E. Flango, Ph.D., Executive Director, Program Resource Development, National Center for State Courts, 300 Newport Avenue, Williamsburg, VA 23185. In contrast, a lower court of 130 was reported for item 1 by Frank Perfinski, Delaware Department of Children, Youth and their Families, Division of Family Services, 1825 Faulkland Road, Wilmington, DE 19805-1195. Perfinski’s source was AFCARS–ADP File 2007 AB, A-69, B-61. We judged that this lower count represented only agency adoptions handled by Mr. Perfinski’s public agency rather than total adoptions in Delaware, so we used the National Center for State Courts (NCSC) count.
2. 41–Perfinski reported 25 for item 2 and 105 for item 3. These proportions were applied to the 214 reported by the NCSC for an estimate of 41 for item 2 and 173 for item 3.
3. 173–See discussion in item 2, above.
4. 169–Perfinski reported 102 public agency adoptions for item 4 of the 105 unrelated adoptions for item 3. This proportion (102 divided by 105) was applied to the 173 estimated for item 3, resulting in an estimate of 169 for item 4.
5. 4–Estimated by subtraction (see discussion for item 4 above).
6. 0–Independent adoptions are illegal in Delaware per Marc Zappala, formerly of the National Council For Adoption.
7. 47–Perfinski reports 29 infant adoptions for item 7, of the 105 unrelated adoptions he reported for item 3. This proportion (29 divided by 105) was applied to the 169 figure generated for item 4.
8. 157–Perfinski reported 95 adoptions of children with special needs out of 105 unrelated adoptions which he reported for item 3. We applied this proportion (95 divided by 105) to the 173 NCFA estimated for item 3 to generate an estimate of 157 for item 8.
9. 29–Perfinski, op. cit.
10. 48–Perfinski, op. cit.

DISTRICT OF COLUMBIA–(13 contact attempts).
1. 356–The National Center for State Courts reported for 2006 that D.C. had 299 incoming and 356 outgoing adoption caseload. We have arbitrarily selected the “outgoing” count whenever “incoming” and “outgoing” were both available, and so we continue this selection pattern.
2. Est.
3. Est.–After imputation of this item to an estimate of 200, then by subtraction, the item 5 estimate is 21.
5. Est.–Private agency adoptions estimated by NCFA. Also note item 2 above.
6. 0–Sharon Knight (op. cit.) reported that all D.C. adoptions must go through a licensed agency.
7. Est.
8. Est.
9. Est.
10. Est.
1. The number of adoptions our office completed in 2007 was 818. These include adoptions only for children born in Idaho in which the birth certificate was amended in 2007; the child may have been any age and includes step parent adoptions. This number does not include adoption of children in Idaho in which the child was born in another state or country.” This quote from Pam Harder, Research Analyst Supervisor, Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare, 450 W. State Street, 1st Floor, Boise, ID 83720-0036. A larger figure of 1,024 adoption caseload outgoing was reported for FY2006 by the National Center for State Courts (op. cit.) was not accepted because the vital records count was so explicitly explained. Also for item 1 (total adoptions) a count of 203 was given by Stephanie Miller, Permanency Program Specialist (Adoption), Idaho Department of Health and Welfare, Division of Family and Community Services, P. O. Box 83720, 450 West State Street, 5th Floor, Boise, ID 83720-0036. However, she stated that the 203 referred to public agency adoptions, and that information for private and independent adoptions was not available. Miller referenced Idaho’s SACWIS data system as the source of her figures.

2. 226—Miller (ibid) reported from SACWIS that 56 of 203 adoptions were related, and 147 of 203 were unrelated. The proportion of total which were related (56 divided by 203) was applied to the 818 item 1 statistic to generate the 226 estimate for item 2 and the 592 estimate for item 3.

3. 592—See discussion for items 2 and 3 above.

4. 480—Outgoing adoption caseload 2006 reported by Victor E. Flango, Ph.D., Executive Director, Program Resource Development, National Center for State Courts, 300 Newport Avenue, Williamsburg, VA 23185. We note that a higher item 1 count of 4,731 was provided by George S. Rudis, Deputy State Registrar and Chief, Division of Vital Records, Illinois Department of Public Health, 605 West Jefferson Street, Springfield, IL 62702-5097. We also note that a much lower number of 1,685 was given by June Dorn, Illinois Department of Children and Family Services, Service Intervention, 100 West Randolph, suite 6-100, Chicago, IL 60601. However, this number is very similar to the Administration for Children & Families FY2006 count of 1,740 public agency children adopted. We believe that this fits the pattern of state public adoption agency experts (not court or vital statistics experts) reporting public agency adoptions as the state total, leaving out private agency and independent adoptions. We discussed this in “Methodological Notes on Total Adoptions, Item 1”. NCFA arbitrarily chose the middle figure, noting that the middle and high figure closely correspond.

5. 1,024—Outgoing adoption caseload by the National Center for State Courts (op. cit.) was not 1,071 reported by Betty Shannon, op. cit. Adams noted that the 813 refers to public agency adoptions only, such that 813 of 1,254 adoptions were special needs.

6. Est.

7. 1,071—Reported by Betty Shannon, op. cit.

8. Est.

9. Est.

10. Est.
Adoption Factbook V

3. 1,610–Parker, op. cit. reported 1,610, and stated the source as “SACWIS and county court offices.”
4. 846–Parker, op. cit. reported 846, and stated the source as “SACWIS”. By way of comparison, the Administration for Children & Families reported 984 public agency children adopted in FY 2006, which compares well with the 846 reported by Parker for calendar 2007.
5. 382–Parker op. cit. reported 764 for private agency and private individual adoptions. Parker op. cit. provides as the source: “county court offices. This is a record of adoptions finalized outside the child welfare system. The information recorded does not specify whether an adoption agency was involved. Almost all adoptions are finalized by an attorney hired by the adoptive family but a private agency may have done the pre- and post-placement services.” NCFA arbitrarily split this reported 764 evenly between items 6 and 7.
6. 382–See item 6 notes.
7. 284–Parker op. cit., reported 284 and stated the source: “Estimates from SACWIS and information provided by the county courts. Did not have the ability to cross reference dates of birth throughout the year to determine an exact number. Based on the number of children with dates of birth after 1/1/05.”
8. 762–Parker op. cit., reported 762 and stated the source: “Estimate of public adoptions based on overall subsidy provision for adopted children. Unable to determine how many of private adoptions were special needs as tracking was not done (for this item) on private adoptions.”
9. 83–Gerry Pine, Deputy Compact Administrator for ICPC, Division of Child and Family Services, Iowa Department of Human Services, reported 83 using ICPC tracking database.

KANSAS–(6 contact attempts).
1. 1,915–The National Center for State Courts reported 1,915 incoming and 1,915 outgoing adoption caseload for 2006. We rejected an item 1 total of 789 provided by Mary Cole, Kansas Department of Social and Rehabilitative Services, 915 S.W. Harrison, 5th Floor North, Topeka, KS 66612 using FACTS/AFCARS data system. We rejected this statistic for the usual reason…it is likely in reality a count of public agency adoptions rather than total adoptions.
2. 757–Mary Cole (ibid) reported 789 for item 1, 312 for item 2, and 477 for item 3. The proportion of (312 divided by 789) was applied to 1,915 to estimate item 2, at 757, and the proportion of (477 divided by 789) was applied to 1,915 to estimate item 3 at 1,158.
3. 1,158–See item 2 discussion above.
4. 471–Mary Cole, op. cit., FACTS/AFCARS data system. By way of comparison, the Administration for Children & Families reported 524 public agency adoptions in FY2006.
5. 344–By subtraction of 471 (public agency adoptions) from 1,158 (unrelated adoptions). This yields 687 private agency and private individual adoptions. NCFA apportioned equally the 687 to private agency (344) and private individual (343) adoptions.
6. 343–See discussion for item 5, above.
7. Est.–Mary Cole, op. cit., reported that 123 of her 477 public agency adoptions were infants, but there were undoubtedly infants among the 344 private agency and 343 private individual adoptions. NCFA chose to estimate this number based on reporting patterns in other states.
8. 380–Mary Cole, op. cit., reported that 380 of 477 public agency adoptions were special needs. This 380 count would be a minimal number since some smaller number of private agency adoptions and private individual would undoubtedly be special needs.
9. 836–Mary Cole, op. cit., PCP database. She stated that this count does not include private and individual adoptions because this information is not available.
10. 23–Mary Cole, op. cit.

IOWA–(14 contact attempts).
1. 2,463–The item 1 total of 2,463 was provided by Tracey Parker, Adoption Program Manager, Division of Child and Family Services, Iowa Department of Human Services, 1305 E. Walnut, Des Moines, IA 50319. She states “The source is SACWIS and information provided by county court offices. The number of private adoptions is based on information provided to DHS from county court offices. This is a record of all private agency adoptions. This yields 687 private agency and private individual adoptions. NCFA apportioned equally the 687 to private agency (344) and private individual (343) adoptions.”
2. 831–Parker (ibid) reported 831, and stated the source as: “SACWIS and county court offices. This is a partially estimated based on percentages of categories if the relationship was not specified.”

INDIANA–(7 contact attempts).
1. 4,700–Reported by Mary Hinds, Coordinator, Indianan Adoption History Program, Division of Vital Records, State Department of Health, Two North Meridian Street, Indianapolis, IN 46204: “We receive an Indiana Record of Adoption form from the clerks of court where the adoptions are finalized in order to amend the original birth certificate. The form only indicates the original name and the amended adoptive name. For 2007, 4,700 adoptions were filed in this office.” In contrast, the National Center for State Courts reported 3,660 incoming and 3,263 outgoing adoption caseload in 2006; these counts were not used. A count of 1,237 from the SACWIS systems was reported for item 1 by Helen Stevenson, Program Director, SNAP, Indiana Department of Child Services, 302 W. Washington St., Room E306-MS47, Indianapolis, IN 46204. However, NCFA believes that she reported public agency adoptions, since that is what the SACWIS system records. The 1,237 Stevenson count is similar to 1,183 public agency children adopted in FY2006 as reported by the Administration for Children & Families. The 1,237 Stevenson count was used for item 4, public agency adoptions.
2. Est.
3. Est.
4. 1,237–Stevenson, op. cit., see item 1 discussion.
5. Est.
6. Est.
7. Est.–Stevenson (op. cit.) reported from SACWIS 135 infant adoptions of 806 public agency adoptions. Note that item 7 refers to infant adoptions from unrelated adoptions (not just public agency adoptions). Therefore, the 135 would be an undercount, and so this figure was not used for item 7. Item 7 was estimated by NCFA.
8. Est.
9. Est.
10. Est.

380–Parker, op. cit. reported 846, and stated the source as “SACWIS and county court offices.”

846–Parker, op. cit. reported 846, and stated the source as “SACWIS”. By way of comparison, the Administration for Children & Families reported 984 public agency children adopted in FY 2006, which compares well with the 846 reported by Parker for calendar 2007.

382–Parker op. cit. reported 764 for private agency and private individual adoptions. Parker op. cit. provides as the source: “county court offices. This is a record of adoptions finalized outside the child welfare system. The information recorded does not specify whether an adoption agency was involved. Almost all adoptions are finalized by an attorney hired by the adoptive family but a private agency may have done the pre- and post-placement services.” NCFA arbitrarily split this reported 764 evenly between items 6 and 7.

382–See item 6 notes.

284–Parker op. cit., reported 284 and stated the source: “Estimates from SACWIS and information provided by the county courts. Did not have the ability to cross reference dates of birth throughout the year to determine an exact number. Based on the number of children with dates of birth after 1/1/05.”

762–Parker op. cit., reported 762 and stated the source: “Estimate of public adoptions based on overall subsidy provision for adopted children. Unable to determine how many of private adoptions were special needs as tracking was not done (for this item) on private adoptions.”

83–Gerry Pine, Deputy Compact Administrator for ICPC, Division of Child and Family Services, Iowa Department of Human Services, reported 83 using ICPC tracking database.

138–Gerry Pine, ibid.

KANSAS–(6 contact attempts).

1,915–The National Center for State Courts reported 1,915 incoming and 1,915 outgoing adoption caseload for 2006. We rejected an item 1 total of 789 provided by Mary Cole, Kansas Department of Social and Rehabilitative Services, 915 S.W. Harrison, 5th Floor North, Topeka, KS 66612 using FACTS/AFCARS data system. We rejected this statistic for the usual reason…it is likely in reality a count of public agency adoptions rather than total adoptions.

757–Mary Cole (ibid) reported 789 for item 1, 312 for item 2, and 477 for item 3. The proportion of (312 divided by 789) was applied to 1,915 to estimate item 2, at 757, and the proportion of (477 divided by 789) was applied to 1,915 to estimate item 3 at 1,158.

1,158–See item 2 discussion above.

471–Mary Cole, op. cit., FACTS/AFCARS data system. By way of comparison, the Administration for Children & Families reported 524 public agency adoptions in FY2006.

344–By subtraction of 471 (public agency adoptions) from 1,158 (unrelated adoptions). This yields 687 private agency and private individual adoptions. NCFA apportioned equally the 687 to private agency (344) and private individual (343) adoptions.

343–See discussion for item 5, above.

Est.–Mary Cole, op. cit., reported that 123 of her 477 public agency adoptions were infants, but there were undoubtedly infants among the 344 private agency and 343 private individual adoptions. NCFA chose to estimate this number based on reporting patterns in other states.

380–Mary Cole, op. cit., reported that 380 of 477 public agency adoptions were special needs. This 380 count would be a minimal number since some smaller number of private agency adoptions and private individual would undoubtedly be special needs.

36–Mary Cole, op. cit., IPF database. She stated that this count does not include private and individual adoptions because this information is not available.

23–Mary Cole, op. cit.
KENTUCKY—(6 contact attempts).
1. 2,370–The National Center for State Courts reported 2,948 incoming and 2,963 outgoing adoption caseload in 2006. However, these data include a footnote that “Kentucky adoption data includes termination of parental rights cases.” This undoubtedly inflated the count, and so NCFA arbitrarily deflated the outgoing count by 20% to compensate, to 2,370. NCFA was unable to obtain most other information from Kentucky experts for this survey.
2. Est.
3. Est.
4. 695–Mike Grimes, Kentucky Department of Community Based Services, Cabinet for Families and Children, 275 East Main Street–3CE, Frankfort, KY 40621. By way of comparison, the Administration for Children & Families reported 759 public agency children adopted in FY2006.
5. Est.
6. Est.
7. Est.
8. Est.
9. 92–Mike Grimes, op. cit.
10. 4–Ibid.

LOUISIANA—(10 contact attempts).
1. 1,358–Reported by Cheryl Barton, MSW, Adoption Program Manager, Louisiana Department of Social Services, Office of Community Services, 627 North Fourth Street, Baton Rouge, LA 70802, based on Office of Community Services, assistant Secretary’s Report FY2007; Louisiana Adoption Petition Tracking System and Louisiana Tracking Information System. By way of comparison, the National Center for State Courts reports mostly “not available” outgoing adoption caseload (N = 360) but 1,459 incoming caseload, with the footnote that Louisiana data are not summed due to missing disposition data from one court. Barton’s data, on the other hand, seemed complete and consistent on ten items.
2. 786–Barton, ibid.
3. 572–Barton, ibid.
5. 38–Barton, ibid.
6. 153–Barton, ibid.
7. 97–Barton, ibid.
8. 401–Barton, ibid.
9. 61–Barton, ibid.
10. 69–Barton, ibid.

MAINE—(10 contact attempts).
1. 619–Items 1-10 reported by Tim Swift, Maine Department of Health and Human Services, Office of Child and Family Services, 2 Anthony Avenue, Augusta, ME 04333-0011. His counts appear to be complete and internally consistent.
2. 97–Ibid.
3. 522–Ibid.
5. 268–Ibid.
6. 15–Ibid.
7. 42–Ibid.
8. 42–Ibid.
9. 52–Ibid.
10. 58–Ibid.

MARYLAND—(12 contact attempts).
1. 3,195–The National Center for State Courts reported 3,195 outgoing adoption caseload and 3,158 incoming adoption caseload.
2. Est.
3. Est.
5. Est.
6. Est.
7. Est.
8. Est.
9. Est.
10. Est.

MASSACHUSETTS—(11 contact attempts).
1. 2,327–The National Center for State Courts reported 2,327 incoming adoption caseload for Massachusetts for 2006 and incomplete data for outgoing adoption caseload.
2. Est.
3. Est.
4. 787–Leo Farley, Massachusetts Department of Children and Families, 24 Farnsworth Street, Boston, MA 02210. This count compares well with 874 public agency children adopted in FY2006 as reported by The Administration for Children & Families.
5. Est.–After items 2 and 3 were imputed based on response patterns in states, which reported these items, the 787 reported for item 4 was subtracted from the estimate for item 3 to derive a count of 319 for item 5.
6. 0–Private individual adoptions are not allowed in Massachusetts, according to Leo Farley and according to NCFA.
7. Est.–Leo Farley reported that 81 of his public agency’s adoptions were infants, but this figure does not include infant adoptions among private agency or private individual adoptions.
8. Est.–Leo Farley estimated that 90% of unrelated adoptions are special needs, but gave no figure for unrelated adoptions. Therefore, NCFA estimated both numbers.
10. 176–Farley reported 95 public and 81 private adoptions to another state in 2007.

MICHIGAN—(16 contact attempts).
1. 4,937–The National Center for State Courts reported 4,937 outgoing adoption caseload, and 4,898 incoming adoption caseload for Michigan in 2006. Detailed but incomplete information was provided by Kate Hanley, Director, Adoption and Permanency Services, Department of Human Services, Child and Family Services Administration, P.O. Box 30037—Suite 413, Lansing, MI 48009. Hanley submitted tabulations to NCFA showing 2,602 FY2007 adoptions—1,244 handled by DHS, and 1,358 handled by private agencies. A query was made on 1/5/2010 back to Lori Johnson, Manager, Data Management Unit, Department of Human Services (DHS), Lansing, Michigan regarding the NCSC and DHS discrepancy. She explained that DHS data did not include private individual adoptions, and she recommended using the larger NCSC figure of 4,937 for total Michigan adoptions.
2. 2,123–With the 2,602 Michigan adoptions submitted by Hanley, a tabulation was provided which indicated that 1,114 were related and 1,488 were unrelated. This included public agency and private agency adoptions but not private individual adoptions. Therefore, the proportion related (1,114 divided by 2,602 = .43) and unrelated (1,488 divided by 2,601 = .57) derived from the
Hanley numbers were applied to the 4,937 NCSC count (0.43 x 4,937 = 2,123); (.57 x 4,937 = 2,814) to generate best estimates for items 2 and 3.

2. 2,814–See discussion above.

3. 1,244–A report by Hanley indicates 1,244 DHS adoptions and 1,358 private agency adoptions, for a total of 2,602. This count compares well with 2,591 public agency children adopted as reported by ACF for FY2006. (Tabulation Report No. A00027, Michigan AFCARS Adoption Reporting System, State Ward Finalized Adoptions by Age Group, October 1, 2006-September 30, 2007, supplied by Kate Hanley, Director Adoption and Permanency Services, Department of Human Services, Lansing, Michigan).

4. 1,358–See discussion above (Hanley, ibid).

5. 212–By subtraction of the items 3 and 4 totals (2,602) for DHS and private agency adoptions from item 3 total (2,814) unrelated adoptions, a count of 212 independent adoptions is derived. While this is a very low number which compared with relative distributions of public agency, private agency, and independent adoptions in other states, the 212 number is based on good assumptions from reliable numbers.

6. 266–Of 2,602 DHS and private agency adoptions reported by Hanley (op. cit.), 1,331 were age 0-5 and the rest were ages 6 and over. Of the 1,331 children age 0-5 NCFA apportioned them into five equal groups (0-1, 1-2, 2-3, 3-4, 4-5) and took two-fifths of this 1,331 to estimate 266 infants in the 0-2 age group (i.e., NCFA's definition of infants).

7. 781–Similar counts of total adoptions were received from two independent sources. The Montana Office of Vital Statistics reported 831 Montana adoptions in 2007, and the National Center for State Courts reports of 3,247 incoming adoption caseload and 3,088 outgoing adoption caseload.

8. Est.

9. 173–Sawdy, Interstate Compact Office, Michigan Department of Human Services, 235 S. Grand Avenue, Lansing, Michigan 48909. Sawdy broke this count down into 33 public incoming plus 143 incoming private ("...including individual, private agencies, attorneys... ").

10. 801–Davis and Bucher, ibid.

MINNESOTA—(12 contact attempts).

1. 2,133–The National Center for State Courts reported 2,205 incoming adoption caseload and 2,133 outgoing adoption caseload for 2006 and the latter figure was accepted. Cheri Denardo (Nosophist with Minnesota Vital Statistics/Minnesota Department of Health, St. Paul, Minnesota 55164-0882) reported: “Our data base administrator had run a report in the winter of 2008 which indicated that our office processes anywhere from 1,400-1,900 adoptions per year. We do not track placement agency type or relative/non-relative adoptions.” Connie Caron of Minnesota Department of Human Services referred this questionnaire to Marvin Davis. Finally, Marvin Davis (Supervisor, Adoption Operations, and his staffer Dave Bucher) reported 867 total adoptions, but noted that “Minnesota does not track private agency adoptions,” so his reported numbers are undercounts and represent only those adoptions handled by the Minnesota Department of Human Services.

2. Est.

3. Est.

4. 525–Davis and Bucher, op. cit. ACF (op. cit.) reported a similar count of 664 Minnesota public agency children adopted October 1, 2005 to September 30, 2006.

5. Est.–Davis and Bucher (op. cit.) reported 342 unrelated adoptions handled by private agencies, but they also noted that “Minnesota does not track... all private agency adoptions”; therefore, the count is higher than 342. Therefore, after items 2 and 3 were imputed based on response patterns in states which reported on these items, the 525 count for item 4 was subtracted from the item 3 estimate to derive a count of 672 for item 5.

6. 0–Marc Zappala, formerly of the National Council For Adoption stated that “independent adoptions are illegal in Connecticut, Delaware, Massachusetts, North Dakota, and Minnesota”. Therefore, zero is reported for item 6 in these five states, as well as in other states where the state adoption expert stated that independent adoptions were not counted.

7. 292–Davis and Bucher (op. cit.) reported 292 infant adoptions, but this number undoubtedly may or may not include infant adoptions among private agency adoptions which were not counted by Davis and Bucher's agency. It is a minimal estimate.

8. 636–Davis and Bucher, op. cit.

9. 475–Davis and Bucher, ibid.

10. 801–Davis and Bucher, ibid.

MISSISSIPPI—(8 contact attempts).

1. Est.

2. Est.

3. Est.

4. 295–Edna F. McLendon, Mississippi Department of Human Services, Division of Family and Children’s Services, 750 North State Street, Jackson, MS 39202.

5. Est.–McLendon stated that her information does not include private agency or independent adoptions.

6. Est.–See note for item 5 above.

7. Est.–McLendon reported that there were 5 infants among the 295 public agency adoptions. To this number must be added private agency and independent adoptions.

8. 233–McLendon reported 233 special needs adoptions among the 295 public agency adoptions which she reported.

9. 142–McLendon, ibid.

10. 115–McLendon, ibid.

MISSOURI—(13 contact attempts).

1. 3,976–Bureau of Vital Records Activity Report for Period Ending December 2007 from Craig Ward, Team Leader, Vital Statistics Analysis, Bureau of Health Informatics Section of Epidemiology for Public Health Practice, Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO 65102. Ward stated that this count excludes the foreign-born. The 3,976 vital statistics count is larger than the National Center for State Courts reports of 3,247 incoming adoption caseload and 3,088 outgoing adoption caseload.

2. Est.

3. Est.

4. 1,244–A report by Hanley indicates 1,244 DHS adoptions and 1,358 private agency adoptions, for a total of 2,602. This count compares well with 2,591 public agency children adopted as reported by ACF for FY2006. (Tabulation Report No. A00027, Michigan AFCARS Adoption Reporting System, State Ward Finalized Adoptions by Age Group, October 1, 2006-September 30, 2007, supplied by Kate Hanley, Director Adoption and Permanency Services, Department of Human Services, Lansing, Michigan).

5. Est.

6. Est.

7. Est.

8. Est.

9. Est.

10. Est.

MONTANA—(7 contact attempts).

1. 781–Similar counts of total adoptions were received from two independent sources. The Montana Office of Vital Statistics reported 831 Montana adoptions in 2007, and the National Center for State Courts reported 743 for Montana in 2006. The vital statistics count was accepted (James R. Edgar, MPA, State Registrar/Supervisor, Montana Office of Vital Statistics, Department of Public Health and Human Services, 111 North Sanders–Room 205, Helena, MT 59604-4210). Note that respondents were told that the sum of item 2 (related adoptions) plus item 3 (unrelated adoptions) should equal item 1 (total adoptions). However, Edgar reported 227 for item 2 (related adoptions) and 554 for item 3 (unrelated adoptions), which totaled 781, rather than 831. The 781 total was used.

2. 227–Edgar, ibid.
1. 675–The National Center for State Courts (op. cit.) reported 649 incoming adoption caseload and 675 outgoing adoption caseload for 2006.

2. Est.

3. Est.

4. 141–Myriam Roeder, New Hampshire Department of Health and Human Services, Division of Children, Youth and Families, 129 Pleasant Street, Brown Building, Concord, NH 03301. A similar count of 135 public agency children adopted from October 1, 2005 to September 30, 2006 was reported from AFCARS by the Administration for Children & Families.

5. Est.

6. Est.

7. Est.

8. 109–Roeder, op. cit.

9. 15–Roeder, ICPC query, op. cit.

10. 5–Roeder, ibid.

NEW JERSEY—(10 contact attempts).

1. 2,409–The National Center for State Courts reported 2,398 incoming adoption caseload and 2,409 outgoing adoption caseload for 2006. Joseph Komosinski, State Registrar, New Jersey State Registrar, Vital Statistics and Registration, New Jersey Department of Health and Senior Services, P.O. Box 370, Trenton, NJ 08625-0370 stated that there were 144,000 adoptions on file in New Jersey for all years, but the count could not be broken down into specific years.

2. Est.

3. Est.


5. 1,365–ACF

6. Est.

7. Est.

8. Est.

9. Est.

10. Est.

NEW MEXICO—(12 contact attempts).


2. Est.

3. Est.

4. 327–A count of 327 unrelated adoptions was reported from AFCARS data by Jill May, New Mexico Department of Children, Youth and Families, P.O. Drawer 5160, PERA Building, Room 254, Santa Fe, NM 87501. This is similar to the count of 338 public agency children adopted October 1, 2005 to September 30, 2006 from the Administration for Children & Families.

5. Est.

6. Est.

7. Est.

8. Est.

9. Est.

10. Est.

NEW YORK—(8 contact attempts).

1. 10,774–The National Center for State Courts (op. cit.) reported 9,125 incoming adoption caseload and 10,774 outgoing adoption caseload for 2006. When queried, Peter Carucci of the New York Bureau of Vital Statistics referred NCFAS to the Office of Court Administration, which is, in fact, the Office which supplied the 10,774 count.

2. Est.

3. Est.

NEW HAMPSHIRE—(7 contact attempts).

1. 675–The National Center for State Courts (op. cit.) reported 649 incoming adoption caseload and 675 outgoing adoption caseload for 2006.

2. Est.

3. Est.
5. Est.
6. Est.
7. Est.
8. Est.
9. Est.
10. 62–Reported by Darlene Dalton, who replaced Stephanie Hughes at the Ohio Department of Job and Family Services, P.O. Box 182709, Columbus, Ohio 43218-2709.

OKLAHOMA—(11 contact attempts).
1. 2,477–Gene Flango of the National Center for State Courts reported 2,477 adoption petitions filed (and “NA” disposed) in 2007 in Table 1 of his article “Adoption Petitions in Courts, 2005-2007.”
2. Est.
3. Est.
4. 1,141–A total of 1,141 public agency children were adopted October 1, 2005 to September 30, 2006, according to the Administration for Children & Families.
5. Est.
6. Est.
7. Est–There were 89 infant adoptions among public agency placements, according to Carlene Harpe, Oklahoma Department of Human Services, 6128 East 38th Street, Suite 300, Tulsa, Oklahoma 74135. Since this item seeks the total of all infants from public agency, private agency, and private individual adoptions, the 89 is an undercount and the item was imputed based on response patterns from states which reported this item.
8. Est–Harpe reported that “all” unrelated adoptions handled by her agency were special needs.
9. 112–Harpe, op. cit., cited ICPC as the source.
10. 278–Harpe, op. cit.

OREGON—(7 contact attempts).
1. 2,043–The National Center for State Courts reported 2,043 adoption petitions in State Courts, per Table 1 in Victor E. Flango’s article in this Factbook entitled, “Adoption Petitions in Courts, 2005-2007.” Information was also received from Beth Englander (who replaced Angela Cause, who the National Council For Adoption originally mailed a questionnaire to), Oregon Department of Human Services, Human Services Building, Adoption Unit, 2nd Floor, 500 Summer Street, NE, E-71, Salem, OR 97310-1068. However, her information pertained to public agency adoptions only rather than total adoptions, and much of the information could not be used.
2. Est.
3. Est.
5. Est.
6. Est.
7. Est–Englander reported 70 infants among the public agency placements, according to her agency which included private adoptions, but additional infants were among the private agency and private individual adoptions, so this number was estimated by NCFA.
8. 644–Englander (op. cit.) reported 644 special needs adoptions among her public agency adoptions, but this count is likely an undercount to the extent that it does not include special needs adoptions among the private agency and private individual adoptions.
9. 189–Englander (op. cit.) ICPC data tracked and reported from the Adoptions Unit, with the source cited as “Quarterly Statistical Report 10/1/06-9/30/07, Placements Into an ICPC State.”
10. 590–Englander (ibid.) cited the same report, except that it referred to placements out of an ICPC state.

PENNSYLVANIA—(13 contact attempts).
1. 4,651–The National Center for State Courts reported 4,900 incoming adoption caseload and 4,651 outgoing adoption caseload

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for 2006. Counts provided by Lorrie Deck (on behalf of Carrie Kelser, who was on extended leave) provided information but from AFCARS for adoptions handled by her as the Director, Pennsylvania Statewide Adoption and Permanency Network, Pennsylvania Department of Public Works, Office of Children, Youth, and Families, P.O. Box 2675, Harrisburg, PA 17105.

2. Est.

3. Est.

4. 1,940–Lorrie Deck, op. cit., AFCARS 2007A and 2007B. This compares well with 1,926 public agency children adopted October 1, 2005 to September 30, 2006 reported by the Administration for Children & Families.

5. Est.

6. Est.

7. 477–Pennsylvania appears to be unique with an adoption item on its 63-item birth certificate. The 63rd item is: “63. ADOPTION? ___ yes ___ no”. Of 149,443 births in 2007, this box was checked “no” 148,950 times, “unknown” 16 times, and “yes” 477 times. Source: Patricia W. Potrzebowski, Ph.D., Director, Bureau of Health Statistics and Research, Pennsylvania Department of Health, 555 Walnut St., 6th Floor, Harrisburg, PA 17101. This is likely an undercount since a relinquishment decision may have been made after the birth certificate was completed.

8. 1,361–Deck, op. cit.

9. 582–The National Center for State Courts reported 541 incoming adoption caseload and 582 outgoing adoption caseload for 2006.

10. Est.

RHODE ISLAND–(8 contact attempts).

1. 558–The National Center for State Courts reported 541 incoming adoption caseload and 582 outgoing adoption caseload for 2006.

2. Est.

3. Est.


5. Est.

6. Est.

7. Est.

8. Est.

9. Est.

10. Est.

SOUTH CAROLINA–(7 contact attempts).

1. 1,605–Shae R. Sutton, Ph.D., Director, Division of Biostatistics, Public Health Statistics and Information Services, South Carolina Department of Health and Environmental Control, 2600 Bull Street, Columbia, South Carolina 29201.

2. Est.

3. Est.

4. 463–Carolyn Orf, South Carolina Department of Social Services, Division of Human Services, P. O. Box 1520, Columbia, South Carolina 29202-1520. By way of comparison, the Administration for Children & Families reported 423 public agency children adopted October 1, 2005 to September 30, 2006.

5. Est.

6. Est.

7. Est.

8. Est.

9. 268–Carolyn Orf, op. cit., ICPC Database.

10. 133–Ibid.

SOUTH DAKOTA–(11 contact attempts).

1. 422–Anthony Nelson, State Registrar and Director, Office of Data, Statistics and Vital Records, State Department of Health, 600 East Capitol Avenue, Pierre, SD 57501-2536. By way of contrast, a lower figure of 285 was reported by Patricia Reiss, South Dakota Department of Social Services, Department of Child Protective Services, 700 Governor’s Drive, Pierre, South Dakota 57501-2291. However, Reiss reported that the count of private individual adoptions was unknown, and she acknowledged that these should be included in the figure of total adoptions. NCFA assumes that the difference of the Nelson figure of 422 and the Reiss figure of 285 (422–285 = 137) is the best estimate of private individual adoptions for item 6.

2. 137–Reiss reported 102 public agency adoptions. (By way of contrast, the Administration for Children & Families reported 150 public agency children adopted October 1, 2005 to September 30, 2006). She also reported 46 public agency adoptions. NCFA estimated 137 private individual adoptions (see discussion for item 1, above). Therefore, the sum of public agency (N = 102), private agency (46), and private individual adoptions (137) is calculated as 285 unrelated adoptions (used for the item 3 total). By subtraction of the 285 for item 3 from 422 for item 1, a total of 137 related adoptions is calculated for item 2.

3. 285–See discussion for item 2, above.


5. 46–Ibid.

6. 137–See discussion for item 1 above.

7. Est.–Reiss (op. cit.) reported 46 infant adoptions, but this did not include infant adoptions among private individual adoptions.

8. 102–Reiss, op. cit., South Dakota FACTS Report-DSS.

9. 39–Ibid.

10. 28–Ibid.

TENNESSEE–(8 contact attempts).


2. 2,095–Leinbach, ibid.

3. 1,559–Ibid.

4. 981~Julie Flannery of the Tennessee Department of Children’s Services referred the survey to John Johnson in her office for completion using Tennessee AFCARS data. (John Johnson, Tennessee Department of Children's Services, Cordell Hull Building, 8th Floor, 436 Sixth Avenue North, Nashville, Tennessee 37243-1290). His figure of 981 corresponds well with 994 public agency children adopted October 1, 2005 to September 30, 2006 as reported by the Administration for Children & Families.

5. 289–Johnson (ibid) reported that his counts did not include private agency or private individual adoptions. However, by subtracting 981 public agency adoptions reported by Johnson (op. cit.) from 1,559 unrelated adoptions reported by Leinbach (op. cit.), we calculate a total of 578 (1,559 – 981 = 578) private agency and private individual adoptions. This 578 total was arbitrarily split evenly into 289 private agency and 289 private individual adoptions.

6. 289–See discussion for item 5, above.

7. Est.–Johnson, op. cit., cited AFCARS data and reported 184 infants among the 981 public agency adoptions. However, there were undoubtedly infants among the private agency and private individual adoptions, so a more reasonable figure was imputed by NCFA.


10. 35–Ibid.

TEXAS–(10 contact attempts).

NCFA NOTE: Texas was a riddle to be solved by basic math and some common sense. Internally consistent counts for items 1-5 and 7-10 were reported by Audrey L. Jackson, LMWS, Adoption Program Specialist, Department of Family and Protective Services, 701 W. 51st Street, Mail Code W-157, Austin, TX 78751. These counts,
respectively, were: 4,023; 1,428; 2,595; 1,100; 1,495; NA; 1,026; 2,118; 475; and 966. Jackson cited: item 1–Databook; item 2–Databook 5A-45 Data Warehouse; item 3–SA-A5 Data Warehouse; item 4–MRSRTD# 35530; item 5–MRSRTD# 35530; item 7–MRSRTD# 35551; item 8–MRSRTD# 35552; item 9–APHSA ICPC Automated Reporting and Tracking System; and item 10–APHSA ICPC Automated Reporting and Tracking System.

Four issues need to be resolved. First, there was no independent count or estimate to compare with Jackson’s report of 4,023 total adoptions—a seemingly very low number. Second, the Administration for Children & Families (ACF) reported 3,409 public agency children adopted in Texas October 1, 2005 to September 30, 2006—a figure so much higher than the 1,100 reported by Jackson that NCFA did not use the Jackson number and used the ACF number instead. Third, Jackson’s figure of 4,023 total adoptions did not include private individual adoptions because she reported “NA” for item 6. Fourth, the number of infants from private individual adoptions needed to be increased from the 1,026 reported by Jackson.

Therefore, the first issue to resolve is that the “NA” is private individual adoptions—item 6. NCFA had to estimate the item 6 count. (This would subsequently increase item 3 unrelated adoptions and item 1 total adoptions). The method of estimation for item 6 was to use the numerical counts for 15 states which reported complete data for items 3, 4, 5, and 6 and did not report “0” for item 6. Private individual adoptions comprised 3,936 of 18,603 unrelated adoptions in these 15 states. Therefore, 18,603 divided by 3,936 = 4.7263719. Solving for x = 697, the number of private individual adoptions which NCFA estimated for item 6. This 697 was added to the reported 3,409 public agency adoptions reported by ACF for item 4 plus the 1,495 private agency adoptions reported by Jackson for item 5 to arrive at a corrected total of 5,601 unrelated adoptions for item 3. Then, the 5,601 unrelated adoptions for item 3 was added to the 1,428 count of related adoptions reported by Jackson to arrive at a corrected total of 7,029 total adoptions in Texas. (No independent counts of total adoptions were available from the National Center for State Courts or Texas Vital Statistics). Therefore, Jackson’s reported counts for items 2, 5, 8, 9, and 10 were accepted, but NCFA adjusted her counts for the other items in two ways. First, NCFA instead used the ACF count for item 4. Second, NCFA estimated private individual adoptions using information from 15 other states to derive NCFA’s estimated of 697 private individual adoptions. This was added to Jackson’s counts of unrelated adoptions and total adoptions, just as the ACF count of 3,409 private agency adoptions was added to Jackson’s counts of unrelated adoptions and total adoptions. The revised counts and estimates, used in Table 1, respectively, were: 7,029 (item 1); 1,428 (item 2); 5,601 (item 3); 3,409 (item 4); 1,495 (item 5); 697 (item 6); 1,302 (item 7); 2,118 (item 8); 475 (item 9); and 966 (item 10).

UTAH—(7 contact attempts).

1. 2,040–Carolyn Lucas, Utah Department of Health, Office of Vital Records and Statistics, 288 North 1460 West, Salt Lake City, Utah 84114–1012. Note that NCFA had also contacted Marty Shannon, Utah Department of Human Services, Division of Child and Family Services, 120 North 200 West, Suite 225, Salt Lake City, Utah 84103. She reported that her office and the Office of Vital Records and Statistics share data sets, and that the Vital Records Office can supply all the information that her office could supply. On a separate note, by way of comparison, the National Center for State Courts reported 1,713 incoming adoption caseload and 1,707 outgoing adoption caseload for 2006. Est.

2. 1,013–Lucas, ibid. Est.

3. 1,027–Lucas, ibid. Est.


5. 546–Lucas, ibid. Est.

6. 10–Lucas, ibid. Est.


VERMONT—(8 contact attempts).


2. 200–A response was received from Diane Dexter, Vermont Department for Child and Families, Family Services Division, 103 South Main Street, Waterbury, VT 05671. She stated: “We do not track relative/non-relative adoption. Out of the 400 plus minus finalizations in the probate courts about 200 are stepparent adoptions. The private adoption agencies do about 50 or so babies per year and most of these are unrelated.” Est.

3. 239–By subtraction, see discussion in item 1, above. Est.


5. 50–See Dexter discussion in item 1, above. Est.

6. 25–By addition of items 4 and 5 subtracted from item 3. Est.

7. Est.

8. Est.

9. 6–Mary Bryce, ICPC Coordinator, Family Services Division, 103 South Main Street, Waterbury, VT 05671. Est.

10. 11–Ibid. Est.

VIRGINIA—(10 contact attempts).

1. Est.

2. Est.

3. Est.


5. Est.

6. Est.

7. Est.

8. Est.

9. Est.

10. Est.

WASHINGTON—(6 contact attempts).


3. Est.

4. 600–Pamela Kramer, Adoptions Program Manager, Children’s Administration, Division of Children and Family Services, 14th and Jefferson OB-2, P.O. Box 45710, Olympia, WA 98504–5710. Est.

5. 293–Kramer, ibid. Est.

6. Est.

7. Est.–Kramer reported 175 infants among the public and private agency adoptions. She also reported that private independent adoptions were legal. Therefore, NCFA believes that the item 7 count would be higher if private independent adoptions were included, and so this item was imputed based on response patterns from states which reported this item. Est.


9. Est.

10. Est.
WEST VIRGINIA—(8 contact attempts).
2. 622—Thompson, ibid.
3. 325—Thompson, ibid.
4. Est.—The Administration for Children & Families reported 419 public agency children adopted October 1, 2005 to September 30, 2006. NCFA did not use this count because it believes that it is likely that unrelated adoptions and possibly even private agency adoptions may be included in the 419.
5. Est.
6. Est.
7. 87—Thompson, ibid.
8. Est.
10. 55–Molitor, ibid.

WISCONSIN—(7 contact attempts).
1. 2,454—The National Center for State Courts reported 2,451 incoming adoption caseload and 2,454 outgoing adoption caseload for 2006.
2. Est.
3. Est.
5. Est.
6. Est.
7. Est.
8. Est.
9. Est.
10. Est.

WYOMING—(5 contact attempts).
1. 385—Wyoming Vital Statistics 2007, as reported by Maureen Clifton, Wyoming Department of Family Services, 130 Hobbs Avenue, Cheyenne, Wyoming 82009.
2. 200—DFS estimate by Clifton, ibid.
3. 185—DFS estimate by Clifton, ibid.
4. 60—DFS estimate by Clifton, ibid. By way of comparison, the Administration for Children & Families reported 57 public agency children adopted October 1, 2005 to September 30, 2006.
5. 60—DFS estimated by Clifton, ibid.
6. 65—DFS estimate by Clifton, ibid.
7. 100—DFS estimate by Clifton, ibid.
8. 70—DFS estimate by Clifton, ibid.
9. 45—DFS estimate by Clifton, ibid.
10. 45—DFS estimate by Clifton, ibid.

LEGEND FOR SOURCES OF 2007 DATA IN TABLE 1

Est.—Estimated by Dr. Paul Placek, Statistical Consultant to the National Council For Adoption, based on “raking” or proportional distribution based on statistical distributions in reporting states. Dr. Placek has used this method in all previous national NCFA surveys. See Technical Appendix for discussion of methodology.

ACF/AFCARS—Administration for Children & Families, U.S. Department of Health and Human Services, www.acf.hhs.gov/programs/cb/stats_research/aftars/statistics/gender_tbl1_2006.htm (2006 data were provisional). These data were sometimes used for item 4 unless state data were more complete and consistent.

NCSC–2006 data collected by Victor Eugene Flango, Executive Director, National Center for State Courts, 300 Newport Avenue, Williamsburg, Virginia 23185-4147, GFLANGO@NCSC.ORG Note that these counts may or may not include international adoptions. NCFA gratefully acknowledges Dr. Flango for making these data available for the 2007 NCFA survey. The Flango data were available for 37 states, and were often used if state data were not available for counts of total adoptions (item #1).

USDHS—U.S. Department of Homeland Security, Washington, D.C. Item 11—“Intercountry Adoptions,” in OIS terms, are “Immigrant Orphans.” For immigration purposes, this is defined as a child whose parents have died or disappeared, or who has been abandoned or otherwise separated from both parents. An orphan may also be a child whose sole or surviving parent is incapable of providing that child with proper care and who has, in writing, irrevocably released the child for emigration and adoption. In order to qualify as an immediate relative, the orphan must be under the age of sixteen at the time a petition is filed on his or her behalf. To enter the United States, an orphan must have been adopted abroad by a U.S. citizen (and spouse, if married) or be coming to the United States for adoption by a citizen. These data were available for all states, and were used in column #11. The link is on Table 1.
Appendix 1: Methodological Notes

Methodological Notes on Total Adoptions, Item 1

Adoption experts in State Departments of Health had a strong tendency to mistakenly report adoptions which their respective public agencies had processed as total state adoptions (item 1), when in fact this count belongs in item 4, public agency adoptions. For this reason, all state adoption experts were mailed (with their questionnaire) a statistical state-by-state count of AFCARS data produced by the Administration for Children & Families “Public Agency Children Adopted October 1, 2005 to September 30, 2006”. This table was found online on 1/5/2009 at http://www.acf.hhs.gov/programs/cb/stats_research/afcars/statistics/gender_tbl1_2006.htm

The AFCARS FY2006 data had not been updated by The Administration for Children & Families with FY2007 data as of 12/2/2009, when state-by-state data collection had been completed. The FY2006 total count for all states was 51,000, and the FY2007 total count was 52,000, although no AFCARS state-by-state counts for FY2007 were published online by 12/2/2009. In the survey, NCFA's instructions suggested that the state counts in the FY2006 table should be similar to what they report for 2007 from their respective states in item 4 (public agency adoptions).

Also, two other information sources were contacted to obtain total adoptions (item 1)—state registrars of vital records because they may amend birth records, and state courts which finalize adoption dispositions. Nearly 50 vital records statisticians were contacted individually, with reminders in the case of nonresponse, and some were able to provide useable 2007 information. The National Center for State Courts (NCSC) had previously collected 2006 incoming and outgoing adoption caseload from 37 states and these counts were generously provided by Victor Eugene Flango, NCSC's Executive Director. If both incoming and outgoing NCSC counts were reported, the outgoing count was considered most useful. The vital statistics and court outgoing counts, if both were available, were usually fairly similar, and often much higher than counts reported by adoption experts in State Departments of Health. NCFA recognized this situation and so, when discrepant counts were reported by state experts, NCSC, or vital statistics, NCFA chose either the vital records amended birth record count or the National Center for State Courts counts. Then, rather than disregard the lower numbers reported by experts in State Departments of Health, the proportional distribution of their numbers were sometimes used as best available estimates for their respective states. In this way, even discrepant numbers were often used.

Methodological Notes on Private/Independent Adoptions, Item 6

Note the zero (“0”) in Table 1, Column 6, for private individual adoptions in a number of states. Research by NCFA revealed that private/independent adoptions are illegal in Connecticut, Delaware, Massachusetts, Minnesota, and North Dakota. Furthermore, adoption experts in the District of Columbia, Colorado, and Nevada responded during NCFA's survey that all adoptions in their respective states had to go through a public or private agency, and that private independent adoptions were illegal in their states in 2007. Therefore, the count in column 6 was reported as zero (“0”) for seven states plus the District of Columbia.

Methodological Notes on Contact Attempts

To obtain counts for items 1-10 in the 2007 NCFA survey, contacts were attempted by NCFA within each state with adoption experts, ICPC experts, vital records directors, and court statisticians. In the case of nonresponse, mail, telephone, fax, and e-mail reminders were made. In a few states, complaints were registered with a prospective respondent’s supervisor. The number of contact attempts specified for each
state includes initial contacts, reminders, queries about reported data, and/or related contacts about the data. Fewer contacts may indicate an early response to the survey, and many contacts often indicate either clarifications or many reminders, sometimes with success. NCFA made no contact attempts with private adoption agencies, attorneys, adoptive parents, or birthparents.

**Overall Methodology for 2007 National Council For Adoption Survey**

The methodologies for collecting and cleaning the 2007 survey data were similar to those used in previous NCFA national adoption surveys (1982, 1986, 1992, 1996, and 2002). In most previous surveys, NCFA staffers collected the data from state adoption experts, and Dr. Paul Placek cleaned and summarized the data. For the 2002 and 2007 survey, Dr. Paul Placek collected, cleaned, and summarized the data.

For the 2007 national survey, NCFA President and CEO Charles E. Johnson signed a cover letter, which was mailed with the survey to the adoption experts identified by NCFA in all 50 states and the District of Columbia. (Copies of the cover letter and survey follow.) The 2007 survey data collection was conducted in 2009, using a first mailing, e-mail reminder, second mailing, faxes and repeated telephone follow-ups (up to 8 attempted contacts). The state adoption experts variously relied on their own data systems, state vital statistics, court records, and calls to private agencies and adoption attorneys in order to supply the needed information. The reported data source for each item 1-10 for each state appears following the methodology where several sources gave conflicting data. In these cases, NCFA made an informal judgment on which statistics to accept, and reported this in the Sources of Data for Table 1.

State statistics were cleaned, imputed, and then combined into nationally-representative U.S. statistics. The following internal and external consistency checks were performed:

1) If figures were provided for related domestic adoptions (survey item #2) and unrelated domestic adoptions (survey item #3), checks were made that they added to the reported total of related and unrelated domestic adoptions (survey item #1).

2) If figures were reported for unrelated domestic adoptions by public agencies (survey item #4), private agencies (survey item #5), and private individuals (survey item #6), checks were made that they added to the reported total of unrelated domestic adoptions (survey item #3).

3) If a figure was reported for unrelated domestic adoptions of infants (survey item #7), checks were made that this figure was less than the figure reported for unrelated domestic adoptions (survey item #3).

4) If a figure was reported for unrelated domestic adoptions of children with special needs (survey item #8), checks were made that this figure was less than the figure reported for unrelated domestic adoptions (survey item #3).

5) The 2007 “total adoptions” data (survey item #1) collected in the NCFA survey were compared with state court data recently collected in a separate project by Eugene Flango, Ph.D., of the National Center for State Courts. Dr. Flango’s 2007 data became available for 37 states in 2009, just as the 2007 NCFA survey began. In the case of a state’s “nonresponse” or questionable data reported about total unrelated and related domestic adoptions, the Flango court data were sometimes shown to state adoption experts and used unless more credible and consistent data were reported by the state adoption experts. NCFA used the Flango court data only after attempting many follow-ups with these state adoption experts and providing them many opportunities to submit data. Nearly all state vital statistics offices were contacted by e-mail (with a second e-mail reminder and often a question and
answer e-mail discussion) in an attempt to obtain the total unrelated and related domestic adoption figure (survey item #1), because original birth certificates are often amended to reflect the adoptive family surname. A figure for total domestic adoptions (survey item #1) was obtained for every state.

6) NCFA used, when necessary, provisional 2006 data on public agency adoptions made available by the Administration on Children and Families (ACF’s) Adoption and Foster Care Analysis Reporting System (AFCARS), which is accessible on the ACF website. The 2006 ACF data were used because ACF’s state-by-state 2007 data were not available at NCFA’s survey completion time. In the original mailings to state adoption experts, these provisional ACF data were shown to state adoption experts, who were given the option to agree, disagree, or provide an alternate statistic. The 2006 ACF data were used for these states unless state adoption experts provided a final number or a number more consistent with the total set of their reported data.

Posting, tabulation, verification, and calculations of data were completed by NCFA’s statistical consultant Dr. Paul Placek. Calculations and statistical typing were 100 percent red dot verified, and computer calculations were performed by Excel and sample-checked with a manual calculator.

Data gaps or holes still remained. These missing data were imputed by Dr. Placek, using procedures he had previously developed for the earlier NCFA surveys. Standardized statistical procedures were then used to complete the missing data cells in order to make reasonable estimates of complete and comprehensive state and national adoption data.

The basic procedure used to complete the missing data count was that of proportional distribution, often called “raking” or “imputation.” The basic assumption underlying imputation is that the adoption patterns in each nonreporting state are similar to those in all reporting states summed together. Partial reported data were always retained, and the imputed data were always made consistent internally with the reported data within each state. The “Sources of Data for Table 1: 2007 NCFA Survey” in this chapter identifies the data items that were reported by a state and those that were imputed by NCFA. The combination of reported and imputed state data is reported in Table 1. Greatly simplified, the missing Table 1 data were imputed as follows.

1) A count for total domestic adoptions (item #1) was available for all 50 states plus D.C. Twenty six states reported data on related (item #2) and unrelated (item #3) domestic adoptions, or provided enough data such that the imputation procedure was not necessary. The related/unrelated ratio for reporting states was applied to the total domestic adoptions data for the 14 states plus D.C. that did not report related/unrelated domestic adoption data, in order to impute items #2 and #3 data for nonreporting states.

2) Data breakdowns for public (item #4), private (item #5), and private individual (column #6) adoptions were examined for 22 reporting states. The observed ratios were then applied to unrelated domestic adoptions for the 28 nonreporting states plus D.C. in order to impute these states’ unreported data for items #4, #5, and #6.

3) Similar procedures were used to impute missing data for infants (item #7) and children with special needs (item #8), based on observed ratios of these items to unrelated domestic adoptions counts in reporting states.

Because most states are neither required by federal law nor reimbursed by the federal government to collect, analyze, or disseminate some of the specific adoption data sought in NCFA’s survey, there is great
variability in state activity in this area. There is no comprehensive uniform minimum data set that all states produce similar to the data that NCFA collects. Furthermore, privacy and confidentiality guarantees are embodied in many state laws. This further restricts the release of detailed case-by-case individual data unit statistical information and restricts the availability of public use data tapes with individual records for secondary analysis. Finally, budget cuts in state statistical offices have often led to maintenance of only the legally-required statistical system, leaving adoption statistic to be variously produced by many states on “as needed” basis only for policy and record-keeping purposes. These were realistic constraints affecting NCFA’s collection of adoption data for the 2007 data year, as in previous surveys.

NCFA believes that some of the reported numbers were minimum counts or undercounts, and has tried to note so whenever suspected. Furthermore, NCFA’s instructions to states in the survey asked states to report actual counts whenever possible, but also to estimate data, use provisional data, use the judgment of state adoption experts, and/or use other reasonable sources, if actual counts were not available. When these types of estimates were made, NCFA has reported them as such. Also, missing state data were estimated based on the proportional distributions for those data in reporting states. This procedure yields reliable national estimates, but sometimes causes extreme variability in counts within individual states, because the reported data and the estimated data exist side by side within a state.

Despite these limitations, NCFA feels that the best possible survey was completed in 2007, given the circumstances. A standardized survey questionnaire with clear instructions was used, and a high degree of statistical rigor was used in collecting, calculating, verifying, and presenting the data.

Comments on Three Data Collection Items

ICPC data on children exiting and entering states for purposes of adoption

Columns 9 and 10 of Table 1 present data on the number of children entering and exiting states for purposes of adoption under the Interstate Compact on the Placement of Children (ICPC). Thirty-seven states reported partial or complete ICPC data.

The ICPC “Entered state for adoption” (item #9) and “Left state for adoption” (item #10) data for the nonreporting states were imputed separately, and, similar to the other imputations, the ratios for these two items, in relation to unrelated domestic adoption in reporting states, were used to impute data missing from nonreporting states.

The number of children entering states for purposes of adoption should not necessarily equal the number of children exiting states for adoption. NCFA’s 2007 survey data show, however, that, nationally, 6,336 children entered states for adoption and 8,111 children exited states for adoption. For the reasons discussed below, NCFA used the survey finding, despite the discrepancy in the two numbers.

A summary of variables considered by NCFA in deciding to use the NCFA survey ICPC data counts is as follows:

1) The quality of state ICPC data is inconsistent due to differing reporting standards among states and ineffective tracking techniques.

2) ICPC includes interjurisdictional adoptive placements, and also interjurisdictional foster care and residential placements. It may also include foster care and residential placements.

3) Private agencies place children into adoption through ICPC as do public agencies.
4) Some states may have reported “requests” (or referrals), rather than “approved requests.”

5) Some states may have used fiscal years rather than calendar years.

6) Most states have no requirements to count private agency or independent adoptions, only public agency-involved adoptions.

7) The American Public Human Services Association (APHSA) has reviewed ICPC on its website (http://www.aphsa.org/).

**Intercountry adoption data: Department of Homeland Security versus Department of State**

NCFA used data from the Office of Immigration Statistics (OIS), of the Department of Homeland Security, in Table 1, column 11, and in Tables 10, 11, 12, 14, 15, and 16, rather than Department of State visa issuance data (used in Table 13 and Chart 1), because there was a much greater level of detailed adoption data available from OIS, such as data on intercountry adoptions by age and intended state of residence. Note that OIS and Department of State data do not vary significantly.

**Abortion data: Centers for Disease Control and Prevention (CDC) versus Alan Guttmacher Institute (AGI)**

There are two sources of national and state abortion data—the Centers for Disease Control (CDC) and the Alan Guttmacher Institute (AGI). The CDC data are collected annually from central state health departments, rather than from local health departments that may serve clients. The AGI survey is periodic. The AGI data are collected from abortion service providers.

NCFA regards the AGI data to be significantly more complete than the CDC data, and so chose to use AGI data in the various Factbook tables that provide abortion data and in calculating the Adoption Option Index for 2007, despite it being two years older.

**Why Do Estimates Of The Same Characteristic Differ Among The Data Sources?**

1) INTERNATIONAL ADOPTIONS. The Office of Immigration Statistics (OIS) (formerly, Immigration and Naturalization Service, INS) within the Department of Homeland Security accurately counts every legal migrant. On the other hand, the Department of State accurately counts every visa issued. However, some visas are not used, or may be used in a subsequent year. This fact will generate two different adoption counts. Furthermore, two different counts from the same agency may be published—one for calendar year, the other for fiscal year. The INS/OIS counts are typically for fiscal years, and the State Department counts are typically for calendar years. Also, the NCFA focus is on the 50 States plus D.C., and some tables may or may not include adoptions to military outposts and U.S. possessions.

2) TOTAL AND INFANT ADOPTIONS BY STATE. Besides state health department estimates, total adoptions can sometimes be obtained from three other sources—courts, vital records, and census. The National Center for State Courts has periodically done excellent data collections of total adoptions from most state courts. However, most court systems cannot break down types of adoptions (related vs. unrelated, agency involvement or not, infant or not, special needs or not). The court counts may or may not include international adoptions, and not all court systems have equally good data systems. State offices of vital records sometimes keep counts of amended birth certificates, which can be used to count state adoptions. Sometimes they can only estimate these numbers of these amended vital records according to fees collected. For the first time in a decennial census, the 2000 Census collected total adoptions by state (see Rose Kreider’s chapter in Factbook).
This was based on a sample of one out of every six housing units. There is sampling error and nonsampling error, and small numbers for some states have higher sampling error. Also, the Census questions are very short, and respondents may have interpreted the term “adoption” in a very informal way, such as caring for a child rather than going through a formal agency process. This was discussed further on the Census link: [http://www.census.gov/population/www/cen2000/briefs.html#sr]. Similar data is not being collected in the U.S. Census of 2010. Finally, we must address whether the NCFA count of 18,078 infants in 2007 is complete. The counts of infants were likely most accurate with public agency adoptions, where many characteristics of the child are known and recorded. Public agency adoptions tend to handle older children, including children being adopted out of foster care. However, few states keep detailed records on the characteristics of private agency adoptions, and fewer yet of independent adoptions. Yet it is these adoptions which may be most likely to be infants. We therefore suspect that the NCFA survey estimate of 18,078 infants may be a minimum number or undercount.

3) PUBLIC AGENCY ADOPTIONS. In the four years since publication of the previous Factbook, the Children’s Bureau within the Administration for Children & Families (ACF) has developed a quality data collection system to track adoptions of children with public child welfare agency involvement (see Table 17). This table was downloaded on April 21, 2010 from the ACF website. This most current 2006 ACF count of 50,705 public agency adoptions (excluding 236 from Puerto Rico) does not agree with the NCFA count of 42,978 unrelated domestic adoptions by public agencies in 2007. First, the years are different—2006 vs. 2007. Second, the word “unrelated” is the key. NCFA focused on “unrelated” in this count, whereas ACF counts likely include “related” adoptions in its higher count. Also recall that, upon NCFA recontact in the case of nonresponse, state adoption experts were shown an earlier provisional ACF count for their respective states. They were asked if they agreed with that count or wished to report an updated count. Updated counts were used in the NCFA survey when offered. We stress that NCFA’s data collection for public agency, private agency, and independent adoptions was supposed to be for unrelated adoptions.

4) ABORTIONS BY STATE. There are two sources of national/state abortion data—CDC and AGI. The CDC data are collected annually, but exclude these states (California, Alaska, and New Hampshire) and in 2006 reported 846,181 abortions. This report was released in November 2009. The AGI survey is periodic, generally every four years, and the year 2005 was the most recent data collection from which statistics are available at this writing. NCFA believes that the AGI data are of higher quality and more complete than the CDC data, and so we used the AGI data in our tables. CDC data are reported by the central health department in the state in which the abortion was performed rather than the area in which the woman resided; data reported by abortion providers to health departments may therefore be incomplete. CDC numbers are significantly lower than AGI numbers for some years. On the other hand, AGI data are collected from the universe of abortion providers. Repeated mail, fax, and phone contact attempts were made with several thousand abortion providers, and estimates were made or obtained in case of nonresponse for each provider. For example, in the year 2005, AGI reported 1,206,240 abortions. In that same year, CDC reported only 820,151 abortions. NCFA regards the AGI data of significantly higher quality and completeness than the CDC data, and so chose to use AGI data in calculating the Adoption Option Index.
ADOPTION STATISTICS FOR ______________________________, 2007

INSTRUCTIONS FOR ADOPTION STATISTICS LINES 1-10

A. Please exclude all adoptions of children from other countries. (NFCA will receive this information from the U.S. Immigration and Naturalization for your state for 2007.)

B. Please estimate 2007 data if you do not have an exact count. If necessary, use 2006 data, provisional data, the judgment of your state adoption experts, summaries assembled from adoption agencies, or other sources which you consider reasonable. For example, if you determine that the number is 200-250, report 225. It is far more preferable for you to estimate based on your expertise with your own state statistics than to have us estimate based on patterns observed in neighboring states. Make sure your counts are consistent for lines 1-10.

C. Please reference the source of your numbers entered on lines 1-10 as precisely as possible. Please attach any reports, technical documents or related material used to derive your counts and estimates. Specify whether each number you provide is an exact count or an estimate. If it is an estimate, describe the method used to derive the estimate. Note on any attached material which of the ten data lines to which it refers.

PART 1. ADOPTION STATISTICS FOR ______________________________, 2007

1. Total number of adoptions.
   Source: ______________________________

2. Of total adoptions reported on line 1, how many were related adoptions (the child of one member of the couple, or related in some other way to the adoptive parents)?
   Source: ______________________________

3. Of total adoptions on line 1, how many were unrelated to the adoptive parents?
   Note: Related adoptions (line 2) plus unrelated adoptions (line 3) must equal total adoptions (line 1).
   Source: ______________________________

4. Of unrelated adoptions reported on line 3, how many were unrelated adoptions handled by public agencies?
   Note: (2006 statistics for your state attached)
   Source: ______________________________

5. Of unrelated adoptions on line 3, how many were unrelated adoptions handled by private agencies?
   Source: ______________________________

6. Of unrelated adoptions on line 3, how many were unrelated adoptions handled by private individuals?
   Note: The sum of public agency adoptions reported on line 4, private agency adoptions on line 5, and private individual adoptions on line 6 must equal unrelated adoptions total on line 3.
   Source: ______________________________

7. Of unrelated adoptions on line 3, how many were “infants”? (Since placements are often not finalized until after babies pass their first year, include in this number infants up to the age of two. The number you report here will be less than the number on line 3 because many unrelated adoptions are age two and over).
   Source: ______________________________
8. Of unrelated adoptions reported on line 3, how many were unrelated adoptions of children with special needs?  

*Note:* Unrelated special needs adoptions are usually defined as disabled physically or emotionally, sibling groups, older children, or children of minority or ethnic backgrounds.

Source: _________________________________

9. How many children entered your state for the purpose of adoption from another state in 2007?  

*(Processed through the Interstate Compact on the Placement of Children)*

Source: _________________________________

10. How many children left your state for the purpose of adoption in another state in 2007?  

*(Processed through the Interstate Compact on the Placement of Children)*

Source: _________________________________

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**PART II. ORGANIZATIONS AND RESOURCES**

**INSTRUCTIONS:**

Please supply us with lists of your state’s adoption specialists, adoptive parent support groups, photo listing books, Interstate Compact on the Placement of Children, administrators, adoption exchanges, and interracial and intercultural support groups. Key contact persons, phone numbers, e-mail addresses, and websites should be included whenever available.

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*Thank you* for completing this survey. Should we need to re-contact you, please insure that your contact information on the cover is correct. If other specialists assisted in completing this survey, please provide their complete contact information.

**OTHER SPECIALISTS?**

Name: ___________________________________________
Address: _________________________________________
Phone: ___________________________________________
Fax: _____________________________________________
E-mail: ___________________________________________

**Please return to:**

Paul J. Placek, Ph.D.
Statistical Consultant, National Council For Adoption
103 Big Holly Court
Stevensville, MD  21666-3333
Tel: 410-643-2817
Fax: 410-643-0390
PJPLACEK@VERIZON.NET

*NOTE:* For a list of state adoption experts and vital records directors contacted in this survey, please contact NCFA at: 
ersman@adoptioncouncil.org
OR
225 N. Washington Street, Alexandria, VA  22314 (703) 299-6633
 RESPONSE COORDINATOR FOR STATE  
*Please correct information below if necessary. Thank you!*  

January 20, 2009

Dear:

The time is long overdue for National Council For Adoption (NCFA) to publish updated statistics and more current resource information. There is no other private agency or federal organization which collects or compiles adoption statistics and resource information in the form produced by NCFA.

The questionnaire responses from state adoption experts such as you have led directly to *Adoption Factbooks I, II, III, and IV* and helped make these books valuable resources for members of Congress considering legislation, and for others needing accurate information concerning adoption—including the media, statisticians, adoption agencies, attorneys, social workers, birthparents and prospective adoptive parents.

Please complete the ten statistical items for 2007. We realize that the information which we need for your state may come from several different experts in your state. If you will coordinate within your state to report those ten items and cite the source and person for each item, we would greatly appreciate it. If you need guidance in completing the survey, please contact Dr. Placek. He was our state data consultant in NCFA’s 1982, 1986, 1992, 1996, and 2002 adoption surveys.

Please return this information to NCFA’s survey staff person by February 20, 2009:

Paul J. Placek, Ph.D.  
103 Big Holly Ct.  
Stevensville, MD 21666-3333  
Tel 410-643-2817  
Fax 410-643-0390  
PJPLACEK@VERIZON.NET

We have made previous survey information from *Adoption Factbook IV* widely available for free on NCFA’s website—just click on “Facts and Statistics” at www.adoptioncouncil.org. You will see how your answers to our survey questions are not only of significance to your state, but also to our nation. The information you give yields a state portrait as well as a national picture on adoption statistics, regulation and policies.

Also, would you please furnish Dr. Placek with your lists of organizations and resources?

Sincerely,

Chuck Johnson  
Chief Operations Officer  
National Council For Adoption  
225 N. Washington St.  
Alexandria, VA 22314-2520  
(703) 299-6633 (phone)  
(703) 299-6004 (fax)  
www.adoptioncouncil.org
Appendix 4: Data Request From State Vital Records

(name and degree)
Director, Division of Vital Records
Office of Public Health Statistics and Information Services
2600 Bull Street
Columbia, South Carolina 29201

Dear Dr. (_______):

From your amended birth certificates data in 2007, we need your help with several 2007 key statistics in the National Council for Adoption’s (NCFA) sixth National Adoption Survey. The focus and content has been consistent in the 1982, 1986, 1992, 1996, 2002, and 2007 surveys. I am pleased to have been directly involved in data collection, processing, and/or analysis for each of these national surveys. Previous results have been published in Adoption Factbooks I, II, III, and IV, and over 50,000 of these Factbooks have been distributed to adoption experts, legislators, birthparents, adoptive parents, and libraries. The data are available free at NCFA’s website – just click on “Facts and Statistics” at www.adoptioncouncil.org.

Counts of amended birth certificates in 2007 may well be able to provide several of the ten items in the survey—especially the first three: 1) total adoptions; 2) related adoptions; and 3) unrelated adoptions. Even the infants question (item #7, children under 2) may be available in the amended birth certificates. Two months ago, this questionnaire was mailed to all state adoption experts identified on this list, including the expert identified in your state—(name in state department of social services). Our results so far indicate that state adoption experts can report on adoptions arranged by public agencies (item #4), but they often have no counts of private agency adoptions (item #5), independent adoptions (item #6), or related adoptions (item #2) which are captured in the total unrelated adoptions counts (item #1). By subtraction and by comparing patterns in states which do relatively more complete reporting, I will be able to count or estimate all ten items for all states, and generate state and national estimates. The more complete information I have, the better.

By blending in your data on total related and unrelated adoptions which is likely captured in amended birth certificate counts, we can get the most complete picture for your state. As the attached survey documents explain, please exclude from your counts, children from other countries.

On a personal note, I worked at the National Center for Health Statistics in Hyattsville for over 30 years. I spent 18 of those years in the Division of Vital Statistics working on vital records followback surveys. This work gave me contact with State vital records registrars and immense respect for the high quality and utility of their vital statistics data.

Thank you in advance for your assistance. Feel free to contact me if you need more information.

Paul J. Placek, Ph.D.
Statistical Consultant to NCFA
103 Big Holly Court
Stevensville, MD 21666
410-643-2817
Fax: 410-643-0390
pjplacek@verizon.net

Attachments: Cover Letter of Explanation
Ten Item survey
State Adoption Program Managers
Adoption Petitions in Courts, 2005-2007

Victor E. Flango

Abstract

This article presents information on adoptions conducted under the auspices of public agencies, adoption petitions filed in court, and international adoptions to present as complete a picture of total adoptions in the United States as possible. For the first time, data from courts are integrated with adoptions from foreign countries to provide a more complete picture of adoptions in the states, and adoption rates (adoptions per 100,000 population) are calculated. The findings emphasize the importance of adoption information, and highlight the loss of data on adoption petitions filed in court, which is less available now than it has been in recent years. No one agency compiles adoption information on all adoptions in the United States, and the agencies that do have access to some types of adoption information have no mandate or incentive to compile that information so that it can be integrated with other sources of adoption information.

Introduction

In my article in Adoption Factbook IV (Flango, 2007), I traced adoption trends based upon petitions filed and disposed of by courts for the years 1985 to 2002. This article will update that information by providing adoption data for the years 2005, 2006, and 2007, and then calculate rates of adoption from states which provide data. For the first time, this data from courts will also be integrated with adoptions from foreign countries to provide a more complete picture of adoptions in the states.

Policymakers, adoption agencies, social workers, attorneys, health professionals, advocacy groups, and even researchers have stated the need for complete and accurate information on adoptions. Adoption information is critical to policy formulation, to planning, and to allocating scarce personnel and financial resources at all levels of government. State governments need adoption information to estimate the personnel, funds, and facilities needed by public adoption agencies, determine the cost of providing adoption assistance, provide reports to state legislatures, and evaluate the success of current state adoption policies. The federal government needs information on adoptions to evaluate the success of current federal policies designed to encourage adoption. Nevertheless, it is still not possible to determine the total number of children adopted in the United States.

Because adoption is a legal process, courts not only decide whether to grant a petition for adoption, but are also involved in many of the collateral issues, such as access to adoption records and the rights of the biological father. Therefore, the number of adoption petitions filed and disposed is the closest approximation of the total number of adoptions conducted in each state. Outgoing petitions, or “dispositions”—the court decision to grant or deny a petition for adoption—provide the best estimate of the number of adoptions in each state. If dispositions are not available, incoming petitions, or “filings”—the written request to adopt filed with the court—can be used as a surrogate measure. As observed in the last edition of the Factbook, which traced the trends in court adoption petitions between 1985 and 2002, incoming cases and outgoing cases are highly related because in most states the number of petitions resolved is closely related to the number
of cases filed. There are, however, some states where incoming cases are filed at a faster rate than they can be resolved. Incoming cases will slightly overestimate the total number of adoptions to the extent that the courts may deny a petition for adoption, but that is a relatively rare event.

Total adoptions from court sources include both unrelated (in which a child is adopted by a person who is not a relative) and related (which includes adoptions by stepparents or other relatives). In states where the child welfare system reports data for only children placed under the auspices of public adoption agencies, the total number of adoptions obtained from courts provides an indication of the public agency proportion of all adoptions. For example, if public agency adoptions are increasing, it may be helpful to know whether individually arranged adoptions are also increasing or decreasing.

Adoptions 2005-2007

Table 1 identifies the state courts with jurisdiction over adoption. In the vast majority of states, adoption petitions are filed in the trial court of general jurisdiction. In eleven states (Colorado, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Mississippi, New Hampshire, New York, Tennessee, and Texas), two or more courts have the authority to adjudicate petitions for adoption, usually one court of general jurisdiction and one of special jurisdiction. In Idaho, for example, adoption petitions are filed in the district court unless the adoption arises from a child protective case, in which case the adoption petition will be filed in the court with jurisdiction over the protective case (Child Welfare Information Gateway, 2007). Similarly, in Massachusetts, adoption petitions are filed in probate court unless there is a proceeding pending in district or juvenile court (Child Welfare Information Gateway, 2007). For those eleven states, totals from multiple courts were added to determine the total number of adoptions.

In Alabama, Connecticut, Indiana, New Hampshire, and Vermont, probate courts have exclusive jurisdiction over adoptions. Even in these states, however, jurisdiction is more complicated than it first appears. For example, in Indiana, probate court has exclusive jurisdiction in adoption matters in those counties that have separate probate courts. In other counties, adoption petitions are heard by the court that handles probate matters (Child Welfare Information Gateway, 2007). Similarly, in New Hampshire, probate court has exclusive jurisdiction according to state statute (Child Welfare Information Gateway, 2007), but the Family Division has jurisdiction over adoption of children in abuse and neglect cases. As the movement toward family court expands in New Hampshire, it is expected that more and more adoptions will be handled in the Family Division.

In Nebraska that responsibility falls to the County Court, a court of limited jurisdiction (unless a separate juvenile court already has jurisdiction over the child to be adopted).

Table 1 reports the number of adoption petitions filed and disposed for in 2005, 2006, and 2007. In the previous Factbook article (Flango, 2007), adoption dispositions were available for 39 states for the period 1985 to 2002. In 2002, 40 states plus the District of Columbia and the Commonwealth of Puerto Rico were able to report adoption filings, and 37 states were able to report the number of petitions disposed. In the remaining 10 states, adoptions were such a small portion of the caseload that courts did not report them separately, but as a subset of a larger case category (e.g., domestic relations, juvenile cases, miscellaneous civil cases). Since 2005, the situation has not improved. South Dakota stopped reporting adoption data after 2002. Wyoming did not report adoption data in 2001 and 2002, did report adoption data in 2003, and then did not do so again until 2007. Thus the table below contains data from 39 states, plus the District of Columbia and the Commonwealth of Puerto Rico.

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1 For further information about New Hampshire adoption proceedings, see: http://www.courts.state.nh.us/probate/referencemanual.pdf
2 States that did not report adoption filings were: Alabama, California, Florida, Georgia, Mississippi, North Carolina, Oklahoma, South Carolina, Texas and Virginia.


**Intercountry Adoptions**

Adoptions by U.S. citizens completed in foreign countries also complicate the adoption count. When U.S. citizens adopt a foreign-born child abroad, they must apply to the U.S. Citizenship and Immigration Services of the U.S. Department of Homeland Security for an IR-3 visa—which classifies the child as an immigrant and provides the child with U.S. citizenship upon arrival in the U.S. (Child Welfare Information Gateway 2008). Recognition and validation of adoption is subject to the laws of the states in which the parents reside. Twenty-four states give full effect and recognition to an adoption decree from the country that granted the adoption, which means that the foreign adoption decree is considered as valid and binding as one issued by a state court (Child Welfare Information Gateway, 2008). Twenty-four states offer re-adoption or validation as an option, but not a requirement. Validation of the foreign adoption means submitting the foreign adoption decree for state approval, and re-adoption is the process of adopting a child previously adopted in another jurisdiction as a way to legitimize the foreign adoption and obtain a United States birth certificate.

Six states require adoptive parents to petition the court to validate or register the foreign adoption, and so presumably in these states the court adoption figures are complete for all adoptions—regardless if finalized in state or abroad. Re-adoption or validation protects the adoption finalized abroad from legal challenge in state courts and permits the adopted child the opportunity to obtain a birth certificate from the parent’s state of residence (Child Welfare Information Gateway, 2008). Table 2 compares the number of adoptions conducted under the auspices of public child welfare agencies in the states, with the total number of adoptions petitions from courts combined with foreign adoptions (except for the six states where these are presumably already included in the totals). Because FY 2006 is the latest time period from which data from child public welfare agencies are available, 2006 was used as the base year for comparison.

Table 2 shows the proportion of total adoptions accomplished under the auspices of public child welfare agencies. Public agency adoptions as a proportion of total adoptions vary greatly, from 67.4 percent in the Commonwealth of Puerto Rico to 11.5 percent in Maryland. The correlation between public agency adoptions and total domestic adoptions and total domestic and foreign adoptions, is moderate (.50), but not high. Accordingly, conclusions drawn based on public agency data may not be characteristic of all adoptions.

**Adoption Rates**

Table 3 compares rates of adoption among public agency adoptions, domestic adoptions derived from court services, and total adoptions (which are a combination of court petitions and foreign adoptions).

The median proportion of public agency adoptions per 100,000 is 23.5. Considering only public agency adoptions, Alaska has the highest proportion of adoptions per 100,000 adult population at 43.4, and Puerto Rico has the smallest proportion (8.1). The rank order of other states does change if we consider only public agency adoptions rather than total adoptions. In addition to Alaska, the states with the highest proportion of public agency adoptions per 100,000 are Iowa, Oklahoma, Nebraska, and Hawaii. After Puerto Rico, the states with the lowest proportion of public agency adoptions per 100,000 population are Maryland, Virginia, Alabama, and Mississippi.

Table 3 also shows the rate of total adoptions per state, including stepparent and other relative adoptions, for all states where data were available from court sources. The rates are a ratio of adoption petitions filed per 100,000 adult population.

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3 Children receive an IR-3 visa when both parents travel to bring the child home. If only one parent travels, then the child travels on an IR-4 visa and is not automatically granted citizenship.


5 Delaware, Kansas, Louisiana, Pennsylvania, South Carolina, and Tennessee.
population in each state. Alaska had the highest proportion of total adoptions (123 per 100,000 population) in both 2006 and 2007. Other states with a high proportion of adoptions were Montana and Utah in both 2006 and 2007, Kansas in 2007, and Idaho in 2006. Puerto Rico, Delaware, and New Jersey had the lowest ratio of adoptions per 100,000 population in 2006 and 2007. These may be jurisdictions in which more adoptions could be encouraged.

Are these ratios affected if foreign adoptions are added to the mix? Obviously, the total numbers of domestic adoptions per state as identified from court data are correlated to total numbers of domestic and foreign adoptions per state (correlation of .99). States with the highest and lowest proportion of adoption petitions filed per state for domestic adoptions are also the states with the highest ratio of adoptions per 100,000 when foreign adoptions are added in.

I will leave the explanation of why adoption rates vary among states to those who have more expertise in this area.

**Limitations on Court-Derived Adoption Data**

There are limitations to using courts as a source of adoption data. First, ten states do not report adoption data separately, and these include some states with large populations. Also, while many adoptions of Native American children are decided in state courts, many others are decided by tribal courts. Consequently, in states with large Native American populations, it is likely that reliance on state court data will undercount the number of Native American children adopted.

Perhaps the most important limitation on using courts as a source of adoption information is the limited variety of case characteristics it contains. In order to process cases, courts need to have information on petitions filed, the status of those petitions, and the petitions disposed. They rarely record information about the characteristics of children adopted or characteristics of adoptive or birthparents.

In sum, court filings and dispositions are an important source of information on the total number of adoptions in the United States. Used together with information on adoptions of children from foster care available from public agencies, counts of amended birth certificates from bureaus of vital records, and information about adoptions completed in foreign countries, these data can help provide a more complete and accurate picture of total adoptions in the United States.

**References**


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### Table 1. Adoption petitions in state courts, 2005-2007

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*continued*
Table 1. Adoption petitions in state courts, 2005-2007  (continued)

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* Data are overinclusive in that additional case types are included in the count of filings.
Table 2. Public agency adoptions as a percentage of all adoptions\(^a\)

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\(^a\) Figures are rounded to the nearest integer.
Table 2. Public agency adoptions as a percentage of all adoptions\(^a\) (continued)

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\(^a\) Sources used for intercountry adoption data are: http://www.dhs.gov/files/statistics/publications/LPR07.shtm - 2007. “Supplemental Table 4 - Immigrant-Orphans Adopted by U.S. Citizens by State of Residence, Gender and Age, Fiscal Year 2007”
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continued
Table 3. Rates of adoption by state (continued)

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<tr>
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<td>68.9</td>
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<td>14.5</td>
<td>93.3</td>
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Internationally Adopted Children in the U.S.: 2008

Rose M. Kreider

Introduction

The number of foreign-born children adopted by U.S. citizens increased until 2004, and then began to decrease. This was the first substantial decrease in the annual numbers of children adopted internationally since Americans began adopting foreign-born children in the mid-20th century (Selman, 2009a). Figure 1 illustrates this turn in the number of annual international adoptions with U.S. State Department data. Although numbers have declined in recent years, the data show international adoption was an important family form during the 2000s, with some 200,700 children joining families in the U.S. from 1998-2008. While the United States has been one of the largest receiving countries (Selman, 2009b), the number of internationally adopted children is relatively small compared with all children living in the U.S., and so is difficult to estimate even in large-scale social surveys. This chapter uses a large, nationally representative data set to profile characteristics of internationally adopted children and their families.1

Background

In 2008, the category “adopted son/daughter” was added to the relationship to householder question on the American Community Survey (ACS), which has replaced the long form of the decennial census. ACS is in the field every month, and produces annualized estimates centered on July 1 of the year. ACS is a very large, nationally representative sample, interviewing approximately three million households annually. Its large sample size provides an opportunity to profile internationally adopted children and their families, which is not possible with the same level of detail from smaller surveys.

The expansion of the item “son/daughter” into three categories: “biological son/daughter; adopted son/daughter; and stepson/daughter” mirrors the format of the Census 2000 relationship to householder question. The ACS is primarily a mail survey and questions are interpreted by the respondent. As a result, “adopted son/daughter” reflects many different types of adoption, including the adoption of biologically related and unrelated children, adoption of stepchildren, adoption through private and public agencies, domestic and international adoption and independent and informal adoption.

Adopted children were identified using the answer to the question, “How is this person related to the householder?” “Adopted children” can only be identified in the ACS if they are the children of the householder2 and were living in the household at the time of the survey. If a married couple lived in the household of one of their parents, their adopted children were identified as the grandchildren of the householder, rather

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1 This paper is released to inform interested parties of ongoing research and to encourage discussion of work in progress. Any views expressed on statistical and methodological issues are those of the author and not necessarily those of the U.S. Census Bureau.

2 The householder is someone in whose name the home is rented or owned. I will use the term householder interchangeably with the term adoptive parent in this chapter. If the child lived with two parents, it is not possible to identify whether the second parent was the child’s biological, step, or adoptive parent using ACS data.
than as adopted children. Because of household
configurations like this, ACS data do not provide
a complete count of all adopted children in
the United States. At the same time, the large
sample size of the ACS makes it one of the few
sources for a nationally representative profile of
the characteristics of adopted children and their
families and households.

Estimates of the number of adopted children
under 18 using data from the 2008 ACS are
roughly consistent with estimates from the
Current Population Survey (CPS), which
identifies both a mother and a father in the
household, if present, as well as the type of
relationship (biological, step, or adoptive)
between parent and child, for all children under
18, regardless of whether they are the children
of the householder. The ACS estimate of adopted
children of the householder was 1.6 million,
higher than the 1.3 million estimated by CPS.

A third independent estimate of the number
of adopted children is available from the 2007
National Survey of Adoptive Parents (Vandivere,
Malm & Radel, 2009). This survey estimated
1.8 million adopted children under 18 in 2007,
although the estimate excluded children living
with one adoptive parent and one biological
parent, which are presumably included in the ACS
estimate.

Data

The data in this chapter are from internal U.S.
Census Bureau ACS 2008 data files. The internal
file is about 50 percent larger than the public
use microdata file, which allows more accurate
estimates of a relatively small group such as
internationally adopted children.

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3 All comparative statements in this presentation have undergone
statistical testing, and unless otherwise noted, all comparisons are
statistically significant at the 90 percent confidence level. The data
are subject to error arising from a variety of sources, including
sampling error, nonresponse error, and model error.

4 Current Population Survey, Annual Social and Economic
Supplement 2008. CPS is a nationally representative survey
conducted jointly by the Bureau of Labor Statistics and the U.S.
Census Bureau.
Definition of Internationally Adopted Children

This chapter focuses on never married adopted children of the householder who were foreign-born, were under 18 at the time of the survey, and whose coresident parents are U.S. natives. The term U.S. native includes those born in the United States or its territories, or born abroad of U.S. citizens. The term “foreign-born” includes all others. It is important to note that people who are foreign-born may also be naturalized U.S. citizens.

As stated above, I exclude foreign-born adopted children with any coresident foreign-born parents. The sample is restricted to foreign-born adopted children whose coresident parent(s) are U.S. natives, because in an analysis of Census 2000 data, I found that estimates of foreign-born adopted Latino children far exceeded State Department counts of visas issued for Latin America, leading to the assumption that many are informally adopted. In that examination of Census 2000 data, I found that excluding these children resulted in an estimate that was more consistent with U.S. Department of State records of visas issued to internationally adopted children when they entered the United States (Kreider, 2007). Foreign-born adopted children with one foreign-born parent and one U.S. native parent are likely to be living with one biological and one adoptive parent. A relatively high percentage of these children (45 percent) are Asian or Pacific Islander, a group that has relatively high rates of intermarriage with Whites. Foreign-born adopted children living with two foreign-born parents are often Hispanic (47 percent) and may be informally adopted.

This sample most closely approximates the group of families usually defined as “internationally adopted” children and their parents: foreign-born non-related children adopted legally by U.S. citizens. Since I use a particular group of foreign-born adopted children, I will refer to them as “internationally adopted” rather than “foreign-born.”

How many internationally adopted children under 18 are there?

The only nationally representative survey to explicitly estimate the number of internationally adopted children is the 2007 National Survey of Adoptive Parents (NSAP). NSAP estimated 444,000 internationally adopted children, roughly double the number estimated by the 2008 ACS (199,284), using the definition given earlier. Respondents to the NSAP who reported an adopted child were asked “Was [the child] adopted from another country?” A positive answer to this question resulted in that child being coded as internationally adopted. NSAP excludes adopted children living with one biological and one adoptive parent, just as I try to do by proxy by excluding foreign-born adopted children with a foreign-born parent. There are many differences between the two surveys, including question text, the definition of internationally adopted children used, the mode of collection (ACS is primarily conducted by mail while NSAP used interviewers), patterns of nonresponse, and differences in sampling frame. Each of these differences may contribute to the large disparity between the two estimates of internationally adopted children.

The ACS estimate can also be compared with the administrative counts of entrance visas issued to orphans arriving in the United States. Based on summary statistics published on the U.S. Department of State website, about 279,500 visas were issued to orphans from 1991 to 2008 (inclusive), a number that falls between the ACS and NSAP estimates. So, while NSAP may

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5 This excludes 64,984 foreign-born adopted children who have at least one foreign-born parent in ACS 2008 data.
6 The two percentages listed in this paragraph (45 and 47) do not differ statistically from each other.
slightly overestimate the number of internationally adopted children, ACS likely underestimates this number, making the difference between the two estimates artificially wide.

**Where do internationally adopted children live in the U.S.?**

In 2008, there were an estimated 1.6 million adopted children under 18 in the United States (see Table 1). Of these, about 199,284, or 12 percent, were internationally adopted. The percentage of adopted children who were internationally adopted was higher in the Northeast (17 percent) and Midwest (16 percent)\(^8\) than in the U.S. overall (12 percent), while the percentages in the South (10 percent) and the West (nine percent) were lower than in the U.S. overall. The more detailed breakdown by Census division shows the same pattern as was seen in region. The West South Central division (made up of Texas, Oklahoma, Arkansas, and Louisiana) had a lower percentage of adopted children who were internationally adopted than any other division.

Due to small sample size, only states with at least 50,000 adopted children are included in Table 1. Of these, California (seven percent), Florida (eight percent), Georgia (eight percent), and Texas (seven percent) had percentages of adopted children who were internationally adopted that were lower than the U.S. overall (12 percent).\(^9\)

**Where were internationally adopted children born?**

The ACS asks whether respondents were born in the United States or abroad. If they were born abroad, they were also asked where they were born and the year they entered the United States. Table 2 displays place of birth for internationally adopted children for broad world regions, showing additional detail where possible. Twenty-eight percent of all internationally adopted children under 18 were born in Europe, 49 percent in Asia, four percent in Africa and 19 percent in Latin America. Most of the children born in Europe were born in Russia (20 percent of all internationally adopted children), while most of the children born in Asia were born in either China (27 percent of total) or Korea (11 percent of total). The largest group of children born in Latin America was born in Guatemala (12 percent of total).\(^10\) Shifts in the birth countries of internationally adopted children over time reflect family policies in those countries, agreements between the United States and specific countries, as well as the numbers and nature of the child population available for adoption in any particular country. For more details about changes in sending countries over time, see Selman’s research (2009a, 2009b).

**How does age at adoption vary by place of birth?**

Children who are adopted at younger ages have a lower chance of experiencing negative life outcomes. Time spent in institutional settings raises the risk of delays in physical development, attachment disorders and impaired cognitive development.\(^11\) The age of children when they are adopted and enter the United States varies by place of birth (see Table 3).\(^12\) This reflects differences in the situations of children available for adoption in their birth countries. While most of the children born in Asia and Latin America who were adopted by U.S. citizens were relatively young, those adopted from Africa or Russia tended to be older. Eighty-nine percent of the Chinese-born children were age zero to two at adoption, as were 97 percent of those born in Korea. Ninety-three percent of those born in Guatemala were age

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\(^8\) Estimates for the Northeast and Midwest do not differ from each other statistically.

\(^9\) The estimates for these four states did not differ statistically from each other.

\(^10\) The estimate of the percentage of children born in Korea, out of all Asia–11 percent does not differ statistically from the estimate of children born in Guatemala, out of all of Latin America–12 percent.

\(^11\) For a comprehensive discussion of these risks and an assessment of the development of internationally adopted children, see Juffer and van IJzendoorn, 2009.

\(^12\) There is no question that directly addresses age at adoption. I use the age of entry to the United States as a proxy, since most of the children are adopted very close to the time they enter the United States.
zero to two at adoption. Forty-two percent of the children born in Africa were age zero to two when they were adopted, as were 68 percent of those born in Russia. The age at adoption for children born in Africa is striking, since 38 percent of these children were age six to 17 when they arrived in the United States. Older age at adoption has been found to be associated with a higher risk of disruption and higher risk of behavioral problems (Rosenthal, 1993; Sharma, et al., 1996). However, a recent study found that while those adopted at older ages had lower educational attainment, there were few differences in socioeconomic outcomes such as income, home ownership, divorce, or depression for adoptees in their mid-30s who had been adopted at older ages, compared with those adopted at early ages (Decker & Omori, 2009).

How do the characteristics of internationally adopted children’s households/parents differ from those of U.S. native adopted children?

Previous research has found that families with internationally adopted children tend to have higher socioeconomic standing than other families (Hjern, Lindblad, & Vinnerljung, 2002; Kreider, 2007; Vandivere, et al., 2009). Table 4 shows characteristics of the adoptive parent(s) and the child’s household for internationally adopted children compared with U.S. native adopted children. A higher percentage of the internationally adopted children lived in married couple households—82 percent compared with 72 percent for U.S. native adopted children.

A very low percentage (two percent) of the internationally adopted children lived in households that were below the poverty level, compared with 14 percent for U.S. native adopted children. A majority (59 percent) of the internationally adopted children lived in households where income was $100,000 or more, while this was true for 29 percent of U.S. native adopted children. One out of three of the internationally adopted children lived in households with income of at least $150,000, while this was the case for 13 percent of the U.S. native children.

Three-quarters of the internationally adopted children lived with an adoptive parent who had a Bachelor’s degree or higher level of educational attainment. One-third of the U.S. native adopted children had an adoptive parent with a Bachelor’s degree or higher. Indeed, 39 percent of the internationally adopted children had an adoptive parent who had a graduate or professional degree, compared with 14 percent of the U.S. native adopted children.

Ninety percent of the internationally adopted children lived with an adoptive parent who was in the labor force, higher than the comparable percentage for U.S. native adopted children (83 percent). In addition, a higher percentage lived in a home that was owned (95 percent), compared with 75 percent of the U.S. native adopted children.

Together, this group of socioeconomic characteristics of the household and adoptive parent(s) demonstrate that internationally adopted children, even more often than their U.S. native adopted counterparts, lived in owned homes with two married parents. They usually had at least one adoptive parent who was employed, and had at least a Bachelor’s degree. A very low percentage lived in poverty, and most resided in households with relatively high income. This should come as no surprise, since it is expensive to adopt a child internationally, usually ranging from $7,000 to $30,000.14

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13 The estimate of the percent of children born in Africa who were age six to 17 at arrival in the United States does not differ statistically from the percent of children born in Africa who were age zero to two at arrival in the United States.

How do the characteristics of internationally adopted children differ from those of U.S. native adopted children?

Table 5 shows selected characteristics of the adopted child, again comparing internationally adopted children with U.S. native adopted children. Internationally adopted children were younger, with 31 percent age zero to five, compared with 26 percent for U.S. native children. A lower percentage of internationally adopted children were White non-Hispanic (31 percent), Black (five percent), or of two or more races (two percent), compared with 56 percent, 18 percent, and six percent, respectively, for U.S. born adopted children. A higher percentage of internationally adopted children were Asian: 46 percent compared with three percent of U.S. native adopted children. The percentage of adopted children who are Hispanic (17 percent) did not differ based on whether the child was internationally adopted or a U.S. native.

While we might expect that some of the internationally adopted children might retain their birth language if they were adopted at older ages, a lower percentage of internationally adopted children age five and older speak a language other than English at home (seven percent) than U.S. native adopted children (11 percent). Of those who do speak a language other than English, a lower percentage of the internationally adopted children speak English “very well” (58 percent) than U.S. native adopted children (78 percent). Keep in mind that some of the U.S. native adopted children may have first been the stepchild of their adoptive parent, and may also be living with a biological parent who may be foreign-born or may speak a language other than English.

While previous research using data from Census 2000 showed that internationally adopted children and U.S. native adopted children had similar disability rates (Kreider & Cohen, 2009), ACS 2008 data show a different pattern. A lower percentage of internationally adopted children age five to 17 had at least one disability (seven percent) than U.S. native adopted children (12 percent).

While a higher percentage of internationally adopted children had a hearing disability, lower percentages of those age five to 17 had the other types of disability compared with U.S. native adopted children. A lower percentage of internationally adopted children also had multiple disabilities (two percent) than U.S. native adopted children age five to 17 (three percent).

Conclusion

Analysis of ACS 2008 data shows that about 12 percent of adopted children were internationally adopted. Forty-nine percent of these children were born in Asia, 28 percent in Europe, and 19 percent in Latin America. Many of the children were age zero to two at adoption: 89 percent of those born in China, 97 percent of those born in Korea, and 93 percent of those born in Guatemala. Internationally adopted children were more likely to live in married couple households, and in households with higher incomes and lower poverty rates than U.S. native adopted children. The parents of internationally adopted children had higher educational attainment, were more often in the labor force, and more often owned their homes than parents of U.S. native adopted children. Together, these characteristics show that internationally adopted children tended to live in homes of higher socioeconomic standing than their U.S. native counterparts.

Internationally adopted children tended to be younger than U.S. native adopted children, and were more likely to be Asian. A lower percentage of internationally adopted children had a disability than U.S. native adopted children. The large

15 The lower rates of disability of internationally adopted children compared with U.S. native adopted children in ACS 2008 data, although they had similar rates in Census 2000 data may be due to compositional differences in the populations, since disability rates differ based on birth country. The data are also not directly comparable since there were also changes in the way the disability questions were asked. For discussion and evaluation of the disability items on Census Bureau surveys and in ACS 2008, see: Brault, 2009; Brault & Stern 2007; and Brault, Stern & Raglin, 2007.
sample size of the ACS provides an opportunity to profile characteristics of internationally adopted children and the families in which they live.

References


Table 1. Percent of adopted children of the householder who are internationally adopted, for the United States, regions, divisions and selected states: 2008

<table>
<thead>
<tr>
<th>Geographic area</th>
<th>Total</th>
<th>Number</th>
<th>Estimate</th>
<th>Margin of error¹</th>
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<td>Under 18 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Internationally adopted</strong></td>
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</tr>
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<td>1.3</td>
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<td>1.1</td>
</tr>
<tr>
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<td>0.9</td>
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<td>New England</td>
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<td>1.6</td>
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<td>129,576</td>
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<tr>
<td>Pacific</td>
<td>257,760</td>
<td>23,342</td>
<td>9.1</td>
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<td><strong>States²</strong></td>
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<tr>
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<td>9,852</td>
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<td>125,211</td>
<td>8,567</td>
<td>6.8</td>
<td>1.3</td>
</tr>
</tbody>
</table>

¹ This figure, when added to, and subtracted from the percent, provides the 90 percent confidence interval.
² Only states with at least 50,000 (weighted) adopted children are included.

Source: U.S. Census Bureau, American Community Survey, 2008.

NOTE: For information on confidentiality protection, sampling error, nonsampling error, and definitions, see http://www.census.gov/acs/www/Downloads/data_documentation/Accuracy/accuracy2008.pdf
Table 2. Adopted children by place of birth and region: 2008

<table>
<thead>
<tr>
<th>Nativity and place of birth</th>
<th>Number</th>
<th>Percent</th>
<th>Margin of Error¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total adopted children²</td>
<td>1,619,777</td>
<td>†</td>
<td>†</td>
</tr>
<tr>
<td>Native</td>
<td>1,355,509</td>
<td>†</td>
<td>†</td>
</tr>
<tr>
<td>Internationally adopted³</td>
<td>199,284</td>
<td>100.0</td>
<td>†</td>
</tr>
<tr>
<td>Europe⁴</td>
<td>54,874</td>
<td>27.5</td>
<td>1.9</td>
</tr>
<tr>
<td>Russia</td>
<td>40,385</td>
<td>20.3</td>
<td>1.6</td>
</tr>
<tr>
<td>Asia⁴</td>
<td>98,021</td>
<td>49.2</td>
<td>2.1</td>
</tr>
<tr>
<td>China</td>
<td>54,297</td>
<td>27.2</td>
<td>1.8</td>
</tr>
<tr>
<td>Korea</td>
<td>21,647</td>
<td>10.9</td>
<td>1.2</td>
</tr>
<tr>
<td>Africa</td>
<td>6,958</td>
<td>3.5</td>
<td>0.8</td>
</tr>
<tr>
<td>Latin America⁴</td>
<td>37,398</td>
<td>18.8</td>
<td>1.5</td>
</tr>
<tr>
<td>Central America⁴</td>
<td>27,730</td>
<td>13.9</td>
<td>1.1</td>
</tr>
<tr>
<td>Guatemala</td>
<td>24,216</td>
<td>12.2</td>
<td>1.1</td>
</tr>
<tr>
<td>South America⁴</td>
<td>6,761</td>
<td>3.4</td>
<td>0.7</td>
</tr>
</tbody>
</table>

¹ Not applicable.
2 This figure, when added to, and subtracted from the percent, provides the 90 percent confidence interval.
3 Internationally adopted includes 1,880 children born in Oceania and 153 born in Northern America who are not shown separately. Internationally adopted children are foreign born children whose coresident parents are U.S. native.
4 Includes areas not shown separately.
Source: U.S. Census Bureau, American Community Survey, 2008.
NOTE: For information on confidentiality protection, sampling error, nonsampling error, and definitions, see http://www.census.gov/acs/www/Downloads/data_documentation/Accuracy/accuracy2008.pdf
### Table 3. Internationally adopted children by place of birth and age they arrived in the United States: 2008

<table>
<thead>
<tr>
<th>Place of birth</th>
<th>Total</th>
<th>0 to 2 years</th>
<th>3 to 5 years</th>
<th>6 to 17 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Total</td>
<td>199,284</td>
<td>100.0</td>
<td>158,421</td>
<td>79.5</td>
</tr>
<tr>
<td>Europe²</td>
<td>54,874</td>
<td>100.0</td>
<td>35,203</td>
<td>64.2</td>
</tr>
<tr>
<td>Russia</td>
<td>40,385</td>
<td>100.0</td>
<td>27,501</td>
<td>68.1</td>
</tr>
<tr>
<td>Asia²</td>
<td>98,021</td>
<td>100.0</td>
<td>86,024</td>
<td>87.8</td>
</tr>
<tr>
<td>China</td>
<td>54,297</td>
<td>100.0</td>
<td>48,526</td>
<td>89.4</td>
</tr>
<tr>
<td>Korea</td>
<td>21,647</td>
<td>100.0</td>
<td>21,080</td>
<td>97.4</td>
</tr>
<tr>
<td>Africa</td>
<td>6,958</td>
<td>100.0</td>
<td>2,905</td>
<td>41.8</td>
</tr>
<tr>
<td>Latin America²</td>
<td>37,398</td>
<td>100.0</td>
<td>33,121</td>
<td>88.6</td>
</tr>
<tr>
<td>Central America²</td>
<td>27,730</td>
<td>100.0</td>
<td>25,171</td>
<td>90.8</td>
</tr>
<tr>
<td>Guatemala</td>
<td>24,216</td>
<td>100.0</td>
<td>22,570</td>
<td>93.2</td>
</tr>
<tr>
<td>South America²</td>
<td>6,761</td>
<td>100.0</td>
<td>6,069</td>
<td>89.8</td>
</tr>
</tbody>
</table>

**NOTE:** Age when the child arrived in the U.S. is calculated by subtracting the child’s year of birth from the year they entered the United States.

1. This figure, when added to, and subtracted from the percent, provides the 90 percent confidence interval.

2. Includes areas not shown separately.

Source: U.S. Census Bureau, American Community Survey 2008.

Table 4. Adopted children by characteristics of their adoptive parent and households: 2008

<table>
<thead>
<tr>
<th>Characteristics of household or adoptive parent¹</th>
<th>Internationally adopted children</th>
<th>U.S. native adopted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Total children</td>
<td>199,284</td>
<td>100.0</td>
</tr>
<tr>
<td>Living Arrangement of the Adoptive Parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married couple households</td>
<td>162,408</td>
<td>81.5</td>
</tr>
<tr>
<td>Male adoptive parent—no spouse present</td>
<td>3,893</td>
<td>2.0</td>
</tr>
<tr>
<td>With an unmarried partner</td>
<td>978</td>
<td>0.5</td>
</tr>
<tr>
<td>No unmarried partner present</td>
<td>2,915</td>
<td>1.5</td>
</tr>
<tr>
<td>Married—spouse absent</td>
<td>539</td>
<td>0.3</td>
</tr>
<tr>
<td>Divorced or widowed</td>
<td>1,488</td>
<td>0.7</td>
</tr>
<tr>
<td>Separated</td>
<td>293</td>
<td>0.1</td>
</tr>
<tr>
<td>Never married</td>
<td>595</td>
<td>0.3</td>
</tr>
<tr>
<td>Female adoptive parent—no spouse present</td>
<td>32,983</td>
<td>16.6</td>
</tr>
<tr>
<td>With an unmarried partner</td>
<td>4,314</td>
<td>2.2</td>
</tr>
<tr>
<td>No unmarried partner present</td>
<td>28,669</td>
<td>14.4</td>
</tr>
<tr>
<td>Married—spouse absent</td>
<td>1,605</td>
<td>0.8</td>
</tr>
<tr>
<td>Divorced or widowed</td>
<td>12,775</td>
<td>6.4</td>
</tr>
<tr>
<td>Separated</td>
<td>1,746</td>
<td>0.9</td>
</tr>
<tr>
<td>Never married</td>
<td>12,543</td>
<td>6.3</td>
</tr>
</tbody>
</table>

continues
Table 4. Adopted children by characteristics of their adoptive parent and households: 2008 (continued)

<table>
<thead>
<tr>
<th>Characteristics of household or adoptive parent</th>
<th>Internationally adopted children</th>
<th></th>
<th>U.S. native adopted</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Margin of Error²</td>
<td>Number</td>
</tr>
<tr>
<td>Household Income in 2007³</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0 or less</td>
<td>547</td>
<td>0.3</td>
<td>0.2</td>
<td>8,867</td>
</tr>
<tr>
<td>$1-$14,999</td>
<td>1,369</td>
<td>0.7</td>
<td>0.3</td>
<td>91,468</td>
</tr>
<tr>
<td>$15,000-$24,999</td>
<td>3,451</td>
<td>1.7</td>
<td>0.7</td>
<td>97,328</td>
</tr>
<tr>
<td>$25,000-$34,999</td>
<td>4,780</td>
<td>2.4</td>
<td>0.7</td>
<td>99,953</td>
</tr>
<tr>
<td>$35,000-$49,999</td>
<td>9,624</td>
<td>4.8</td>
<td>0.9</td>
<td>175,150</td>
</tr>
<tr>
<td>$50,000-$74,999</td>
<td>29,737</td>
<td>14.9</td>
<td>1.3</td>
<td>279,480</td>
</tr>
<tr>
<td>$75,000-$99,999</td>
<td>32,885</td>
<td>16.5</td>
<td>1.5</td>
<td>210,414</td>
</tr>
<tr>
<td>$100,000-$149,999</td>
<td>56,758</td>
<td>28.5</td>
<td>1.7</td>
<td>222,671</td>
</tr>
<tr>
<td>$150,000-$199,999</td>
<td>26,172</td>
<td>13.1</td>
<td>1.6</td>
<td>79,616</td>
</tr>
<tr>
<td>$200,000 or more</td>
<td>33,961</td>
<td>17.0</td>
<td>1.6</td>
<td>90,562</td>
</tr>
<tr>
<td>Median household income⁴</td>
<td></td>
<td>†</td>
<td>†</td>
<td>$67,807</td>
</tr>
<tr>
<td>In Poverty</td>
<td>4,556</td>
<td>2.3</td>
<td>0.7</td>
<td>189,675</td>
</tr>
</tbody>
</table>

continued
Table 4. Adopted children by characteristics of their adoptive parent and households: 2008 (continued)

<table>
<thead>
<tr>
<th>Characteristics of household or adoptive parent</th>
<th>Interracially adopted children</th>
<th>U.S. native adopted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Educational Attainment of the Adoptive Parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>882</td>
<td>0.4</td>
</tr>
<tr>
<td>High school graduate</td>
<td>9,401</td>
<td>4.7</td>
</tr>
<tr>
<td>Some college</td>
<td>39,303</td>
<td>19.7</td>
</tr>
<tr>
<td>Bachelor's degree</td>
<td>71,270</td>
<td>35.8</td>
</tr>
<tr>
<td>Graduate or professional school degree</td>
<td>78,428</td>
<td>39.4</td>
</tr>
<tr>
<td>Labor Force Participation of the Adoptive Parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In labor force</td>
<td>179,651</td>
<td>90.1</td>
</tr>
<tr>
<td>Employed</td>
<td>177,208</td>
<td>88.9</td>
</tr>
<tr>
<td>Unemployed</td>
<td>2,443</td>
<td>1.2</td>
</tr>
<tr>
<td>Not in labor force</td>
<td>19,633</td>
<td>9.9</td>
</tr>
<tr>
<td>Tenure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owns home</td>
<td>189,750</td>
<td>95.2</td>
</tr>
<tr>
<td>Rents home^5</td>
<td>9,534</td>
<td>4.8</td>
</tr>
</tbody>
</table>

† Not applicable.
1 The adoptive parent is the householder.
2 This figure, when added to, and subtracted from the percent, provides the 90 percent confidence interval.
3 This is adjusted household income—in 2008 dollars.
4 Median calculated using SAS9.
5 Includes those who occupy without cash payment.
Source: U.S. Census Bureau, American Community Survey, 2008
NOTE: Age when the child arrived in the U.S. is calculated by subtracting the child’s year of birth from the year they entered the United States.
For information on confidentiality protection, sampling error, nonsampling error, and definitions, see http://www.census.gov/acs/www/Downloads/data_documentation/Accuracy/accuracy2008.pdf
Table 5. Selected characteristics of adopted children: 2008

<table>
<thead>
<tr>
<th>Characteristic of Child</th>
<th>Internationally adopted children</th>
<th>Same race adopted children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>199,284</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Age at Interview</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 to 5 years</td>
<td>62,370</td>
<td>31.3</td>
</tr>
<tr>
<td>6 to 11 years</td>
<td>85,327</td>
<td>42.8</td>
</tr>
<tr>
<td>12 to 17 years</td>
<td>51,587</td>
<td>25.9</td>
</tr>
<tr>
<td><strong>Race and Hispanic Origin</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White alone</td>
<td>74,954</td>
<td>37.6</td>
</tr>
<tr>
<td>Black or African American alone</td>
<td>10,128</td>
<td>5.1</td>
</tr>
<tr>
<td>American Indian and Alaska Native alone</td>
<td>4,056</td>
<td>2.0</td>
</tr>
<tr>
<td>Asian alone</td>
<td>92,179</td>
<td>46.3</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander alone</td>
<td>2,165</td>
<td>1.1</td>
</tr>
<tr>
<td>Some other race alone</td>
<td>12,460</td>
<td>6.3</td>
</tr>
<tr>
<td>Two or more races</td>
<td>3,342</td>
<td>1.7</td>
</tr>
<tr>
<td>Hispanic or Latino (of any race)</td>
<td>32,885</td>
<td>16.5</td>
</tr>
<tr>
<td>White alone, not Hispanic or Latino</td>
<td>60,777</td>
<td>30.5</td>
</tr>
</tbody>
</table>

continued
Table 5. Selected characteristics of adopted children: 2008 (continued)

<table>
<thead>
<tr>
<th>Characteristic of Child</th>
<th>Internationally adopted children</th>
<th>Same race adopted children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>English Ability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 5 and over</td>
<td>150,590</td>
<td>75.6</td>
</tr>
<tr>
<td>Speaks non-English language at home²</td>
<td>9,970</td>
<td>6.6</td>
</tr>
<tr>
<td>Speaks English &quot;very well&quot;</td>
<td>5,797</td>
<td>3.8</td>
</tr>
<tr>
<td>Disability Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing disability</td>
<td>2,637</td>
<td>1.3</td>
</tr>
<tr>
<td>Vision disability</td>
<td>629</td>
<td>0.3</td>
</tr>
<tr>
<td>Age 5 and over</td>
<td>150,590</td>
<td>100.0</td>
</tr>
<tr>
<td>At least one disability</td>
<td>10,208</td>
<td>6.8</td>
</tr>
<tr>
<td>Physical disability²</td>
<td>999</td>
<td>0.7</td>
</tr>
<tr>
<td>Mental disability³,4</td>
<td>7,993</td>
<td>5.0</td>
</tr>
<tr>
<td>Self-care disability²</td>
<td>1,387</td>
<td>0.9</td>
</tr>
<tr>
<td>Multiple disabilities²,4</td>
<td>2,680</td>
<td>1.8</td>
</tr>
</tbody>
</table>

† Not applicable.
1 This figure, when added to, and subtracted from the percent, provides the 90 percent confidence interval.
2 These questions were asked only of people aged 5 and over.
3 The question asks if the person has difficulty learning, remembering, or concentrating.
4 This includes children with any combination of two or more of the disabilities listed above.
Source: U.S. Census Bureau, American Community Survey, 2008.
NOTE: For information on confidentiality protection, sampling error, nonsampling error, and definitions, see http://www.census.gov/acs/www/Downloads/data_documentation/Accuracy/accuracy2008.pdf
Interracial Adoptive Families and Their Children: 2008

Rose M. Kreider

Overview

Interracial adoption in the United States is an issue that has been contested as to the benefits for the children. There are few nationally representative data sources that can provide information about interracial adoptive families and how they might compare in basic demographic and socioeconomic characteristics with interracial families that were formed in other ways. Even estimates of the percentage of adopted children that are interracially adopted are very few.¹

This chapter will look at families in which, due to at least one child being adopted, the householder is of a different race than at least one of their children under 18. These families will be compared with interracial nonadoptive families. This chapter also contains a profile of the characteristics of adopted children whose race differs from that of their householder/parent.

Introduction and Definitions

In order to highlight families that are most often the focus of public policy related to adoption, I limit my sample to households that include at least one biological, step, or adopted child who is under 18. Tables that contain numbers of children represent never-married children under 18 who are the children of the householder.²

In this chapter, I use the word “family” to refer to a household that contains a householder who reports a never-married biological, step, or adopted child under 18 in their household. Adoptive families are those in which the householder has at least one adopted child under 18. Nonadoptive families are those in which the householder has at least one biological or stepchild under 18, but no adopted children under 18. Similarly, adopted children are the adopted children of the householder, while nonadopted children are the biological children or stepchildren of the householder. Since the householder is always a parent in this chapter, I will use the terms interchangeably.

¹ This paper is released to inform interested parties of ongoing research and to encourage discussion of work in progress. Any views expressed on statistical and methodological issues are those of the authors and not necessarily those of the U.S. Census Bureau.

² The householder is someone in whose name the home is rented or owned. I will use the term householder interchangeably with the term adoptive parent in this chapter. If the child lived with two parents, ACS data do not identify whether the second parent was the child’s biological, step, or adoptive parent.
**Definition of Interracial Families**

There are various definitions that can be used to determine whether a parent-child relationship is interracial. In this chapter, a family is referred to as interracial if the householder and at least one of their children under 18 are of a different race group, where the groups are:

1) White alone
2) Black alone
3) American Indian and Alaska Native alone
4) Asian alone or Native Hawaiian and Other Pacific Islander alone (referred to as Asian here)
5) Some Other Race alone
6) White/Black
7) White/American Indian or Alaska Native
8) White/Asian or White/Native Hawaiian and Other Pacific Islander
9) White/Some Other Race
10) Some other combination of race groups not mentioned above

If either the parent or child is in the tenth category listed above (multiple race combination not otherwise listed), the pair/family is considered to be interracial. In other words, an interracial adoptive family contains a householder who has at least one adopted child who is of a different race group, and an interracial nonadoptive family contains a householder who has at least one biological or stepchild who is of a different race group, but no adopted children. Only the race difference between the householder/parent and the child is checked, since we do not know whether the second parent is a biological, step, or adoptive parent to the child.

I include the most common multiracial combinations as race categories as not to count families as interracial if both the parent and the child identify as “White/Black,” for example. Of course, whether the family is interracial is most often defined by those outside the family, and since skin tones vary substantially within and between categories, some parents and children who may identify different race categories on the survey may not be viewed as interracial families by others, and vice versa.

**Data**

In 2008, “adopted son/daughter” was added to the American Community Survey (ACS), which has replaced the long form of the decennial census. ACS is in the field every month, and produces annualized estimates for the calendar year. ACS is a very large, nationally representative sample, interviewing over two million households annually. This provides an opportunity to look at interrallically adopted children and their families, which is not possible with the same level of detail from smaller surveys.3

The data in this chapter are from internal U.S. Census Bureau ACS 2008 data files. The internal file is about 50 percent larger than the public use microdata file, which allows more accurate estimates of a relatively small group, such as interrallically adopted children and their families.

**How were interracial families created?**

Families with children come to include members of different race groups in various ways. A couple who are of different races might have a child together, or a mother with a child of the same race might marry a man of a different race, creating an interracial family. A parent of one race might adopt a child of another race. Since ACS data are representative of interracial families of all of these types, Table 1 shows the distribution of interracial families and whether they were formed by birth (biological child’s race differs from parent’s race), marriage (stepchild’s race differs from parent’s race), or adoption (adopted child’s race differs from parent’s race).4

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3 See the chapter in this Factbook on internationally adopted children for a discussion of how the estimate of adopted children in ACS 2008 compares with other data sources.

4 All comparative statements in this presentation have undergone statistical testing, and unless otherwise noted, all comparisons are statistically significant at the 90 percent confidence level. The data are subject to error arising from a variety of sources, including sampling error, nonsampling error, and model error.
Out of a total of 34.7 million households in which the householder lived with at least one of their children under 18, there were an estimated 2.8 million families, or eight percent, in which the householder was of a different race than at least one of their children. Although interracial adoptive families are often the focus of policy, most interracial families are created by birth (83 percent). The next most common way interracial families were created was by adoption (eight percent). Six percent of interracial families came to include parents and children of different races through marriage. About one percent of interracial families included parents who differed in race from both a biological and adopted child (birth and adoption). The remaining three percent of interracial families were formed by some combination of birth, marriage, and adoption. While interracial adoptive families are a relatively small percentage of all interracial families, they are the subject of much debate.

Are interracial adoptive families prevalent in different areas than nonadoptive interracial families?

Previous research has shown that interracially married couples are likely to live in the West (Qian, 1999; Simmons & O’Connell, 2003), so since most of the interracial nonadoptive families were formed by birth, we would expect a higher percentage of interracial families to live in the West. Figure 1 shows that one-third (34 percent) of interracial nonadoptive families live in the West, while one-quarter of the interracial adoptive families live there. A higher percentage of interracial nonadoptive families live in the South (33 percent) compared with interracial adoptive families (29 percent). Interracial adoptive families live in the Northeast at a higher rate than nonadoptive interracial families (19 percent compared with 14 percent). They also have a higher percentage living in the Midwest (27 percent) than nonadoptive interracial families (19 percent). This reflects the overlap between interracial adoptive families and families who adopt foreign-born children, who are more likely to live in the Northeast and Midwest (see chapter on internationally adopted children in this volume). Thirty-eight percent of interracial adoptive families have children who were born abroad. These families are more likely to be interracial than adoptive families in which the child is a U.S. native (Kreider, 2007). The Northeast and Midwest have less racial diversity than the South and West, so it’s possible that interracial families in those areas may elicit more attention.

Figure 1. Percent distribution of interracial families, by type and region: 2008

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5 In the chapter published in Adoption Factbook IV (see Kreider, 2007) I used a seven category definition of race: White alone, Black alone, American Indian or Alaska Native alone, Asian alone, Native Hawaiian and other Pacific Islander alone, Some Other Race alone, and Two or More races. If either the parent or child was multiracial (Two or More races), the pair/family was considered to be interracial. Using the same definition with ACS 2008 data would result in 3.0 million, or 8.9 percent of households in which the householder lived with their child under 18 being categorized as interracial.
What percentage of adoptive and nonadoptive families with children under 18 are interracial?

Table 2 shows the percentage of family households with children of the householder under 18 that are a different race than their parent, by region and division for adoptive and nonadoptive families. The table also provides a measure of racial diversity in the geographic area—the percentage of the overall population in that area who are nonwhite. The idea is to see if areas with higher percentages of racial minorities are also the areas that have a higher percentage of interracial families, or whether some areas have a relatively high percentage of adoptive families that are interracial without a corresponding higher percentage of nonwhite individuals overall.

A frequent topic of research is the adjustment of adopted children and their identity formation (Hjern, Lindblad & Vinnerljung, 2002; Scherman & Harré, 2008). Attention is also paid to parents’ ability to socialize interracially adopted children with respect to their birth culture (Johnston, et al., 2007; Samuels 2009; Vonk & Massatti, 2008). Presumably formation of a racial identity may be more complicated for children of color when they live in areas where they are unlikely to interact with others of their race.

Overall, 22 percent of adoptive families were interracial, while just eight percent of nonadoptive families were interracial. For adoptive families, the percentages of families that were interracial did not vary much by region, with the exception of families in the South. One-quarter of adoptive families in the Northeast, Midwest, and West were interracial, with the South having a lower percentage (18 percent). For nonadoptive families, the region with the highest percentage of interracial families was the West, at 11 percent, with the next highest percentage in the South, at seven percent, while the Northeast and Midwest had the lowest percentages (six percent).

The remainder of the table shows the percentage of families that were interracial by census division. To see a map of the location of the divisions, see http://www.census.gov/geo/www/us_regdiv.pdf While all of the percentage estimates for adoptive families differ statistically from the estimates for nonadoptive families, many of the estimates do not differ statistically when comparing across divisions within type of family.

The right-most column of Table 2 shows the percent nonwhite for the population in the geographic area listed. The data show that the division with the highest percentage of interracial nonadoptive families—the Pacific, at 12 percent—is the also the division with the highest percentage of the population who are nonwhite (34 percent). This makes sense given that interracial nonadoptive families are mainly created when men and women of different races have children together, and these couples are more likely to meet in areas in which a higher percentage of adults are nonwhite. Of course, given residential segregation, simply living in an area with a higher percentage of the population who is nonwhite does not guarantee that any particular individuals interact with members of different race groups. But for adoptive families, the Pacific is not the division with the highest percentage that is interracial. There are several divisions that share a relatively high percentage of adoptive families that are interracial—New England, East North Central, West North Central, and the Pacific.

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6 Using the seven-category race definition used in the chapter for Adoption Factbook IV with ACS 2008 data results in 22.8 percent of adoptive families being counted as interracial, and 8.4 percent of nonadoptive families being counted as interracial.

7 These estimates do not differ statistically. Also, the estimate of the percentage of adoptive families that are interracial in the Pacific division does not differ statistically from that for the Mountain division.
To what extent are adopted children the only person of color within their household?

Table 3 looks more closely at the children by whether they were white and whether they lived in a household that had other members who were nonwhite. For the 62 percent of adopted children who were white (995,535), eight percent of them lived in a household in which at least one other household member was nonwhite. Five percent of white adopted children had a sibling who was nonwhite.5 For the 39 percent of adopted children who were nonwhite (624,242), most lived with others who were nonwhite. Eighty-nine percent had at least one other household member who was nonwhite. For 74 percent of the nonwhite adopted children, at least one sibling was also nonwhite. So nonwhite adopted children who were the only nonwhite person in their household were the clear minority (11 percent). At the same time, the percentage of adopted nonwhite children who lived only with white household members (11 percent) was higher than the corresponding percentage for nonwhite biological children or stepchildren (one percent).

What are the most common interracial adoptive child/parent race combinations?

Given the large sample size of the ACS, we can look at particular child/parent race combinations to see which are more common. First we look at the overall estimate of the percentage of adopted children that are interracially adopted. Out of 1.6 million adopted children, 350,209 were interracially adopted, or 22 percent.

There are very few estimates of the percentage of adopted children in the U.S. who are interracially adopted. The Current Population Survey (CPS), a large nationally representative survey, asks directly whether the child’s mother and father are present, and also asks the type of relationship they have with the child, whether biological, step, or adoptive. The CPS 2008 Annual Social and Economic Supplement data estimated that 25 percent of children under 18 were of a different race than their adoptive mother, and 25 percent of children were of a different race than their adoptive father.9 The 2007 National Survey of Adoptive Parents (NSAP) estimated that 40 percent of adopted children were involved in a transracial, transethnic, or transcultural adoption (Vandivere, Malm & Radel, 2009). Of course this definition is much more inclusive, since not only race was considered, so it is not surprising that the percentage is significantly higher than that estimated in the ACS, which considers only race categories. In addition, the NSAP definition looked at whether the child was of a different race group than both parents, if two were present, allowing for a higher percentage by default.

Table 4 details the five most common child and householder/parent race combinations for interracially adopted children. The child’s race is listed first, followed by that of their householder/parent. Of the 350,209 interracially adopted children, 34 percent were Asian or Pacific Islanders adopted by a white parent. The majority of these 117,184 children (84 percent) were foreign-born. The next largest group was black children who were adopted by a white parent—18 percent. The majority of these children were U.S. natives; just 17 percent were foreign-born. Another 11 percent of the children were identified as “White/Black,” and had been adopted by a white parent. Not significantly different from the percentage of interracially adopted children who were “White/Black” with a white parent was the percentage of interracially adopted children who had a sibling who was a member of a different race group than both parents, if two were present.

---

5 Grouping together all those who are not white alone disguises the fact that a child who is black may have a sibling who is Asian, and these two children may face very different issues as they form their racial identity.

9 Current Population Survey is not as large as ACS, and cannot show the same level of race detail. Categories used for this definition were: White alone, Black alone, Asian alone, and all others. If the parent and child differed on these categories, or if either or both were in the “all others” category, then the pair was considered interracial. The percentage of children of a different race than their adoptive mother in CPS did not differ statistically from the percentage of children who were of a different race than their adoptive father. The CPS estimates for percent with an adoptive mother who are interracially adopted differs statistically from the ACS 2008 estimate of the percentage of adopted children who are interracially adopted.
percentage who were “Some Other Race” with a white parent (10 percent). The fifth largest group of children consisted of American Indian or Alaska Natives who were adopted by a white parent (four percent). Together, these five groups made up 76 percent of all interracially adopted children.

**How do interracially adopted children compare with same-race adopted children in demographic characteristics?**

Table 5 profiles selected demographic characteristics of interracially adopted children compared with their same-race counterparts. Interracially adopted children tended to be a bit younger than same-race adopted children. While 30 percent of the interracially adopted children were age five or younger, this was true of 25 percent of those who were the same race as their parent. The younger age structure for interracially adopted children as a group likely reflects the fact that many are internationally adopted, a group that tends to have a relatively younger age at adoption compared with U.S. native children who are adopted.

The race distributions of the two groups are markedly different. Given that the majority (79 percent) of householders in the U.S. are white, it is not surprising that 77 percent of the same-race adopted children are also white. Of the interracially adopted children, 34 percent were Asian or Pacific Islander, 20 percent were black, 13 percent where “White/Black,” and 11 percent were “Some Other Race.” On federal surveys, race is a separate question from whether or not the respondent is Hispanic. The “Some Other Race” category overlaps heavily with those who report being Hispanic. For interracially adopted children, 87 percent of those reported as “Some Other Race” were also reported as Hispanic.

As mentioned before, the large percentage of adopted Asian and Pacific Islander children represent international adoptions, often of children born in China or Korea. The 33 percent of the interracially adopted children who were black or “White/Black” were mainly U.S. natives, many adopted through the foster care system, in which African Americans are overrepresented (Pérez, O’Neil, & Gesiriech, 2003). A substantial percentage (24 percent) of the interracially adopted children were multiracial. A little over half of the multiracial children were “White/Black.”

One in five of the interracially adopted children were Hispanic, compared with 18 percent of the same-race adopted children. One in five of the interracially adopted children differed from their parent in terms of whether or not they were Hispanic. That is, 20 percent of the children were Hispanic and their parent was not, or vice versa. This group overlaps heavily with the 20 percent of the group of children who were Hispanic, but it is not a one-to-one match since some pairs were non-Hispanic children with a Hispanic parent (3.3 percent of the interracially adopted children). Some people would consider children who differed in Hispanic origin from their parent to have been interracially adopted. For the purpose of this chapter, I have used only categories the Census Bureau considers “race” groups when defining interracial adoption. Of course, since many of the Hispanic children (46 percent) were reported as “Some Other Race,” and their parent is often white (for 91 percent of the “Some Other Race” children), these children are still counted as interracially adopted under the definition used here.

Overall, 38 percent of the interracially adopted children were foreign-born, compared with 10 percent of their same-race counterparts. This reflects the race difference between white U.S. parents and the racial makeup of the birth countries of most of the internationally adopted children.

The ACS 2008 included some basic measures of disability. Most of these questions are asked of people age five and over. Of interracially adopted children age five to 17, about 12 percent had at least one disability. This was not different from
the 11 percent of same-race adopted children with a disability. Looking at the types of disability, a higher percentage of interracially adopted children (age zero to 17) had a hearing disability or a self-care disability, although the rates for these disabilities were very low.\textsuperscript{10} A higher percentage of interracially adopted children age five to 17 had multiple disabilities (four percent) than same-race adopted children (three percent), although again, these rates were low.\textsuperscript{11}

Characteristics of the households in which the children lived, as well as characteristics of their adoptive parents, are shown in Table 6. A higher percentage of interracially adopted children lived with married parents: 77 percent, compared with 72 percent of their same-race counterparts. The next largest group of children lived with a mother who did not have a spouse present: 19 percent of the interracially adopted children and 21 percent of the same-race adopted children. A higher proportion of the interracially adopted children lived with a mother who had an unmarried partner in the household: four percent of the interracially adopted children compared with two percent of the same-race adopted children.

Interracially adopted children lived in households with relatively higher incomes than their same-race counterparts. While 42 percent of them lived in households with at least $100,000 in income, this was true for 30 percent of the same-race adopted children. Household poverty rates for the two groups showed the same contrast, with eight percent of interracially adopted children living in a household below the poverty level, compared with 14 percent of same-race adopted children. This compares with 18 percent of biological and stepchildren of the householder, who lived in households below the poverty level.

A higher percentage of interracially adopted children than same-race adopted children lived with parents who had advanced educational levels. More than half of the interracially adopted children lived with a parent who had at least a Bachelor’s degree, compared with 34 percent of the same-race adopted children. Indeed, 28 percent of the interracially adopted children had a parent with a graduate or professional degree, while this was true for 14 percent of their same-race counterparts.

Interracially adopted children more often lived with a parent who was employed (84 percent) than did same-race adopted children (80 percent). A higher percentage of interracially adopted children lived in homes owned by their parent (86 percent) than did same-race adopted children (74 percent).

**Conclusion**

Overall, nine percent of interracial families (defined as households in which the parent is a different race than at least one child under 18) were interracial adoptive families. Interracial adoptive families were more likely than nonadoptive interracial families to live in the Northeast and Midwest. Interracial adoptive families were more likely to live in areas with a relatively lower percentage of nonwhite individuals, while interracial nonadoptive families were more likely to live in areas with a relatively higher nonwhite percentage. Still, the vast majority of nonwhite adopted children lived in a household in which there was at least one other nonwhite person (89 percent).

Compared with same-race adopted children, interracially adopted children tended to be younger, were more likely to be nonwhite, and were more likely to be foreign-born. Overall, their disability rates were about the same as for same-race adopted children, although a higher percentage of interracially adopted children had multiple disabilities. Interracially adopted children more often lived with married parents, and lived in households with relatively higher income and lower poverty rates than did same-race adopted children. Interracially adopted children lived with parents who had advanced educational levels. More than half of the interracially adopted children lived with a parent who had at least a Bachelor’s degree, compared with 34 percent of the same-race adopted children. Indeed, 28 percent of the interracially adopted children had a parent with a graduate or professional degree, while this was true for 14 percent of their same-race counterparts.

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parents who had more education and were more likely to be employed than parents of same-race adopted children. Because of its large sample size, ACS data can provide a detailed look at the characteristics of interracially adopted children and their families, information which is available from very few sources that represent the United States as a whole.

References


### Table 1. Interracial families\(^1\) with own child under 18, by type: 2008

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number</th>
<th>Percent</th>
<th>Margin of error(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL Interracial Families</td>
<td>2,833,285</td>
<td>100.0</td>
<td>†</td>
</tr>
<tr>
<td>Formed by birth</td>
<td>2,340,839</td>
<td>82.6</td>
<td>0.37</td>
</tr>
<tr>
<td>Formed by marriage</td>
<td>156,900</td>
<td>5.5</td>
<td>0.24</td>
</tr>
<tr>
<td>Formed by adoption</td>
<td>232,731</td>
<td>8.2</td>
<td>0.22</td>
</tr>
<tr>
<td>Formed by birth and adoption</td>
<td>24,477</td>
<td>0.9</td>
<td>0.09</td>
</tr>
<tr>
<td>Formed by birth and marriage and adoption, or all three</td>
<td>78,338</td>
<td>2.6</td>
<td>0.18</td>
</tr>
</tbody>
</table>

\(†\) Not applicable.

\(^1\) Interracial families are defined here by a difference in race between the householder/parent and their child under 18.

\(^2\) This figure, added to, or subtracted from the percent, provides the 90-percent confidence interval on the preceding percentage.

Source: U.S. Census Bureau, American Community Survey, 2008.

NOTE: For information on confidentiality protection, sampling error, nonsampling error, and definitions, see [http://www.census.gov/acs/](http://www.census.gov/acs/)
### Table 2. Number and percent of families, by type, for the United States, regions, and states: 2008

<table>
<thead>
<tr>
<th>Area</th>
<th>Total adoptive families</th>
<th>Interracial adoptive families</th>
<th>Total nonadoptive families</th>
<th>Interracial nonadoptive families</th>
<th>Percent nonwhite for area²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Margin of error¹</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>United States</td>
<td>1,161,042</td>
<td>259,296</td>
<td>22.3</td>
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<td>33,565,979</td>
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<tr>
<td>Region</td>
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<tr>
<td>Northeast</td>
<td>206,110</td>
<td>49,499</td>
<td>24.0</td>
<td>1.44</td>
<td>5,938,875</td>
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<td>Midwest</td>
<td>278,448</td>
<td>70,410</td>
<td>25.3</td>
<td>1.33</td>
<td>7,540,146</td>
</tr>
<tr>
<td>South</td>
<td>413,537</td>
<td>74,902</td>
<td>18.1</td>
<td>0.93</td>
<td>12,375,585</td>
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<td>West</td>
<td>262,947</td>
<td>64,485</td>
<td>24.5</td>
<td>1.17</td>
<td>7,711,373</td>
</tr>
<tr>
<td>Division</td>
<td></td>
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<td></td>
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<tr>
<td>New England</td>
<td>63,083</td>
<td>17,341</td>
<td>27.5</td>
<td>2.57</td>
<td>1,567,207</td>
</tr>
<tr>
<td>Mid Atlantic</td>
<td>143,027</td>
<td>32,158</td>
<td>22.5</td>
<td>1.62</td>
<td>4,371,668</td>
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<tr>
<td>East North Central</td>
<td>185,863</td>
<td>46,181</td>
<td>24.8</td>
<td>1.59</td>
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<td>West North Central</td>
<td>92,585</td>
<td>24,229</td>
<td>26.2</td>
<td>2.34</td>
<td>2,325,156</td>
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<tr>
<td>South Atlantic</td>
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<td>40,956</td>
<td>19.0</td>
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<td>East South Central</td>
<td>68,841</td>
<td>10,711</td>
<td>15.6</td>
<td>1.86</td>
<td>2,014,416</td>
</tr>
<tr>
<td>West South Central</td>
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<td>23,635</td>
<td>18.0</td>
<td>1.50</td>
<td>4,072,119</td>
</tr>
<tr>
<td>Mountain</td>
<td>87,872</td>
<td>20,215</td>
<td>23.0</td>
<td>1.91</td>
<td>2,373,723</td>
</tr>
<tr>
<td>Pacific</td>
<td>175,075</td>
<td>44,270</td>
<td>25.3</td>
<td>1.52</td>
<td>5,337,650</td>
</tr>
</tbody>
</table>

**NOTE:** Families included in this table are households that have at least one never married adopted child of the householder who is under 18 (adoptive families) or at least one never married biological or stepchild of the householder who is under 18, and no adopted children under 18 (nonadoptive families). There are 7,341 weighted interracial families that contain a householder who differs in race from one of their biological or stepchildren, but also had adopted children who were the same race as they were. These families are considered same race adoptive families, and are not shown with the interracial nonadoptive families in this chapter. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see [http://www.census.gov/acs/www/Downloads/data_documentation/Accuracy/accuracy2008.pdf](http://www.census.gov/acs/www/Downloads/data_documentation/Accuracy/accuracy2008.pdf).

1 This figure, added to, or subtracted from the percent, provides the 90-percent confidence interval on the preceding percentage.

2 The denominator for this percentage is the total population for the geographic area listed.

Source: U.S. Census Bureau, American Community Survey, 2008.
Table 3. Children, by whether they live in an interracial household: 2008

<table>
<thead>
<tr>
<th>Subject</th>
<th>Adopted Children</th>
<th>Biological and Stepchildren</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Total</td>
<td>1,619,777</td>
<td>100.0</td>
</tr>
<tr>
<td>Children who are white</td>
<td>995,535</td>
<td>100.0</td>
</tr>
<tr>
<td>At least one household member is nonwhite</td>
<td>77,310</td>
<td>7.8</td>
</tr>
<tr>
<td>At least one sibling is nonwhite</td>
<td>45,010</td>
<td>4.5</td>
</tr>
<tr>
<td>Children who are nonwhite</td>
<td>624,242</td>
<td>100.0</td>
</tr>
<tr>
<td>Child is only nonwhite household member</td>
<td>68,674</td>
<td>11.0</td>
</tr>
<tr>
<td>Child and at least one household member are nonwhite</td>
<td>555,568</td>
<td>89.0</td>
</tr>
<tr>
<td>Child and at least one sibling are nonwhite</td>
<td>459,244</td>
<td>73.6</td>
</tr>
</tbody>
</table>

† Not applicable.

¹ This figure, added to, or subtracted from the percent, provides the 90-percent confidence interval on the preceding percentage.

Source: U.S. Census Bureau, American Community Survey, 2008

NOTE: For information on confidentiality protection, sampling error, nonsampling error, and definitions, see http://www.census.gov/acs/www/Downloads/data_documentation/Accuracy/accuracy2008.pdf
### Table 4. Five most common interracial adoptive child-parent combinations: 2008

<table>
<thead>
<tr>
<th>Rank</th>
<th>Race Combination¹</th>
<th>Number</th>
<th>Percent</th>
<th>Margin of error²</th>
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<tr>
<td></td>
<td>Total adopted children</td>
<td>1,619,777</td>
<td>†</td>
<td>†</td>
</tr>
<tr>
<td></td>
<td>Total interracially adopted children</td>
<td>350,209</td>
<td>100.0</td>
<td>†</td>
</tr>
<tr>
<td>1</td>
<td>Asian Pacific Islander - White</td>
<td>117,184</td>
<td>33.5</td>
<td>1.58</td>
</tr>
<tr>
<td>2</td>
<td>Black - White</td>
<td>63,016</td>
<td>18.0</td>
<td>1.38</td>
</tr>
<tr>
<td>3</td>
<td>White/Black - White</td>
<td>37,659</td>
<td>10.8</td>
<td>1.03</td>
</tr>
<tr>
<td>4</td>
<td>Some other race - White</td>
<td>33,468</td>
<td>9.6</td>
<td>1.02</td>
</tr>
<tr>
<td>5</td>
<td>American Indian or Alaskan Native - White</td>
<td>14,052</td>
<td>4.0</td>
<td>0.56</td>
</tr>
</tbody>
</table>

¹ Not applicable.

¹ Child’s race appears first, followed by the adoptive parent’s race.

² This figure, added to, or subtracted from the estimate, provides the 90-percent confidence interval on the preceding percentage.

NOTE: Only groups with at least 10,000 weighted children are shown due to small sample size of other groups. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see [http://www.census.gov/acs/www/Downloads/data_documentation/Accuracy/accuracy2008.pdf](http://www.census.gov/acs/www/Downloads/data_documentation/Accuracy/accuracy2008.pdf)

Source: U.S. Census Bureau, American Community Survey, 2008.
### Table 5. Characteristics of adopted children under 18: 2008

| Characteristic of child | Interracially adopted children | | Same race adopted children | | | |
|-------------------------|-----------------------------|---|-----------------------------|---|---|
|                         | Number | Percent | Margin of error | Number | Percent | Margin of error |
| Total                   | 350,209 | 100.0 |     | 1,269,568 | 100.0 |     |
| **Age of Child**        | | | | | | |
| 0-2 years               | 39,609  | 11.3* | 0.8 | 131,420 | 10.4 | 0.5 |
| 3-5 years               | 65,047  | 18.6* | 1.2 | 183,400 | 14.4 | 0.6 |
| 6-8 years               | 69,610  | 19.9* | 1.0 | 204,853 | 16.1 | 0.5 |
| 9-11 years              | 68,415  | 19.5  | 1.0 | 238,605 | 18.8 | 0.5 |
| 12-14 years             | 59,408  | 17.0* | 1.1 | 247,885 | 19.5 | 0.6 |
| 15-17 years             | 48,120  | 13.7* | 0.9 | 263,405 | 20.7 | 0.6 |
| **Race and Hispanic Origin of Child** | | | | | | |
| White alone             | 24,153  | 6.9* | 0.8 | 971,382 | 76.5 | 0.7 |
| Black or African American alone | 69,260 | 19.8* | 1.4 | 188,720 | 14.9 | 0.6 |
| American Indian and Alaska Native alone | 15,346 | 4.4* | 0.6 | 12,111 | 1.0 | 0.2 |
| Asian or Pacific Islander alone | 120,349 | 34.4* | 1.6 | 35,596 | 2.8 | 0.3 |
| Some other race alone   | 36,827  | 10.5* | 1.0 | 55,726 | 4.4 | 0.4 |
| Two or more races       | 84,274  | 24.1* | 1.5 | 6,033 | 0.5 | 0.1 |
| White-Black             | 45,935  | 13.1* | 1.1 | 1,827 | 0.1 | 0.1 |
| White-American Indian and Alaska Native | 8,328 | 2.4* | 0.6 | 2,410 | 0.2 | 0.1 |
| White-Asian and Pacific Islander | 9,084 | 2.6* | 0.4 | 690 | 0.1 | 0.0 |
| White-Some other race   | 6,405   | 1.8* | 0.4 | 1,106 | 0.1 | 0.0 |
| Other multiple races    | 14,522  | 4.1* | 0.6 | 0 | 0.0 | - |
| Hispanic or Latino (of any race) | 69,926 | 20.0* | 1.2 | 222,785 | 17.5 | 0.7 |
| White alone, not Hispanic or Latino | 18,898 | 5.4* | 0.8 | 809,545 | 63.8 | 0.8 |
| Child Hispanic, householder non-Hispanic, or child non-Hispanic, householder Hispanic | 69,911 | 19.8* | 1.07 | 84,312 | 6.6 | 0.40 |
| Foreign born             | 134,587 | 38.4* | 1.5 | 129,681 | 10.2 | 0.5 |

*continued*
Table 5. Characteristics of adopted children under 18: 2008 (continued)

<table>
<thead>
<tr>
<th>Characteristic of child</th>
<th>Inter racially adopted children</th>
<th>Same race adopted children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Disability Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing disability</td>
<td>4,953</td>
<td>1.4*</td>
</tr>
<tr>
<td>Vision disability</td>
<td>3,626</td>
<td>1.0</td>
</tr>
<tr>
<td>Age 5 to 17</td>
<td>267,258</td>
<td>100.0</td>
</tr>
<tr>
<td>At least one disability</td>
<td>30,803</td>
<td>11.5</td>
</tr>
<tr>
<td>Physical disability²</td>
<td>3,556</td>
<td>1.3</td>
</tr>
<tr>
<td>Mental disability²,³</td>
<td>26,017</td>
<td>9.7</td>
</tr>
<tr>
<td>Self-care disability²</td>
<td>6,368</td>
<td>2.4*</td>
</tr>
<tr>
<td>Multiple disabilities²,⁴</td>
<td>9,557</td>
<td>3.6*</td>
</tr>
</tbody>
</table>

† Not applicable.

1 This figure, add to, or subtracted from the percent provides the 90 percent confidence interval on the preceding percentage.
2 These questions were asked only of people aged 5 and over.
3 The question asks if the person has difficulty learning, remembering, or concentrating.
4 This includes children age 5 to 17 with any combination of two or more of any of the disabilities.

* Indicates that the difference between the percentage for inter racially adopted and same race adopted children is statistically significant at the p>.10 level.

Source: U.S. Census Bureau, American Community Survey, 2008

NOTE: For information on confidentiality protection, sampling error, nonsampling error, and definitions, see http://www.census.gov/acs/www/Downloads/ACS/accuracy2008.pdf
Table 6. Characteristics of the adoptive parent of adopted children under 18: 2008

<table>
<thead>
<tr>
<th>Total children</th>
<th>Interracially adopted children</th>
<th>Same race adopted children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Percent</td>
<td>Margin of error</td>
</tr>
<tr>
<td>350,209</td>
<td>100.0</td>
<td>1,269,568</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living Arrangement of the Adoptive Parent</th>
<th>Number</th>
<th>Percent</th>
<th>Margin of error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married couple households</td>
<td>271,074</td>
<td>77.4</td>
<td>1.56</td>
</tr>
<tr>
<td>Male adoptive parent—no spouse present</td>
<td>13,472</td>
<td>3.8</td>
<td>0.58</td>
</tr>
<tr>
<td>With an unmarried partner</td>
<td>4,826</td>
<td>1.4</td>
<td>0.37</td>
</tr>
<tr>
<td>No unmarried partner present</td>
<td>8,646</td>
<td>2.5</td>
<td>0.49</td>
</tr>
<tr>
<td>Married—spouse absent</td>
<td>954</td>
<td>0.3</td>
<td>0.28</td>
</tr>
<tr>
<td>Divorced or widowed</td>
<td>4,975</td>
<td>1.4</td>
<td>0.28</td>
</tr>
<tr>
<td>Separated</td>
<td>990</td>
<td>0.3</td>
<td>0.14</td>
</tr>
<tr>
<td>Never married</td>
<td>2,092</td>
<td>0.6</td>
<td>0.25</td>
</tr>
<tr>
<td>Female adoptive parent—no spouse present</td>
<td>65,663</td>
<td>18.7</td>
<td>1.41</td>
</tr>
<tr>
<td>With an unmarried partner</td>
<td>12,112</td>
<td>3.5</td>
<td>0.60</td>
</tr>
<tr>
<td>Married—spouse absent</td>
<td>4,246</td>
<td>1.2</td>
<td>0.28</td>
</tr>
<tr>
<td>Divorced or widowed</td>
<td>990</td>
<td>0.3</td>
<td>0.14</td>
</tr>
<tr>
<td>Separated</td>
<td>2,092</td>
<td>0.6</td>
<td>0.25</td>
</tr>
<tr>
<td>Never married</td>
<td>5,351</td>
<td>1.5</td>
<td>0.25</td>
</tr>
<tr>
<td>Married—spouse absent</td>
<td>3,653</td>
<td>1.0</td>
<td>0.31</td>
</tr>
<tr>
<td>Divorced or widowed</td>
<td>2,337</td>
<td>0.7</td>
<td>0.14</td>
</tr>
<tr>
<td>Separated</td>
<td>4,344</td>
<td>1.2</td>
<td>0.37</td>
</tr>
<tr>
<td>Never married</td>
<td>2,927</td>
<td>0.8</td>
<td>0.08</td>
</tr>
</tbody>
</table>

continued
Table 6. Characteristics of the adoptive parent of adopted children under 18: 2008 (continued)

| Household Income in 2007² | Interracially adopted children | | Same race adopted children | |
|---------------------------|---------------------------------|---------------------------------|---------------------------------|
|                           | Number  | Percent  | Margin of error¹ | Number  | Percent  | Margin of error¹ | |
| $0 or less                | 1,866  | 0.5      | 0.30             | 7,786  | 0.6      | 0.15             | |
| $1-$14,999                | 11,019 | 3.1*     | 0.61             | 86,226 | 6.8      | 0.50             | |
| $15,000-$24,999           | 14,065 | 4.0*     | 0.68             | 93,325 | 7.4      | 0.51             | |
| $25,000-$34,999           | 16,860 | 4.8*     | 0.81             | 96,314 | 7.6      | 0.52             | |
| $35,000-$49,999           | 30,405 | 8.7*     | 0.83             | 161,887| 12.8     | 0.71             | |
| $50,000-$74,999           | 67,966 | 19.4     | 1.41             | 250,916| 19.8     | 0.65             | |
| $75,000-$99,999           | 61,861 | 17.7*    | 1.16             | 188,605| 14.9     | 0.59             | |
| $100,000-$149,999         | 78,068 | 22.3*    | 1.37             | 210,073| 16.5     | 0.61             | |
| $150,000-$199,999         | 31,708 | 9.1*     | 0.95             | 79,764 | 6.3      | 0.44             | |
| $200,000 or more          | 36,391 | 10.4*    | 0.91             | 94,672 | 7.5      | 0.49             | |

Median household income³

| Below the poverty level | 27,215 | 7.8* | 1.02 | 178,742 | 14.1 | 0.73 |

Educational Attainment of the Adoptive Parent

| Less than high school | 15,441 | 4.4* | 0.76 | 157,877 | 12.4 | 0.64 |
| High school graduate  | 42,253 | 12.1* | 1.02 | 277,730 | 21.9 | 0.84 |
| Some college          | 101,444| 29.0* | 1.49 | 399,622 | 31.5 | 0.81 |
| Bachelor’s degree     | 92,422 | 26.4* | 1.35 | 256,531 | 20.2 | 0.73 |
| Graduate or professional school degree | 98,649 | 28.2* | 1.48 | 177,898 | 14.0 | 0.51 |

continued
### Table 6. Characteristics of the adoptive parent of adopted children under 18: 2008 (continued)

<table>
<thead>
<tr>
<th></th>
<th>Interracially adopted children</th>
<th>Same race adopted children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td><strong>Labor Force Participation of the Adoptive Parent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In labor force</td>
<td>300,832</td>
<td>85.9*</td>
</tr>
<tr>
<td>Employed</td>
<td>293,772</td>
<td>83.9*</td>
</tr>
<tr>
<td>Unemployed</td>
<td>7,060</td>
<td>2.0*</td>
</tr>
<tr>
<td>Not in labor force</td>
<td>49,377</td>
<td>14.1*</td>
</tr>
<tr>
<td><strong>Tenure of the Adoptive Parent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owns home</td>
<td>300,286</td>
<td>85.7*</td>
</tr>
<tr>
<td>Rents home⁴</td>
<td>49,923</td>
<td>14.3*</td>
</tr>
</tbody>
</table>

† Not applicable.
1 This figure, added to, or subtracted from the percent, provides the 90 percent confidence interval.
2 This is adjusted household income—in 2008 dollars.
3 Median calculated using SAS9.
4 Includes those who occupy without cash payment.
* Indicates that the difference between the percentage for interracially adopted and same race adopted children is statistically significant at the p>.10 level.

Source: U.S. Census Bureau, American Community Survey, 2008

For information on confidentiality protection, sampling error, nonsampling error, and definitions, see http://www.census.gov/acs/www/Downloads/data_documentation/Accuracy/accuracy2008.pdf
Adoption USA: Summary and Highlights of a Chartbook on the National Survey of Adoptive Parents

Sharon Vandivere, Karin Malm and Amy McLindon

This article was originally published as NCFA Adoption Advocate No. 22.

Introduction

The 2007 National Survey of Adoptive Parents (NSAP) is the first large, nationally representative survey of adoptive families across adoption types. The NSAP was conducted as a collaboration among the Office of the Assistant Secretary for Planning and Evaluation (ASPE), the Administration for Children & Families (ACF), and the National Center for Health Statistics (NCHS), all agencies within the U.S. Department of Health and Human Services. Data were collected via telephone interviews during 2007–2008 and provide information about the characteristics, adoption experiences, and wellbeing of adopted children and their families in the United States. The NSAP was conducted as an add-on to the National Survey of Children’s Health (NSCH) that is it surveyed NSCH respondents identified as adoptive parents. Comparable data for the general population of children in the United States were drawn from the NSCH.

This article highlights some of the findings that can be explored in greater detail in Adoption USA: A Chartbook Based on the 2007 National Survey of Adoptive Parents (Vandivere, Malm, & Radel, 2009). Detail on the survey’s methodology is also available in the chartbook. Focusing on key population characteristics of adopted children and their families, this article makes comparisons between adopted children and the general population of children in the United States and between children across adoption types (foster care adoption, private domestic adoption, and international adoption).

In 2007, about two percent of all U.S. children are adopted. Among all adopted children—with the exclusion of those living with at least one biological parent (i.e., in stepfamilies)—one out of four was adopted from other nations; of the remaining children adopted domestically, half were adopted from foster care and half from private sources; see Figure 1.

Figure 1: Number and percentage distribution of adopted children by adoption type

1 Children adopted from foster care are those who, prior to their adoption, were involved with the child protective services system and were removed from their families due to their families’ inability or unwillingness to provide appropriate care.
2 Private domestic adoptions involve children who were adopted privately from within the United States and were not part of the foster care system at any time prior to their adoption.
3 Children adopted internationally originated from countries other than the United States. Typically, adoptive parents work with private U.S. adoption agencies, which coordinate with adoption agencies and other entities in children’s countries of origin.
Children’s History, Prior Relationship with Parents

According to the survey findings, children’s experience living with their birth families and in other settings varies depending on adoption type. The data also indicate that, while the vast majority of internationally adopted children were adopted by strangers, nearly half of children adopted within the United States were adopted either by a relative or by someone else who knew them previously.

More than four out of ten adopted children (43 percent) lived with their birth families at some time prior to their adoption. The proportion of children who have ever lived with their birth families varies across all adoption types; it is highest for those adopted from foster care (59 percent) and lowest for children adopted internationally (25 percent).

Children’s pre-adoptive placement differs depending on adoption type, with the majority of children adopted internationally living in congregate care facilities (70 percent) and with foster families (24 percent) prior to the adoptive placement. In contrast, 62 percent of children adopted privately in the United States lived in their adoptive placement as newborns or when they were younger than one month old.

Twenty-four percent of adopted children were adopted by relatives, and an additional 12 percent were adopted by a nonrelative who knew the child prior to adoption, although this distribution varies by adoption type. Parents of children adopted privately in the United States are most likely to be related to the child, and parents of children adopted from foster care were most likely to be nonrelatives who knew the child prior to adoption.

Race, Ethnicity, and Gender

The race and ethnic distribution of adopted children is different from that of children in the general population and varies across adoption type; a substantial number are in transracial adoptive placements. The gender distribution of adopted children differs as well.

Adopted children are less likely to be white or of Hispanic origin than children in the general U.S. population and they are more likely to be black; see Figure 2. Children adopted from foster care are most likely to be black (35 percent), children adopted privately from the United States are most likely to be white (50 percent), and the majority of children adopted internationally are Asian (59 percent).

The race and ethnic distribution of adopted children also differs from that of adoptive parents. Whereas the majority of adopted children are nonwhite, the majority of these children’s parents are white (73 percent). Given that the racial and ethnic distribution of adopted children differs from that of their parents, it is not surprising that for 40 percent of adopted children, the adoption is transracial. Eighty-four percent of children adopted internationally are in transracial adoptions, compared to 28 percent of children adopted from foster care and 21 percent of children adopted privately from within the United States.

While about half of all adopted children are male, gender distribution varies substantially by adoption type. Only one-third of children adopted internationally are male (33 percent) compared with a slight majority of children adopted from foster care and through private domestic adoptions (57 percent and 51 percent, respectively). This gender difference is largely driven by the high proportion of girls adopted from China.

Among internationally adopted children, more than twice as many were born in China as in any other country. Specifically, 33 percent of internationally adopted children lived in China.

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4 Transracial adoptions are identified as those in which both adoptive parents are (or the single adoptive parent is) of a different race, culture, or ethnicity than their child.
prior to their adoption; the second-most common
country of origin is Russia, representing 13
percent of internationally adopted children.

Figure 2: Percentage distribution of all children
and adopted children by race and
Hispanic origin

Other Demographic and
Socioeconomic Characteristics

Adopted children tend to be somewhat older
than children in the general population. Survey
findings indicate that while adopted children fare
better than children in the general population
on certain socioeconomic measures, there are
substantial differences across adoption types.

Fourteen percent of adopted children are under
five years old, compared with 27 percent of
children in the general population. Among
other reasons, this age difference is due to the
fact that some children are adopted at older ages,
rather than as infants. Additionally, the estimates
presented here are representative of children with
finalized adoptions, and adoptions typically take a
minimum of six months to finalize.

Adopted children are less likely than children
in the general population to live in families
with incomes below the poverty threshold (12
percent compared with 18 percent), and they are
more likely to have a parent who has completed
education beyond high school. However, these
characteristics vary substantially by adoption type;
see Figure 3. Nearly half (46 percent) of children
adopted from foster care live in households with
incomes no higher than two times the poverty
threshold.

Family Structure

The majority of adopted children live with two
married parents. While most adopted children
have known birth siblings, fewer than half of those
children have birth siblings who were also adopted
by the adoptive parent, and the presence of other
children in the household varies by adoption type.

Over two-thirds of adopted children – 69 percent
– live with two married parents, and they are
just as likely to do so as children in the general
population. Children adopted internationally
are most likely to have two married parents (82
percent), while children adopted through private
domestic sources are least likely (59 percent).

Seventy-one percent of adopted children have
known birth siblings, and of these, 29 percent have
birth siblings also adopted by the adoptive parent.
Parents of internationally adopted children are less
likely than parents of children adopted from the
United States to have reported knowing of birth
siblings.

Many adopted children (38 percent) are the only
child in the household, and privately adopted
U.S. children are the most likely to be the only child in the household (48 percent, compared with 27 and 37 percent of foster care and international adoptions, respectively). Children adopted from foster care are most likely to live in households with three or more children and have more complex family structures. Children adopted from foster care are most likely to live in families with both adopted and birth children; see Figure 4.

Physical Health

The fact that the NSAP was an add-on to the National Survey of Children’s Health (NSCH) allows for the examination of many health and wellbeing measures both for adopted children and for all U.S. children, regardless of adoptive status. Here we focus on six health indicators: general health status, having special health care needs, having been injured, missing school due to illness or injury, having moderate or severe health difficulties, or having asthma; see Figure 5.

The majority of adopted children fare well on these six measures (e.g. 85 percent have parents who rate their health as “excellent” or “very good”). However, 39 percent of adopted children have special health care needs, which is defined to include those who currently experience at least one out of five consequences attributable to
a medical, behavioral, or other health condition that has lasted or is expected to last for at least 12 months. In comparison, 19 percent of children in the general population had special health care needs. Additionally, while a minority of adopted children have moderate or severe health difficulties (26 percent) or have been diagnosed with asthma (19 percent), they are more likely to have experienced these health issues than are children in the general population (10 percent and 13 percent, respectively).

The vast majority of adopted children not only have health insurance (95 percent), but have been consistently covered over the prior 12 months (91 percent) and have adequate insurance (78 percent). Sixty percent of adopted children receive care in a medical home. Adopted children fare better than or as well as children in the general population on these measure; see Figure 6.

While adequacy and consistency of health insurance coverage is similar across adoption types, the type of health insurance coverage varies. Over half of children adopted from foster care (59 percent) and one-third of children adopted privately from the United States are covered by public health insurance. In contrast, internationally adopted children are far more likely than children adopted from foster care and privately adopted U.S. children to be covered by private insurance (92 percent, compared with 37 and 61 percent, respectively).

Social and Emotional Wellbeing

Most adopted children fare well, according to six measures of social and emotional wellbeing, but a small minority experience serious problems; five of these six measures indicate differences by adoption type.

Parents’ responses indicated that the majority of adopted children have never been diagnosed with the four psychological disorders included in the survey (attachment disorder, depression, attention

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**Figure 5:** Percentage of children according to their health status, by adoptive status

<table>
<thead>
<tr>
<th>Health status NOT &quot;excellent&quot; or &quot;very good&quot;</th>
<th>Special health care needs</th>
<th>Injured and required medical attention in the past year (Ages 0-5)</th>
<th>Missed &gt; 10 school days due to illness/injury</th>
<th>Moderate or severe health problem(s)</th>
<th>Moderate or severe asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>15</td>
<td>19</td>
<td>39</td>
<td>10</td>
<td>14</td>
</tr>
</tbody>
</table>

- [All children](#) | [All adopted children](#)
deficit disorder/attention deficit hyperactivity disorder [ADD/ADHD], and behavior/conduct disorder). Compared to the general population of children, adopted children are more likely to have ever been diagnosed with – and to have moderate or severe symptoms of – depression, ADD/ADHD, or behavior/conduct disorder; see Figure 7.

Attachment disorder is not included in Figure 7, as this question was not asked of parents in the general population sample. Twelve percent of adopted children have ever been diagnosed with attachment disorder; however, most adopted children diagnosed with attachment disorder have parents who report a “very warm and close” relationship with their child.

Children adopted from foster care are more likely than those adopted privately from the United States or internationally to have been diagnosed with ADD/ADHD, behavior/conduct problems, and attachment disorder. Children adopted from foster care are also more likely to have problems with social behaviors than children privately adopted in the U.S. and are somewhat less likely to exhibit positive social behaviors.

### Cognitive Development and Educational Achievement

Survey findings indicate that while the majority of adopted children fare well on measures of cognitive development and educational achievement, there are some differences when comparing this group with the general population of U.S. children. Reading and math performance also shows some variation by adoption type.

More than half of school-age adopted children have excellent or very good performance in reading and language arts, and the same is true for math. Nearly seven out of ten are engaged in school, and about eight out of ten typically spend time reading for pleasure on a daily basis. However, compared to children in the general population, adopted children are less likely to be engaged in school (69 percent, compared with 81
percent). Among children ages 12–17, adopted children are slightly less likely to read for pleasure; see Figure 8.

**Figure 8: Percentage of children ages 6–17 who spend any time reading on an average school day, by adoptive status and by child age**

Children adopted from foster care are somewhat less likely than other adopted children to have excellent or very good performance in reading and language arts and in math, and this pattern holds true regardless of age; see Figure 9.

**Family and Community Activities**

Overall, most adopted children have families that engage in positive and supportive activities, and adopted children are more likely than children in the general population to experience each of the four family activities examined.

Sixty-eight percent of young adopted children were read to every day during the prior week, compared with 48 percent in the general population. Similarly, 73 percent of young adopted children were sung to or told stories every day during the prior week; this was true of 59 percent of all young children. Adopted children were also more likely than children in the general population to eat meals with their families six or seven days a week (56 percent, compared with 52 percent) and, among children ages 6 and older, participate in an organized activity (85 percent, compared with 81 percent).
Parenting and Parent Wellbeing

The majority of adopted children fare well according to parenting measures; some of these measures indicated differences by adoption type.

A substantial portion have parents who rate their parent-child relationship as “better than they ever expected;” see Figure 10. Furthermore, for the vast majority of adopted children living with two parents, their parents’ relationship quality is high. Adopted children are somewhat less likely than children in the general population to fare well on the parenting measures, but they are more likely to have parents who have satisfying relationships. Finally, children adopted from foster care fare less well than internationally adopted children on some parenting measures; on other measures there were no differences among adoption type; see Figure 11.
Adoption Satisfaction

Very few adopted children (three percent) have parents who say that they “probably would not” or “definitely would not” make the same decision to adopt their child. In fact, 87 percent say they would “definitely” make the same decision.

Parents’ Prior Connections to Adoption

Three out of four adopted children have parents who have some prior experience with or connection to adoption (see Figure 12). Children adopted internationally were the most likely to have a parent with some prior personal connection to adoption, whereas those adopted privately from the U.S. were the least likely.
Conclusion

The survey findings presented here provide the first nationally-representative information about the characteristics and wellbeing of adopted children and their families in the United States. These findings indicate largely positive experiences, with the majority of adopted children faring well on measures of physical health, social and emotional wellbeing, and cognitive development and educational achievement. Most adopted children have home environments that are enriching, and more than eight out of ten adoptive parents report having a “very warm and close” relationship with their child.

Some differences do emerge, however, when comparing adopted children with children in the general U.S. population. While adopted children fare less well on certain measures of wellbeing (e.g., special health care needs, diagnoses of psychological disorders, and school engagement), they fare better than the general population of children on other measures (e.g. consistency and adequacy of health insurance, being told stories or sung to daily as young children, and participating in family and community activities). The NSAP also allows for comparisons across adoption types, which points to considerable variation on certain measures of child and family wellbeing depending on the type of adoption.

A more detailed analysis of these findings is available in Adoption USA: A Chartbook Based on the 2007 National Survey of Adoptive Parents (Vandivere et al., 2009), available online at http://aspe.hhs.gov/hsp/09/NSAP/chartbook/ or in hardcopy from the Child Welfare Information Gateway (info@childwelfare.gov; 800-394-3366). More information about the NSAP is available through the National Center for Health Statistics (http://www.cdc.gov/nchs/slaits/nsap.htm).

Adopted Children with Special Health Care Needs: National Survey Findings

Amy McKlindon, Kate Welti, Sharon Vandivere and Karin Malm

Introduction

The 2008 National Survey of Adoptive Parents of Children with Special Health Care Needs (NSAP-SN) provides nationally representative information about the health and wellbeing of adopted children with special health care needs (CSHCN) and their families. Children are identified as having a special health care need if they experienced one or more of five health care consequences as the result of a chronic health condition lasting (or expected to last) at least 12 months: ongoing use of prescription medications; higher than normal health care service utilization; activity limitations; specialized therapies; and treatment or counseling for a behavioral or emotional problem (Bramlett et al., 2010).

Building on previous work that compared CSHCN in the general population and all adopted CSHCN, the present article makes comparisons among CSHCN adopted in three different ways: through foster care adoption, private domestic adoption, and international adoption. Children adopted from foster care are those who, prior to their adoption, were involved with the child protective services system and removed from their families due to their parents’ inability or unwillingness to provide appropriate care. Public child welfare agencies oversee such adoptions, although they may contract with private adoption agencies to perform some adoption functions. Other children adopted from within the United States who were not in the foster care system at any time prior to their adoption joined their

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1 Bramlett et al. (2010) provide further information on the methodology of the NSAP-SN.

families through private domestic adoptions. These adoptions may be arranged independently or through private adoption agencies. Children adopted internationally originated from countries other than the United States; typically, their adoptive parents work with private U.S. adoption agencies, which coordinate with adoption agencies and other entities in the children’s countries of origin.

In 2008, there were over 400,000 adopted CSHCN, representing 39 percent of all adopted children. Previous analyses based on the NS-CSHCN have shown that adopted CSHCN are more likely than the broader population of all CSHCN to be identified as CSHCN on the basis of elevated need for services; physical, occupational, and/or speech therapy; behavioral, developmental, and/or emotional problems requiring treatment or counseling; or limitation in activity (but not on the basis of elevated prescription medication use). Additionally, they are more likely than the general population of CSHCN to meet multiple screening criteria (Bramlett & Radel, 2008). Almost half of adopted CSHCN were adopted from foster care, one in three was adopted from private domestic sources, and the remaining CSHCN were adopted internationally; see Figure 1. Survey findings indicate that the majority of adopted CSHCN have parents who are satisfied with their adoption experience and their relationship with their child, and also perceive their child as having a positive view of adoption. Differences do emerge across adoption types, including variation in the types of services received after adoption and need for additional services.

Children’s History, Prior Relationship with Parents

Adopted CSHCN lived in a variety of settings prior to their adoptive placements, and those settings vary by adoption type. Almost half of adopted CSHCN lived with birth family members at some point prior to adoption, and this experience also varies by adoption type.

Children adopted from foster care are nearly twice as likely as those adopted internationally to have lived in a foster home (39 compared with 21 percent), and they are also more likely to have lived with birth family members or relatives immediately prior to adoptive placement (26 compared with three percent). Approximately three out of four (74 percent) CSHCN adopted privately within the United States were adopted at birth or within one month of birth, while the majority of CSHCN adopted internationally lived in a congregate care setting (74 percent) prior to adoption.

Just under half (46 percent) of adopted CSHCN lived with birth family members at some point prior to adoption. CSHCN adopted from foster care are the most likely to have lived with birth family members (64 percent), compared with children adopted from private domestic sources (32 percent) and internationally (24 percent).

Overall, 19 percent of adopted CSHCN were adopted by relatives, and 18 percent were adopted by nonrelatives who previously knew the child. CSHCN adopted privately in the United States are the most likely already to have been related to their parent prior to adoption, whereas those adopted from foster care are the most likely to have a parent who was not previously related to the child, but who knew the child. Among CSHCN who were adopted by their foster

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**Figure 1: Number and percentage distribution of adopted CSHCN by adoption type**

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<tr>
<th>Adoption Type</th>
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<tr>
<td>Private domestic</td>
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<td>33%</td>
</tr>
</tbody>
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3 All findings pertain to adopted children with special health care needs; we use the term children for brevity.
4 All differences described in the text are statistically significant at p<.05, unless otherwise noted.
parents, 43 percent have parents who had become foster parents in the hopes of adopting.

**Transracial, Transethnic, and Transcultural Adoptions**

The survey asked parents whether their child was of a different race or ethnicity or from a different culture than they themselves, and whether the child was of a different race or ethnicity or from a different culture than the respondent’s spouse/partner (if applicable). Over one-third (36 percent) of adopted CSHCN differ racially, culturally, or ethnically from their parent (and their parent’s spouse/partner, if applicable); these are children who were adopted transracially, transculturally, or transethnically. Among the three groups, children adopted internationally are the most likely to be in transracial adoptions (78 percent), compared with children adopted from foster care (28 percent) and children adopted privately within the United States (26 percent).

Among CSHCN adopted internationally, Asia and Europe are the two most common regions of origin, with 58 percent and 37 percent of children originating from these areas, respectively. One in four (25 percent) internationally adopted CSHCN was adopted from China, and 21 percent were adopted from Russia.

**Figure 2: Percentage of adopted CSHCN with birth siblings also adopted by parent, by adoption type**

![Graph showing percentage of adopted CSHCN with birth siblings also adopted by parent, by adoption type.](#)

Family Structure

Over half of adopted CSHCN live with two married parents. The majority of adopted CSHCN have known birth siblings, and one in four has at least one birth sibling also adopted by their parent. The presence of birth siblings and other children in the household varies by adoption type.

Fifty-two percent of adopted CSHCN live with two married parents. Internationally adopted CSHCN are the most likely to live with two married parents (61 percent), compared with those adopted from foster care (52 percent) and from private domestic sources (46 percent).

While 25 percent of adopted CSHCN have at least one birth sibling who was also adopted by their parent, this varies by adoption type and is most common for CSHCN adopted from foster care; see Figure 2. Among the three groups, CSHCN adopted internationally are the most likely to have parents who did not know whether the child’s birth siblings were ever available for adoption (35 percent). Almost half (46 percent) of children adopted privately within the United States have birth siblings who were never available for adoption.

The majority of adopted CSHCN (85 percent) live with other children in the household. Those adopted from foster care are the least likely to be the only child in the family (10 percent, compared to 19 percent and 20 percent of children adopted privately in the United States or internationally, respectively) and the most likely to live with both adopted siblings and siblings born to the parent (40 percent, compared to 22 percent and 20 percent of children adopted privately in the United States and internationally, respectively). CSHCN adopted privately within the United States are the most likely to live with siblings born to their parent but with no adopted siblings (34 percent, compared to 20 percent and 21 percent of children adopted from foster care and internationally, respectively).
**Parenting and Parental Wellbeing**

The majority of adopted CSHCN have a parent who feels that his/her relationship with the child is very warm and close, and there are few differences in parenting measures across adoption types.

Seventy-one percent of adopted CSHCN have a parent who feels that the parent-child relationship is very warm and close, and 26 percent have a parent who feels that the relationship is better than ever expected. Approximately four in ten children (42 percent) have parents who feel that having the child in their life is better than they ever expected.

Parents do experience some challenges, however; approximately one in three children (32 percent) have a parent who describes the parent-child relationship as more difficult than they ever expected, and 28 percent have a parent who feels that having the child in their lives is more difficult than they ever expected.

**Adoption Satisfaction**

The vast majority of parents adopting CSHCN would probably or definitely make the same decision to adopt their child, with slight variation by adoption type. Parents also feel that their adopted children have positive feelings about adoption.

Among adopted CSHCN, 78 percent of children have a parent who would “definitely” make the same decision to adopt, and an additional 17 percent would “probably” make the same decision. CSHCN adopted privately within the United States were the most likely to have a parent who would “definitely” make the same decision to adopt (89 percent), compared with CSHCN adopted from foster care (74 percent) and internationally (72 percent); see Figure 3.

Parents of children ages five and older were also asked about their perceptions of the child’s feelings about adoption, and over nine out of ten children have a parent who feels that their child has positive or mostly positive feelings. Children’s feelings about adoption, as reported by parents, do not differ by adoption type.

**Figure 3:** Percentage of adopted CSHCN according to whether their parents would make the same decision to adopt again, by adoption type

![Figure 3: Percentage of adopted CSHCN according to whether their parents would make the same decision to adopt again, by adoption type](image)

NOTE: Values corresponding to unreliable percentage estimates (i.e., estimates for which the relative standard error exceeded 0.3) have been suppressed in this figure.
Parental Involvement/Advocacy in Adoption Community

While most families of adopted CSHCN were not asked to help or recruit other adoptive families, some families were involved in these activities. Involvement varied by adoption type. It is most common for parents to be involved in helping other adoptive families (46 percent), as compared to recruiting other adoptive families (10 percent). CSHCN adopted internationally are the most likely to have a parent who helped other families (65 percent, compared with 41 percent each of CSHCN adopted from foster care or internationally). While the majority of adopted CSHCN have parents who were not asked to recruit other adoptive families, CSHCN adopted from foster care were the most likely to have a parent involved in recruitment efforts (16 percent).

Parents’ Prior Connections to Adoption

Three out of four adopted CSHCN have parents with a prior connection to adoption (see Figure 4), and there were no significant differences by adoption type. While parents could describe multiple prior connections to adoption, the closest connection is reported in Figure 4. It is most common for children to have a parent with a relative outside of his/her immediate family who was adopted, or to have a parent with friends who had adopted.

Parents’ Motivation to Adopt

Parents of adopted CSHCN are motivated to adopt by a variety of different factors, and the most common motivations included wanting to provide a permanent home for a child, wanting to expand their family, and/or infertility. Motivations to adopt differ by adoption type; see Figure 5.

Children adopted from foster care are less likely than children adopted privately within the United States or children adopted internationally to have parents who were motivated to adopt by infertility (35 percent, compared to 55 percent and 57 percent, respectively).

Children adopted internationally are more likely than children adopted from foster care or privately within the United States to have parents who wanted a sibling for their child (40 percent, compared to 20 percent and 22 percent, respectively) or wanted to expand their family (90 percent, compared to 67 percent and 72 percent).

Parents’ Satisfaction with Attorney or Agency

The majority of adopted CSHCN (87 percent) have parents who had positive or very positive experiences with their attorney or agency, with no differences according to adoption type. Among all adopted CSHCN, 11 percent have parents who felt that important information was not disclosed to them prior to the adoption, and this was slightly more common among CSHCN adopted from foster care.5

Adoption Expenses

Adoption-related expenses vary greatly depending on adoption type, and they tend to be lowest for CSHCN adopted from foster care. Many adopted CSHCN have parents who received some type of assistance with adoption expenses.

5 The difference in the percentages of CSHCN adopted from foster care and those adopted from private domestic sources or internationally is marginally significant (p<.10).
Figure 5: Percentage of adopted CSHCN by parents' reasons for choosing to adopt, by adoption type

Note: Values corresponding to unreliable percentage estimates have been suppressed in this figure. Parents were able to select more than one motivating factor.

Figure 6: Percentage distribution of adopted CSHCN according to the cost of the adoption, by adoption type

Note: Values corresponding to unreliable percentage estimates have been suppressed in this figure.
One-third of adopted CSHCN have parents who incurred no adoption-related expenses, while three out of ten have parents who incurred expenses of $10,000 or more. CSHCN adopted from foster care are the most likely to have parents who paid no adoption expenses (56 percent), while CSHCN adopted internationally are the most likely to have parents who paid $10,000 or more in adoption-related expenses (84 percent); see Figure 6.

Parents may have received assistance with adoption-related expenses from the federal adoption tax credit, agency reimbursement (for foster care adoptions), and/or employer assistance. Three out of four adopted CSHCN have parents who filed for the federal adoption tax credit. Although 37 percent of CSHCN adopted from foster care have parents who were reimbursed for some or all of the cost of adoption from their agency, they are the least likely to have parents who received financial assistance from their employers (six percent, compared with 12 percent and 18 percent for children adopted privately in the United States and internationally, respectively).

Adoption Openness

The majority of adopted CSHCN know that they are adopted. Among CSHCN adopted by nonrelatives, fewer than half have a pre-adoption agreement regarding openness or have had post-adoption contact with birth families.

Ninety-seven percent of adopted CSHCN ages five and older know that they are adopted. This differs slightly across adoption types, with privately adopted U.S. CSHCN less likely to know that they are adopted (94 percent).

Among CSHCN adopted by nonrelatives, 36 percent have a pre-adoption agreement regarding openness and 44 percent have had post-adoption contact with birth relatives. CSHCN adopted privately within the United States are the most likely to have a pre-adoption agreement and post-adoption contact; see Figure 7.

Post-Adoption Supports

Adoption-Specific Supports

Survey findings indicate that among adoption-specific supports (i.e., meeting with someone at the agency to discuss post-adoption services, child support groups for ages five and older, parent support groups, and training for parent), the most commonly received service was meeting with someone at the agency to discuss post-adoption services. Receipt of services varies by adoption type, and over one in three adopted CSHCN have parents who needed at least one adoption-specific support that was not received post-adoption.

CSHCN adopted privately within the United States are less likely than the other two groups to have received certain adoption-specific supports, including training for the parent (22 percent, compared to 42 percent and 39 percent for children adopted from foster care and internationally, respectively); see Figure 8. Compared with internationally adopted CSHCN, these children are also less likely to have participated in child support groups or to have a parent who participated in a parent support group. Internationally adopted CSHCN are the most likely to have parents who used web-based resources (57 percent, compared to 34 percent and 29 percent for children adopted from foster care and privately in the United States, respectively).

6 Children whose adoptions occurred before this tax credit was available (prior to 1997) are excluded from this analysis.
7 The difference in the percentage of CSHCN adopted from foster care and CSHCN adopted from private domestic sources is marginally significant (p<.10).
8 The difference in percentages of CSHCN adopted from private domestic sources and CSHCN adopted from foster care is marginally significant (p<.10).

9 The difference in percentages of CSHCN adopted from private domestic sources and CSHCN adopted internationally participating in child support groups is marginally significant (p<.10).
Figure 7: Percentage of CSHCN adopted by nonrelatives who have pre-adoption agreements regarding openness and who have had post-adoption contact with birth family members, by adoption type

![Chart showing percentages of adopted CSHCN with pre-adoption agreements and post-adoption contact by adoption type]

NOTE: Values corresponding to unreliable percentage estimates have been suppressed in this figure.

Figure 8: Percentage of adopted CSHCN whose parents received various post-adoption services (adoption specific) by adoption type

![Chart showing percentages of parents receiving various post-adoption services by adoption type]

NOTE: Values corresponding to unreliable percentage estimates have been suppressed in this figure.
Thirty-five percent of adopted CSHCN have parents who needed at least one adoption-specific post-adoption service that was not received. Support groups for children were the most common service that parents wanted to receive but did not; see Figure 9. CSHCN adopted from foster care were the most likely to have parents who did not receive a needed adoption-specific support (44 percent, compared to 25 percent and 32 percent of children adopted privately in the United States and internationally, respectively).

The majority of CSHCN adopted from foster care receive health insurance and an adoption subsidy through an adoption agreement. Eighty-one percent of CSHCN adopted from foster care have an adoption agreement guaranteeing health insurance coverage and a subsidy, and 82 percent currently receive a subsidy.

Rehabilitative Services and Other Services Not Specific to Adoption

The NSAP-SN also asked whether families received rehabilitative services not specific to adoption (i.e., family counseling, crisis counseling, mental health care for children ages five and older, psychiatric residential treatment/hospitalization for children ages eight and older, drug/alcohol services for children ages 13 and older, and mentors or tutors for children ages five and older). Two out of three adopted CSHCN and their families received at least one rehabilitative or general service, most commonly mental health care for the child (67 percent). Children ages 12 to 17 are more likely to have received these services than children ages five to 11.

Receipt of services varies by type of adoption; see Figure 10. CSHCN adopted internationally were the least likely to receive at least one rehabilitative service (54 percent, compared to 72 and 69 percent of children adopted from foster care and internationally, respectively). CSHCN adopted from foster care are more likely to have received family counseling, mental health services, and to have a mentor than CSHCN adopted internationally or privately within the United States.10

Twenty-six percent of adopted CSHCN have parents who needed but did not receive at least one support (not specific to adoption) post-adoption. CSHCN adopted from foster care are more likely to have a parent report an unfilled need (31 percent) than are those adopted internationally (17 percent). Among all adopted CSHCN, tutoring and mentoring services were the most commonly desired general services that were not received.

Conclusion

CSHCN represent an important segment of the population of adopted children in the United States, as almost four in ten adopted children (39 percent) have special health care needs (Vandivere et al., 2009). The survey findings presented here provide nationally representative information about their characteristics and their families’ adoption experiences. However, it is important to note that these findings are representative of adopted CSHCN, not all adopted children.11 The majority of adopted CSHCN have parents who feel that their parent-child relationship is very warm and close and that their adopted children view adoption positively as well. While many parents received adoption-related and nonadoption-related services after finalization, there are still gaps in services.

The NSAP-SN also allows for comparisons across adoption types, which points to some variation in experiences before, during, and after adoption depending on the type of adoption. For instance, CSHCN’s living arrangements prior to the adoption and prior relationships with birth family

10 The percentage difference between CSHCN adopted from foster care and CSHCN adopted from private domestic sources was marginally significant for receipt of family counseling and mental health care services (p<.10).

11 Adoption USA: A Chartbook Based on the 2007 National Survey of Adoptive Parents (Vandivere et al., 2009) provides further information on the wellbeing and adoption experiences of all adopted children.
Figure 9: Percentage of adopted CSHCN whose parents wanted to receive various post-adoption services (adoption specific) but did not

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<td>Parent support group</td>
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<td>Training for parent</td>
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Figure 10: Percentage of adopted CSHCN whose parents received various post-adoption services (general) by adoption type

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<th>Service</th>
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<td>Crisis counseling</td>
<td>10%</td>
<td>10%</td>
<td>4%</td>
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<tr>
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<td>68%</td>
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<td>Psychiatric residential treatment/ hospitalization (ages 8+)</td>
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<td>14%</td>
<td>10%</td>
</tr>
<tr>
<td>Mentor (ages 5+)</td>
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<tr>
<td>Tutor (ages 5+)</td>
<td>49%</td>
<td>46%</td>
<td>49%</td>
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</table>

NOTE: Values corresponding to unreliable percentage estimates have been suppressed in this figure.
members and adoptive parents vary depending on the type of adoption, as do parents’ motivations to adopt. At the time of adoption, differences can be seen in the cost of the adoption, forms of financial assistance utilized by parents, and whether or not the family has an agreement regarding openeness with the birth family. Post-adoption, there is variation in the types of services received by the child and family and their desire for additional services.

References


Dave Thomas Foundation for Adoption Names America’s 100 Best Adoption-Friendly Workplaces for 2010

Dave Thomas Foundation for Adoption

Introduction

On September 23, 2010, the Dave Thomas Foundation for Adoption announced the fourth annual 100 Best Adoption-Friendly Workplaces list recognizing organizations nationwide for their adoption benefits. The Wendy’s/Arby’s Group earned the top spot by offering a maximum of $24,300 in financial assistance and up to six weeks paid leave.¹

“This is one of the highest honors our company can receive. Dave Thomas was passionate for the cause of adoption, and he personally contacted thousands of companies asking them to extend adoption benefits to employees. We’re extremely proud to follow his lead and help our employees realize the joys of adoption,” said David Karam, President of Wendy’s International.

Teressa Johnson has worked for Wendy’s for 21 years. She and her husband have adopted three children: one as an infant and two siblings from foster care. “We knew adoption was our way of building our family,” said Teressa. “Wendy’s helped us throughout the whole process. For our foster care adoption, Wendy’s covered the minimal expense. We didn’t pay anything. It’s such a benefit to have help and support from your employer.”

¹ The Foundation is not an affiliate of Wendy’s International Inc.

Rankings for the Best Adoption-Friendly Workplaces list are determined by an analysis of a company’s adoption benefits, such as financial reimbursement and paid leave, available to employees who adopt. The Foundation compiled the results from survey data collected from nearly 500 U.S. employers, and partnered with Employee Benefit News, a SourceMedia publication that is the leading source of information for benefits decision makers, to announce the winners.

The average financial reimbursement for all Foundation survey participants is $5,500, and the average paid leave offering is five weeks. More than 40 percent also offer unpaid leave beyond that required by the Family and Medical Leave Act, ranging from one week to three years. Utilization rates remain consistently low, with less than one half of one percent of eligible employees using the benefit in an average year. Because of this and the small amount of paperwork needed, most human resource executives administer the benefit in-house.

Today, more than 114,000 children in the U.S. foster care system are available for adoption. Most will spend nearly four years in the system before they are adopted. The release of the fourth annual Best Adoption-Friendly Workplaces list helps the Foundation increase foster care adoption awareness while celebrating those businesses that support adoptive families.
“Whether the child is a 12-year-old victim of child abuse and neglect who has spent years in U.S. foster care, a toddler who has been living in a foreign orphanage, or a newborn from a domestic adoption, it is critical for every child to have the opportunity to adjust and thrive in their adoptive home,” said Rita Soronen, executive director of the Foundation. “This is why employer support of adoption and family-friendly work environments is so crucial.”

For more information, visit www.DaveThomasFoundation.org or call 1-800-ASK-DTFA.
## Dave Thomas Foundation for Adoption 100 Best Adoption-Friendly Workplaces List 2010

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<th>U.S. Rank</th>
<th>Employer</th>
<th>Maximum Reimbursement</th>
<th>Maximum Weeks Paid Leave</th>
<th>Headquarters</th>
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continued
## Dave Thomas Foundation for Adoption 100 Best Adoption-Friendly Workplaces List 2010 (continued)

<table>
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<tr>
<th>U.S. Rank</th>
<th>Employer</th>
<th>Maximum Reimbursement</th>
<th>Maximum Weeks Paid Leave</th>
<th>Headquarters</th>
<th>Industry</th>
<th>Employees</th>
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<th>U.S. Rank</th>
<th>Employer</th>
<th>Maximum Reimbursement</th>
<th>Maximum Weeks Paid Leave</th>
<th>Headquarters</th>
<th>Industry</th>
<th>Employees</th>
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Section 2

Information for Adoptive Parents
Recognizing Five Common Expectations: Preventing the Shattering of the Dream

Jayne E. Schooler

This article was adapted from Jayne Schooler’s book, Wounded Children, Healing Homes: How Traumatized Children Impact Adoptive and Foster Families. “Used by permission of NavPress. All rights reserved. © 2009 www.navpress.com”

Introduction

“I expected my new child to appreciate all that I do for her. After all, look where she came from.”

“I expected my birth children to sacrifice for this new child in our home.”

“I expected my extended family to take to this new child as they would a birth child.”

“I expected the agency to be readily available to offer answers and support.”

“I expected that I would feel happy and fulfilled because we’ve helped this child.”

“I didn’t expect to get so angry.”

“It wasn’t supposed to be this way!” That statement could be the title of a book written by almost anyone who has confronted unmet expectations. Every parent has expectations, hopes, and dreams, whether their child joins the family by birth or adoption. It is a normal and natural part of parenthood.

We expect our child to walk and talk at the right time. We expect our child to be more than ready for kindergarten and beyond. We dream of a child who excels in school, sports, or the arts. Occasionally, based on their child’s pictures or their own imagination, adoptive parents create an image of the child they hope to adopt. They enter the relationship with high expectations of performance and behavior for themselves and the child. When those expectations go unmet, parents may find it difficult to invest in the child.

“As adoptive parents, we have the same dreams that all parents have, although we usually embark on our trip with less information about the biological road map of our children,” says Ellen Singer, LCSW-C. “Although many of our friends find that their children by birth are surprisingly different than they expected them to be, it is true that we take a fork in the road when it comes to perceived certainty about the future. Whether we adopt because of infertility or not, we are told we must set aside our ‘fantasy child’ in order to be emotionally prepared to love and attach to one who brings her own set of genes, family history, and talents. Logic tells us that she may look and be different from what we hoped our biological child would be like.”1

However, what happens when the surprises are viewed as negative or undesirable? What if the child’s temperament and characteristics are a mismatch for the family? What if the child’s behavior or accomplishments don’t measure up? What if the child’s needs are exceptional? What happens then? Why is it important to raise the subject of unmet expectations?

Unmatched or unmet expectations about the child often create unyielding tension on the newly formed family system. The ground underneath the adoption commitment begins to shift. Numerous studies have examined predictors of adoption disruption. It is estimated that adoption disruption rates are highest among children with special needs and older children, with rates ranging from zero to twenty percent. The greatest predictors for disruption among adoptions involving children with special needs that relate most to the adoptive family include unrealistic expectations, rigidity, insufficient social support for the adoptive family, and the adoption by new or “matched” families (as opposed to foster families adopting a child they already know). Other predictors relate to the child: a history of physical and sexual abuse, prenatal exposure to drugs and alcohol, and acting out behaviors. It is significant that adoptive parents’ unrealistic expectations top the list as a predictor for risk of adoption disruption. Parents who don’t adjust their expectations of themselves, the child, their birth children, extended family, and the adoption agency will find themselves cornered in a maze of frustration without the resources to find their way out. They may find themselves broadsided by shattered assumptions. We don’t want to blame the parents for struggling with unmet expectations. Rather, our goal is to create awareness of potential pitfalls, even land mines, related to unmet expectations. We will look at five expectations often found, consciously or unconsciously, in the new adoptive family.

Five Common Expectations About Adoption

1. **Our love will be enough.**
Many adoptive parents who fall in love with a picture of a child begin a fantasy journey of what life will be like. They believe that love will heal all wounds. With that belief, they fail to hear the child’s story and aren’t open to the potential challenges resulting from trauma and how those challenges might affect their family.

2. **We will feel love and connection to this child quickly.**
Parents can be broadsided by their lack of connection to the child they are adopting. “When we planned to adopt, I never questioned whether I would feel love for this child. There wasn’t a child who couldn’t be loved,” said Katie. “However, what I felt totally surprised me. It was something I couldn’t tell anyone, I felt so guilty about it. There were days that I dreaded getting up in the morning. I felt absolutely no connection to this child we brought home from Russia. I felt anger and remorse over bringing her into the family. I beat myself up daily and told no one. Something had to be very wrong with me that I didn’t feel any love for or connection to Sarah. I wish someone had told me that it might be that way.”

3. **This child’s needs will be just like those of our biological children.**
When David arrived home at six years old, he became the youngest child in the Wittenbach family, which included three kids, two dogs, mom, and dad. Rachel and Robert felt competent as successful parents of their older children, who ranged in age from nine to seventeen. “When we decided on the adoption of an older child, we felt this would be a breeze... We knew how to parent,” they explained. “However, we were perplexed that the parenting techniques we used with our other children had no effect on David. There didn’t seem to be any consequence that

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3. Ibid.

mattered to him. We began to feel incompetent as parents and really questioned ourselves and our ability to parent this child.”

The Wittenbachs expected that parenting David, whose traumatic history involved severe neglect and sexual abuse, would be just like parenting their other children, who had no such traumatic history. When familiar, tried-and-true parenting techniques fail to work with a newly adopted child, parents may feel deep frustration. They may question themselves, wondering if they’re competent for the task ahead. Often, they fail to share their concerns with those who could help them the most.

4. Our child will fit well into our extended family and be welcomed by them.
Many adoptive families experience incredible family support. However, when that support disappears as a result of the child’s difficult behaviors, it becomes a crisis. Debbie Riley, executive director of the Center for Adoption Support and Education (C.A.S.E.) in Burtonsville, Maryland (personal communication, March, 2008) has observed this family dynamic. “Perhaps from the beginning, the prospective adoptive family received ambivalent messages about adoption from their extended family members,” she explains. “Some of those messages included subtle questions like ‘Why would you take on those problems? Why don’t you wait and get a baby?’ Once the older child arrives home, and the extended family members see the family struggling, they become angry at the child and begin to withdraw what little support and encouragement they offered in the beginning. They also become angry at the adoptive parents because [the adoptive parents] are determined to maintain their relationship with the child. Extended family members may be particularly concerned about the impact of the adoption on other children in the family, causing them to feel protective of those children and resentful of the ‘intruder.’ As the family continues to embrace the child, the extended family withdraws their support, leaving them alienated and cut off from a key support system.”

For some adoptive parents, the withdrawal of support and help from their extended family makes them feel uncertain and gravely disappointed. The child/grandparent relationship they dreamed of is threatened by the difficulties of managing not only the child’s behavior, but that of family members as well.

5. We will never feel any regrets or ambivalence in adopting this child with a traumatic past.
In the 1995 spring issue of Roots and Wings magazine, June Bond first coined the term “post-adoption depression syndrome” that is still applicable for some families today.5 Symptoms are very similar to postpartum depression and the causes can be many, from unmet expectations to a sense of loss of control of one’s life. Parents may also feel exhausted and overwhelmed.

“It is important for adoptive parents to know that these feelings are normal and common,” explains adoption expert Karen Foli. “Experts agree that stress, depression, ambivalence, and anger are emotions they frequently see, and part of the assistance they offer to parents is to help them realize these feelings are normal” (p. 20).6 Expected and unexpected feelings, as well as the many joys and satisfactions of parenting, can occur in healthy adoptive families, just as they can occur in healthy biological families. So what should families do?

**Key Points for Families**

**Key Point 1: Recognize Expectations**
Parents need to recognize, consider and confront their own expectations or they may find themselves broadsided by shattered assumptions.

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It is critical to examine the “what”s and “why”s of one’s personal expectations as well as the family’s expectations.

**Key Point 2: Readjust Shattered Assumptions**

The experience of unmet expectations will fall on a continuum from mild disappointment to severely shattered dreams. When expectations encounter reality, what can parents do? The following are ways to manage expectations:

1. Re-examine your motivation for adoption and reframe your expectations.
2. Recognize that feeling ambivalent is sometimes a part of the attachment process.
3. Adjust your expectations of each other and other family members.
4. Keep communication open and honest as the responsibilities increase.
5. Work at keeping the family system open and flexible in responding to unmet expectations.
Parental Post-Adoption Depression

Karen J. Foli

Introduction

Activities over the past thirty years have offered much information about postpartum depression in birthmothers. While rates vary, we know the prevalence of postpartum depression (10-15 percent), and we have instruments to help us predict and detect it. The Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) has classified postpartum depression as a specific mood disorder (depression).1,2 We know the negative effects that postpartum depression has on children, and as a society, we feel compassion for those who experience postpartum depression. Yet we have much to learn about parental post-adoption depression.

An adoption professional, June Bond, identified “post-adoption depression syndrome” in 1995 as encompassing symptoms of panic anxiety, depression, and “cloudy blue feeling.”3 Yet it has been only in the past few years that the adoption community’s awareness of parental post-adoption depression created mainstream conversations. These much-needed conversations are based, however, on individuals who decide to share their experiences versus systematic evidence. Only a dozen or so studies on post-adoption depression have been completed over the past decade.

Moreover, inconsistent measures have been used to assess post-adoption depression in adoptive parents. These measures have included postpartum depression and general depression scales, which makes overall rates of post-adoption depression difficult to discern. In the research reported thus far, the rate of post-adoption depression has a wide range, from eight percent to 15.4 percent, to 32 percent, with parents surveyed in varying contexts (intercountry and domestic).4,5,6,7 In a recent study of note, 86 adoptive mothers of infants under 12 months of age were followed during the first year post-placement. Significant depressive symptoms were found in 27.9 percent of subjects at 0-4 weeks, 25.6 percent at 5-12 weeks, and 12.8 percent at 13-52 weeks post-adoption. Interestingly, significant depressive symptoms were not associated with personal or family psychiatric history, but were associated with stress and adjustment difficulties.8

4 Dean, C., Dean, N.R., White, A., & Liu, W.Z. (1995). An adoption study comparing the prevalence of psychiatric illness in women who have adoptive and natural children compared with women who have adoptive children only. Journal of Affective Disorders, 34, 55-60.
Today, informal accounts in the national and international press are bringing the topic of adoptive parental depression to a general audience. Indeed, the media has been one of the main drivers in describing this phenomenon to the general public. Having been interviewed by journalists from national and international newspapers, radio shows, and even *O! The Oprah Magazine* on the topic of parental post-adoption depression, I appreciate that the media is taking note of depression in adoptive parents. However, because of space and time constraints, media coverage tends to be superficial, and we run the risk of sensationalistic accounts that paint adoption in ways that lack accuracy or don’t truthfully depict the effects of depression on the adoptive family.

**Understanding the Effects of Post-adoption Depression on the Family**

In addition to the burden of depression on those suffering, we also know from the postpartum literature that the existence of parental depression can lead to adverse outcomes in children. One study validated this effect in children who were adopted by comparing the effect of parental depression on both adopted adolescents and nonadopted adolescents. Overall findings included an association between parental depression and a greater risk for major depression and disruptive behavior in both nonadopted and adopted adolescents. It should be noted that there is preliminary evidence that both adoptive mothers and fathers may experience post-adoption depression. Furthermore, many children who are adopted are already at a higher risk than birth children to experience adverse outcomes caused by parental depression due to the environments they were in prior to placement and the relocation to a new family.

What follows is a narrative from a mother who decided to dissolve her adoption. She is not alone, as anecdotal reports indicate that disruptions and dissolutions of adoption may be linked to post-adoption depression:

> I feel strange writing to you. One year ago my husband and I placed our adopted baby girl into a new home because of severe depression. We had her for three months. Her welfare was our utmost concern, and we didn’t understand what was going on with me. Oh, how I wish I had read about post-adoption depression before we got her. We have so many regrets now that I am much, much better. I long to have her back.

Parents who are struggling report feeling that they are “losing their minds,” a suffocating guilt and inadequacy as a parent, an inability to problem solve, or a perceived lack of supports. Events and emotions evolve, and in extreme cases, the decision to relinquish the child to the foster care system or new adoptive parents may be made.

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15 Foli, K. J. (submitted for publication). Adoption professionals’ perceptions of post-adoption depression: Findings from a web-based survey.
Understanding Post-Adoption Depression: A Proposed Theory

In attempting to grasp the dynamics of parents who experience depression after a child is home, I conducted a qualitative study, which involved interviewing adoptive parents and adoption experts as well as taking observations from a parent support group. What I found was that despite adoption paths differing along various contexts such as domestic/intercountry, domestic public/domestic private, and so forth, parental post-adoption depression cuts across these lines. The majority of prospective adoptive parents, no matter what their path, enter into the process of adoption with a set of expectations. When the reality and the expectations of the parenting experience are compared, there may be a significant difference. If the reality is different in a negative way, and there are no supports or interventions to ameliorate it, a dissonance is created within the adoptive parent that may leave them with depressive symptoms of varying intensity.16

The individual often holds high expectations of herself as an adoptive parent, a role that has been actively and eagerly sought. The parental bond and attachment that she assumed would be strong and occur “at first sight” may be absent or weak. Adoptive parents may feel that who they were as people is now lost or changed. Perhaps the grief of infertility and past loss resurfaces. Their expectations for the child may not be met. Some parents, depending on the circumstances, find that their child’s needs overwhelm them. Parental love and affection may be unmet because of the child’s need to learn how to attach and bond. Or their closest loved ones, family and friends, may withhold support either consciously or through a lack of awareness. Last, society and others may intrude on the family boundaries, offering little help and asking for much in the way of stories and high standards of parenting. As a result, parents often panic. They are in an unexpected place emotionally; a place that they believe cannot be shared with others. Guilt, shame, and secrecy consume them. Whatever the causative factors—and we haven’t enough information to fully understand what these are—post-adoption depression exists. And so the question becomes: What can the adoption community do to educate, prevent, detect, and treat depression in adoptive parents?

Three Action Items for the Adoption Community

1. Open the Conversation about Post-Adoption Depression and Build a Culture of Acceptance

The adoption triad—birthparents, the child who is adopted, and the adoptive parents—all have unique needs. Nonetheless, there have been occasions when the needs of adoptive parents have been suspended, and adoptive parents may be seen as the least affected by the losses that often surround adoption. Second, some individuals believe that if we talk about post-adoption depression, then the decision to adopt will be more frightening and the discussion will have a dampening effect on potential adoptive parents. I do not believe this to be the case. In numerous interactions with adoptive parents who struggled with depression, parents have voiced unanimous convictions that knowing about post-adoption depression would have helped them emotionally and also helped them recover more quickly.17

We need to open the conversations with parents and thereby reduce the stigma, guilt, and shame. There are barriers, however. Adoption professionals consistently report that it is difficult to help an adoptive parent if the parent is unwilling to share that they are struggling with depression. Indeed, some parents use covert strategies to hide their depression from the adoption professional. It becomes the clinician’s responsibility to look closely at the parent for


signs and symptoms of depression through nonverbal cues, and through the use of active and nonjudgmental listening. A reflection on nonverbal behaviors—flat affect, poor eye contact, closed body posture, or agitation—may be enough to open the conversation, which is a critically important intervention.

2. Screen for Depression in Adoptive Parents

Resources are limited, but screening for depression may be effective with a simple 2-Question Screen; evidence exists that supports this method as an effective tool in screening for postpartum depression. The 2-Question Screen asks about the two fundamental symptoms of depression, diminished mood and pleasure:

1. During the past month, have you often been bothered by feeling down, depressed, or hopeless? (Yes/No)
2. During the past month, have you often been bothered by having little interest or pleasure in doing things? (Yes/No)

If the parent responds “yes” to either of these questions, then follow-up is required. A third question, “Is this something with which you would like help?” further increased the strength of the screening method.

If screening and subsequent evaluation do result in a diagnosis of depression, the adoption professional may feel a sense of personal unease or loss—or even confusion. As human beings, we want to make sense out of experiences, and there may be no single answer as to why this parent is struggling with depression. What is important is to make sure the parent understands the importance of seeking treatment, for her sake and the sake of her child.

3. Strengthen Post-Adoption Support Services with Adoption Smart Mental Health Professionals

Adoptive families were recently assessed in a landmark survey of 2,089 adoptive parents who had adopted a child zero to 17 years old. The National Survey of Adoptive Parents (2009) revealed that 14.75 percent of the parents felt that things had been more difficult than they “ever expected.” Further, the findings also revealed that almost 20 percent of the families had engaged in family counseling since the adoption. Clearly, there are parental needs either antecedent to the child’s placement or after the child is home.

Moreover, there is a call to refocus federal funding to support post-adoption services that include finding “adoption-competent” individuals who can assist in stabilizing the family and establishing a “set of principles for adoption-competent mental health services.”

When seeking treatment from primary caregivers and mental health professionals, adoptive parents—as their children do—need to feel safe. Clinicians and therapists who understand the dynamics of adoption are able to stabilize and help parents gain insight into their own personal pain, loss, and grief so that they can become more fully present to meet their child’s needs.

Healing Can Take Place

The potential for adoption professionals to make an impact on a parent struggling with depression is immeasurable. While there is a tendency to look at post-adoption depression from a model of pathology, we instead need to frame it as a focus of intervention and support. With support, time, and treatment, the majority of adoptive parents are

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able to experience a remission in their depressive symptoms, regain their functioning, and bond with their child.

Recently, I spoke at an adoption conference and was stopped by a young woman. Although she was in the middle of her lunch, she stood up, but she was unable to continue to speak and hurriedly wiped away tears. After a short time, she told me that she wanted to thank me for my work, but again stopped as tears made speech difficult. I inquired in a somewhat awkward manner if things were all right now. The young woman looked at me and hesitated as if remembering something and began to smile. “Yes,” she nodded. “They’re wonderful, absolutely wonderful.”
What to Do If You’re Experiencing Post-Adoption Depression or Know Someone Who Is

Karen J. Foli

Introduction

According to *The Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition), the book that professionals use to diagnose individuals, the signs and symptoms of depression include*:

- A depressed mood; feeling sad or empty
- Loss of interest or pleasure
- Significant (unintended) weight loss or weight gain
- Difficulty sleeping or wanting to sleep all the time
- Feeling as though you can’t sit still/restless, or feeling as though you’re slowed down/can’t physically get going
- Fatigue or loss of energy
- Feelings of worthlessness or excessive guilt
- Diminished ability to think or concentrate; indecisiveness
- Recurrent thoughts of death or thinking about suicide/acting on these thoughts

* For a diagnosis to be made, five of the nine symptoms above should be present for at least two weeks, and at least one of these five symptoms should include depressed mood or loss of interest or pleasure.

While these signs and symptoms are clear and well-defined, the *reasons* behind the depression may take individualized forms. For example, is there a history of depression that makes a parent vulnerable to a recurrence? Is attachment and bonding with the child delayed or difficult? Are the needs of the child overwhelming the parents? Is there role conflict in the family, especially in the areas of work and family? Is the father struggling with attachment? Is he coping by avoidance and disengaging with the family? Is he reacting to the mother’s depression? Understanding the individual dynamics will help guide what to do next.

For Professionals

First, examine personal feelings. Do you feel disappointment, confusion, or a sense that you are somehow responsible for the parent who is struggling? Are there negative feelings present, such as resentment, frustration, or even unease?

Second, open the conversation with the parent and decide if she or he has a support system to draw upon or if there are outside resources that need to be secured. Does the agency or organization offer post-adoption services/counseling? If there is a support system that may be engaged, decide if the services are adequate for the intensity/severity of the depression. It is critical to remember the safety of the child and parent.

For Parents

There is a “double whammy” of stigma for the adoptive parent who experiences depression. As a society, we have become more enlightened and compassionate towards those who have a mental illness, but the hesitation to self-report such an illness is real and a significant barrier to receiving treatment. Adoptive parents crave control because so much of the adoption process has been out
of their control. Experiencing the symptoms of depression means that part of their lives is out of control, and it is extremely hard to admit that.

The good news is that parents are often accustomed to putting the well being of others before their own. If there is a “silver lining” to post-adoption depression, it is that when a parent recognizes his or her depression, actively seeks help, and begins to heal, his or her child and partner also benefit. Research has supported this.

If you are experiencing post-adoption depression as a parent, persist in finding the right treatment for yourself. What works to alleviate depression in one individual may not work for another. The right professional can make all the difference, as can other forms of support. From online support groups and educating yourself about your child’s needs to finding pleasure in what was once pleasurable, there are many paths to relieving post-adoption depression. It’s about identifying that first step and knowing in your heart that it’s time to take action.

For Family and Friends

You may have noticed little things or big things that indicate a change in your loved one’s mood or how she has been interacting with you. You are not sure what to do or say, and feel hesitant to bring these perceptions up in conversation. Gentle ways to open a discussion might include a general query into how the person is doing. Wait, be present, and allow silence. Be sure to give her time to answer.

You can then follow up with your observations: “The reason I’m asking is that I care about you, and I’ve noticed that you seem sad at times” (or explain whatever behaviors you’ve noticed). You might then say: “I know that postpartum depression is very real and experienced by some birthparents, and I know that some adoptive parents also struggle with emotions after their child comes home…” This leading comment will offer permission for the parent to respond if she is experiencing depressive symptoms.

Comments that may not be as helpful include, “Your child is so fortunate to have come home to you,” or, “It’s probably just the normal feeling of letdown after what you’ve been through.” Contrast these with statements that validate the parent’s feelings, such as, “This must be a difficult time for you,” and “What kind of support do you feel you need the most right now? What can I do to help?” Most of all, being present with active, non-judgmental listening is critical.
Introduction

Parents decide to adopt an older or at-risk child for many different reasons. Some desire to provide a loving family for a child without as many opportunities; others feel the calling to adopt an identified child, a sibling group, or a child with a specific medical condition. Regardless of how these parents begin their journeys, they have common experiences along the way. For most families, the children transition wonderfully into their new homes and life is full of all the joys and challenges they expected. For too many families, however, life after the adoption is not as smooth. While they continue to be committed to the child, these families may find themselves living in crisis, parenting a child with needs beyond their understanding.

Emma’s parents could not understand why she could feel happy one minute and be in a rage the next. Johnny’s parents could not understand why one bad grade at school would cause him to run away after four years in their home. Sarah’s parents longed to understand why she continued to harm herself and still “hated” them after one year of family intervention. For these families, and many others, the challenges become overwhelming. (Names of children have been changed to protect their privacy.)

The most unfortunate scenario is when a family cannot remain intact. Receiving a call from a discouraged and tearful parent saying, “We just can’t do this anymore” is heartbreaking for everyone involved. Disruption is an unfortunate scenario adoption professionals have come to know all too well.\(^1\) A significant number of studies from different groups have attempted to identify the average rate of disruption. While the data varies, the conclusion is the same: the older the child, the greater the risk for both child and family.\(^2\)

Crisis intervention focused solely on preventing disruption does result in some families staying together. But too often they do so with a sense of resignation, accepting that this is what life will be like with this child, without any hope of progress. Staying together isn’t enough; happy

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1 Disruption is the term used to describe an adoption that fails before it is finalized, while dissolution is the term used when an adoptive placement fails after finalization. In both cases the child is removed to foster care and/or to another set of adoptive parents.

2 A word about statistics: evaluating unsuccessful families has proven to be problematic due to the nature of the data collection. One metric is failed adoptions. However, there is no single source for national data collection on disruptions or dissolutions. Data is gathered from public agencies, or entities under contract with public agencies, and is reported differently in each state. Data related to dissolutions are even more difficult to find, as the adoptions have been finalized and it becomes the family’s prerogative to report dissolution unless the child is relinquished to the public welfare system. The Adoption and Foster Care Analysis and Reporting System (AFCARS) includes children that were previously adopted and at what age they were adopted. However, this data only includes the cases in which this information was brought to the attention of the public welfare system. It is likely this information is inconsistently reported by each state due to differing definitions. Based on these challenges, we can presume that reported disruptions and dissolutions may be low, and many cases go unreported.

A significant number of individual studies from different groups have attempted to identify the average rate of disruption. Most studies indicate a disruption rate of 10 to 25 percent. The reasons for the wide range in percentage include the population studied, the duration of the study, geographic and other factors (Festinger, 2002; Festinger, 2005; Goerge, Howard, Yu & Radomsky, 1997).

Less than one percent of infant adoptions disrupt, while the rate is 10 percent for children older than three years (Barth & Berry, 1988). In 1990 Barth and Berry reported the disruption and dissolution rate to be 24 percent in placements of children 12 to 17 years of age.
and whole must be the goal for every family. The adoption community must take a more holistic approach that focuses on building:

- Capable Families
- Prepared Families and Children
- Supported Families

**Family assessment** is key to ensuring that the parents themselves are healthy and capable of parenting an older child. Proper assessment can also help ensure that an appropriate match is made. **Parent and child preparation** helps the family and the child set realistic expectations about what their lives will be like together. Education and training arms families with the tools they may need to deal with the challenges that arise. **Parental support and early intervention** are essential in helping families resolve the issues they may face and navigate through a potential crisis. Better, and earlier, crisis intervention must be incorporated into a holistic approach to building successful families from the start.

**Capable Families**

**Adequate Family Assessment**

Pre-adoption work with families is the most critical part of the process in creating whole and happy homes for children. For many families and agencies, the homestudy is seen as nothing more than a required document. In reality, the homestudy is a crucial step that should not be taken lightly. It provides the agency an opportunity to fully assess the family and provide appropriate education. When done well, the homestudy also places parameters on the age and characteristics of the child that could be a good match for the family. These parameters are important and can help to ensure success for the family if they are based on the capabilities of the parents.

Multiple meetings with the parents may be necessary to fully determine the family’s capabilities. Capable families are willing to explore the following areas with their homestudy worker. If there are significant concerns in any one of these areas for the homestudy worker or assessment team, it should result in a denial to adopt.

**Motivation to Adopt**

Every family has their own set of motivations for wanting to adopt an older child. In older child adoption, the initial motivation is likely to begin with a tugging of the heart, only later to be weighed against the practical concerns of the mind. The decision to adopt is a process for most families, and the homestudy provides an opportunity to explore this process. Asking the following questions can help assess the parents’ motivations:

- How did the family come to the decision to adopt an older child?
- What are the reasons they want to parent this child?

These questions will help to reveal whether the family has reached a point of clarity in their decision and if they feel confident in their reasons for adopting an older child. It is important for both parents to feel equally confident in their decision to adopt and to be honest with each other and the social worker if there are any concerns about parenting an older child. Families who educate themselves about the needs of an older child and have honestly evaluated their own capabilities are more likely to be successful.

Unfortunately, there are families that bypass this type of thorough self-evaluation. These families can be led by the heart and adopt for the wrong reasons, with the best of intentions. Bringing a child into a home for the wrong reasons places that child at risk of further harm and rejection. It is the adoption professional’s obligation to ensure that children are being placed with families for whom the motivation to adopt is founded in the parents’ commitment to nurture the physical, emotional, and spiritual needs of the child.
**Parent Commitment**

Emma’s parents did not know what commitment really meant until they were faced with ongoing and severe behaviors. Emma had become aggressive toward her teacher and was suspended from school for the third time. Difficult situations such as this put commitment to the real test.

“Parent commitment” was the only parent factor identified as representing a “significant difference” between intact and disrupted or dissolved adoptions (McRoy, 1999), making it a critical area to assess, but a universally difficult factor to discern pre-adoption. The challenge during a homestudy is that parents cannot accurately answer theoretical questions about what they would do in situations such as those Emma’s parents faced. However, asking parents questions about past committed endeavors and how they dealt with those experiences will bring some insight to their commitment capabilities.

Two signals may help identify a high level of commitment. One signal is that committed parents will have less detailed preferences for their child, an indication of high flexibility, another positive attribute for successful families. Commitment to learning is the second: commitment to learning about the potential needs of their future child, learning the skills to meet those needs, and building a support system before placement are also important areas that can be assessed pre-adoption.

Even when a parent feels pushed to the limit, those with commitment will continue to focus on the child’s needs and use language that is child-centered and not founded in their own emotional needs. As parents start to lose their sense of commitment, they will begin to focus primarily on parental and family sacrifices and what the child has done to affect family dynamics, etc. At that point it is important for the social worker or post-placement worker to recognize the need to refocus attention on the child’s pain and need for healing in order to once again instill compassion in the parents.

Johnny’s parents had to remind themselves not to take his running away as a personal rejection. They remembered that his fear is triggered by his past harm. He needed help to heal in his own time with their safe guidance. Johnny needed his parents to continue to see his preciousness despite his behavior. His parents were committed to helping him heal, and they had to learn new ways to reach him in order to bring about that healing. It took patience and commitment to use the right tools over and over.

It is common for parents to feel as though progress takes the form of one step forward and three steps back. The journey of healing is slow, and progress is found in small victories along the way. It is through commitment that parents can see these small victories and celebrate alongside their child. For Johnny, a warm glance and his touch on their shoulder was a small victory after four years in their home.

Commitment is the core ingredient of permanency for children, but it does not stand without flexibility, compassion, knowledge, insight, and realistic expectations.

**Realistic Expectations**

Sarah’s parents hoped and dreamed of their happy life together, but were constantly discouraged by the need to take time off from work and travel to counseling appointments. They never expected self-harming behavior. Therefore, they were overwhelmed by the behavior when it surfaced and did not learn how to deal with it.

Successful parents expect to feel disappointed and discouraged at times. It is not the feelings themselves that are the downfall; it is their unexpected nature that shakes the foundation of success. It is impossible for a parent to be prepared and expect all possible behaviors that may come their way. However, expecting the unexpected brings flexibility to parenting.

Unrealistic expectations can lead parents down a difficult path very quickly. It is extremely
important to assess the expectations of the parents before the child comes home. The adoptive parents’ child preferences will be important to explore. For example, if a couple is accepting of a child age six to 12 years with severe abuse in the child’s history, but at the same time the couple does not wish to utilize any outside counseling services unless absolutely necessary, then their expectations of life post-placement are unrealistic. Their limited degree of flexibility highlights a risk in their ability to parent this child successfully. For these parents, their dream is to provide love and support to their child, with the hope that will be enough. Love is not always enough. These parents risk finding themselves lost and disappointed.

It is possible to determine whether parents’ expectations are realistic by assessing how they describe their future child or what they imagine their life to be like after placement. The most successful parent is one that focuses on meeting the child’s needs, expecting that each day will bring both joys and challenges. Flexibility and realistic expectations can set the foundation for a smooth transition of a child into a new home.

Another area to assess in the homestudy is the parents’ ability to adjust to change, including an exploration of how they have dealt with change in the past. A parent should expect to change many aspects of his current life in order to meet the needs of his child. Post-placement, many parents are surprised by the needs of their children and the significant amount of time and money necessary to meet these needs. The family must have the financial means or access to financial support to meet the child’s needs.

A parent must be flexible as changes occur. In an older child adoption, parents should not focus on making the child into who the parents want the child to be. Instead, parents should focus on accepting the child for who she is. This support will help the child reach her full potential.

It is difficult for adoptive parents to give so much of themselves to their children and get little reward. Adopting an older child demands a parent that is committed to love unconditionally and expect nothing in return. Support systems can help when families are faced with this type of challenge by providing encouragement and proof that commitment to give openly can be exhausting, but great progress and rewards come with time.

Making a Good Match—The Heart’s Desire

In McRoy’s 1999 study, 87 percent of the disrupted adoptions and 76 percent of the dissolved adoptions were considered poor matches. Berry (1997) noted that a “good match” is based on compatibility (not physical similarity) between parent and child, and on finding families for adoptive placements based on their ability to meet the individual needs of the child. Sadly, as a child ages, fewer and fewer opportunities for adoption arise. It is crucial that, when the opportunity does arise, the matching process is taken under serious consideration.

- How well do the needs of the child and the expectations of the family match?
- Is this a qualified family that has been fully assessed and determined to be capable of meeting the needs of this particular child?

The heart’s desire is the starting point when assessing a good match for a family. Some parents begin with the idea of a younger child, but are led to older child adoption through the process of education, prayer, or an eventual change of heart.

For some families, it can be more difficult to make the decision to adopt an older child. It is saddening to hear a parent state, “I knew in my heart I really wanted a toddler, but I thought I was doing a good thing by adopting an older child.” From the beginning, the parents’ hopes, dreams, and expectations for the child are being negatively affected by an inappropriate match. Unintentionally, the parent begins a relationship with the new child while grieving for the younger
child originally envisioned. This type of loss can prevent the parents from connecting with their new child. They may find themselves needing healing alongside their child, which makes for a very long journey for both.

Each parent must be brutally honest about his or her heart’s desire, as it may be different for each spouse. The homestudy can provide an opportunity to explore these issues and ensure that each parent is confident in his or her preferences and wishes.

**Birth Order**

Birth order is a concern for many parents with children already in the home. Potential adoptive parents commonly ask the question, “What age child will best fit into our home?” While birth order is important to consider, families must recognize that any time a new child enters a family, every member is in transition to some degree. Interrupting birth order can bring special challenges to the transition, such as excessive competition and jealousy between siblings. Parents must consider the personalities of their children and the role they play in birth order. They must also explore how the new child will change the roles of children currently within the family. It will be important to help all children in the family achieve ownership of their new roles, and their special places in the family.

Families and agencies should work together to understand and prepare for the risks and challenges of adopting an older child out of their family’s birth order. Although there is no way to know if a child will be a perfect match for a family pre-placement, recognizing the desire of the family and how well the family’s expectations and capabilities match the child’s needs will lay a sound foundation for success.

**Prepared Families**

**Transparency About Risks**

Many families are alarmed to hear the risks related to adopting an older child, or the specific risks that face the child entering their home, but adoption professionals should not back away from sharing this information. Families need to be aware of all the risks involved in older child adoption. Awareness of these risks can promote more effective learning for parents in preparation for meeting the needs of their child.

For children with a difficult past, who may have come from a harmful environment, there are various ways these experiences can affect their behavior, health, and mental capabilities. Transparency concerning the child’s information will promote a secure and honest relationship between the agency and family, and the family will be more likely to seek support for post-placement services. Adoption agencies and adoption professionals have an obligation to families and children to fully disclose the child’s information. The more informed decision the parents can make, the better match they will have, and the more successful they can be.

**Parent Preparation**

Every parent should be fully prepared for the specific child that enters their home. Howard and Smith’s 2001 study showed that being fully prepared for adoption is a key predictor of positive child adjustment after adoption. Education and training must be provided to parents both pre- and post-adoption. Whether an adoptive placement is considered low risk or high risk, preparation and support programs for families should not be optional. Parental training should be extensive and specialized in order to truly prepare the family. Pre-adoption education programs should include information that will arm families with an understanding of the behaviors they may encounter and tools to deal with them.
Pre-adoption education also assists parents in ensuring that their expectations for the child are realistic. The preparation parents receive when adopting an older child should challenge them to learn about themselves while educating them about the barriers that may arise in connecting with their child. Parents need to be fully aware of the effects of trauma, loss, abuse, and neglect. The educational programs should be impactful, including hands-on activities and insightful information about the child’s perspective on adoption. Parents need to fully understand the child’s interpretation of the world in order to provide their child with a safe place for healing.

After a child comes home, the focus of education and training will most likely shift from teaching skills to helping parents apply the tools that were previously taught. Some families who have been successful parents of birth children may find it very frustrating when their trusted parenting tools fail to work. When true challenges begin to appear, the parents need encouragement, new tools, and insights to help them parent their adopted child.

All parents adopting children internationally or from state care are required to complete a specified number of education hours. However, parents adopting an older child should strive to educate themselves far beyond what is required. Prepared families are more successful, as they are more likely to have the tools necessary to reach the hearts of their children.

Child Preparation

Sarah did not know what her life would be like after she was adopted. She wishes she had been able to see her house and her school before placement, but instead she was taken to the house by a new caseworker she had never met, and was expected to hug two strangers she was to call Mom and Dad. For Sarah, the transition could have been easier, if only she had known what to expect. She was able to understand this would be a journey and it would be hard, but she was not given a chance to process all she was enduring. As a result, her journey has been much longer and more difficult than it needed to be. Our adoption procedures and systems failed Sarah and many more like her.

Older child adoption has given hope to many children from foster care, orphanages, and other difficult situations. The best hope for these children is to have a safe place in which they can learn to be happy and whole. For a child, the transition from all that is familiar to an adoptive home can be emotional and devastating. These children are likely to have come from a fearful past and do not believe they are safe in the home of their new family.

Children need to be prepared for this transition. Many children are leaving their culture, everything that is familiar. They need to be educated about what to expect in their new family, school, and community. Readiness programs for internationally adopted children should include language lessons for easier transition, as well as cultural education and family dynamics-focused activities, including role-play.

We know that predictability creates emotional safety for a child. We can begin to teach a child to feel safe in her new home by providing some sense of what her life will be like once she gets there. She will need to be provided with information about what her new surroundings will look like, and what the schedule and new rules will be. Pictures of the new family should be provided whenever possible. Contact between the parents and child is encouraged if this does not bring legal or emotional risk to the child or family pre-adoption.

Life books are important for children, and they are something each agency and family should encourage as the child begins his or her transition in a new family. Life books will help give the child
a sense of history and self-awareness.\textsuperscript{3} A child who understands where he came from can begin to understand who he can be.

**Supported Families**

**Support Systems**

Support systems are crucial for families of older child adoption. A call from a mother of two adopted daughters revealed exhaustion and frustration in her voice that sounded unbearable. Both young girls were exhibiting severe behaviors that had been going on for months. Her husband traveled for work and the nearest family member was 10 hours away. Support by phone and over the Internet can only provide so much help. Even for resourceful families that have all the tools, a lack of support can lead to discouragement.

Creating a support system pre-adoption has proven very valuable, because once families are at the point of crisis they are less likely to reach out to new support groups or adoption groups. Families need to look to others who have adopted and organizations that offer adoption support groups in order to build a support system that can be in place once their child comes home.

Finding a support group that is like-minded, that will provide sound advice, unconditional love, and nonjudgmental support is vital for each family. These support systems are commonly mentioned by families as their “saving grace.”

Assisting parents in finding the right help for their children is crucial. There are times when outside professional help is necessary. Therapists or mental health professionals can be invaluable to families in crisis or in need of supplemental guidance, but the family should be involved in the treatment. Parents should be brought into the intervention as much as possible.

It is important to note that parents are the true healers of their child. Healing occurs in the arms of safe parents, not necessarily in the office of the counselor or therapist. Whether dealing with serious behaviors, mental illness, or depression, parents remain the safe guide for their children.

**Early Intervention**

Studies have shown that 12 to 18 months from the time of placement constitutes a “danger zone” for families. Among disrupted families, one study (Barth & Berry, 1988) found an average 18-month period between placement and return of the child to the agency. Families who wait to reach out for help, hoping the situation was an isolated incident or that it will get better by itself, and families who have hesitated to reach out to their placing agency for post-adoption support for fear of being scrutinized as parents, are the families that find themselves in very tough places and take longer to heal from their experiences. Parents should always be encouraged to stay connected to their agencies or placing entities for support, resources, and tools.

**Common Challenges Faced in Intervention**

Although each family will encounter their own unique challenges, two common issues weigh heavily on many adoptive families. The impact of fear on a child and the dynamics of adult attachment are the underlying causes of problems for most parents living in crisis with a child. Parents that struggle with adult attachment issues commonly fail to see that their parenting style is contributing to the problem. The following sections will explain the importance of these two issues in older child adoption, and how parents can be proactive in their parenting to help themselves and their child.

**Impact of Fear**

Fear plays a significant role in the lives of children placed into homes at older ages. Their past experiences have shaped the way they trust and how they react to others. Many of these children have lived in fear of their caregivers.

\textsuperscript{3} A life book is scrapbook or story of a child’s life, starting at birth, and written for him or her. It may include pictures, mementos, souvenirs, etc. Because it may include sensitive parts of the child’s personal story, a life book should not necessarily be shared outside the immediate family.
and their environments. Fear is a powerful driver for children. “Disturbing behaviors –tantrums, hiding, hyperactivity, or aggressiveness are often triggered by a child’s deep, primal fear. They may be safe in their adoptive homes, but past traumas encoded in their brains are easily reactivated” (Purvis, Cross, & Sunshine, 2007, pp. 47-48).

Parents do not always understand why their children behave the way they do, and would likely react differently if they knew the child was scared as opposed to angry or defiant. Looking beyond the behavior to the needs of the child and what may be driving the behavior is a key for parents. Imagining what these past experiences were like for their child will give parents needed insight.

Johnny had been missing for six hours. His teacher reported that she had sent a note home that indicated a failing grade on a test. Johnny’s father was angry and frustrated because he ran away over a grade. “How could he be scared of us? He knows we won’t hurt him.” But Johnny’s past experiences had taught him he might not be safe, emotionally and/or physically, if he returned home. Johnny’s fear response caused him to react irrationally and attempt to keep himself out of harm’s way by hiding. He will have to re-learn how the world works within safe walls.

All older children available for adoption, regardless of their country of origin or circumstances, have experienced trauma and loss of some kind. These experiences may cause the child to suffer from chronic fear. It will manifest in each child differently through different behaviors. Every parent must have the patience to identify the fear and need behind the behavior. Nurturing that need will help disarm the fear and bring safety to the child.4

Adult Attachment
A mother pulls away as her newly adopted 12-year-old daughter tries to hug her. Surprised by her own behavior, the mother reaches out for help to understand why she cannot be openly affectionate with the daughter she loves so dearly. Through counseling she recognizes that she has not healed from the lack of affection and rejection she felt from her biological father.

A father becomes increasingly angry when his seven-year-old adoptive son cries as he speaks of missing his biological father. The father is aware his emotions are inappropriate and preventing him from providing his son with the support he needs. In counseling, the father explores his need to resolve his guilt from infertility.

Every parent brings his or her own experiences and the feelings attached to those experiences into parenting. Each parent has his own attachment style that dictates his relationship with his children. Parents can only help their children heal if they are willing to look at themselves and, if need be, heal alongside their children.

Ideally, potential adoptive parents should examine their attachment capabilities before adoption. During the homestudy, it is the social worker’s responsibility to ask the right questions to explore these areas with each parent. One way to do this is to listen for consistent, coherent life narratives. Gaps or difficulties in recalling a storyline indicate that some information is not integrated or resolved (Gray, 2007). Once these gaps are identified, these concerns should be discussed openly with the family. Another way is for the social worker to explore emotional or behavioral triggers that may exist in their current parenting or in other relationships, discussing events, and the emotions attached to these events, to fully assess the needs of the parent.

Everyone has past losses of some kind and everyone has experiences they have not yet processed; it is the willingness to accept and resolve these experiences that matter. Prospective

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4 Chapters 3 and 4 of The Connected Child (Purvis, Cross, & Sunshine, 2007) explain in more detail the impact of fear. These chapters provide the necessary tools for adoption professionals and parents to utilize in order to bring healing to children and parents alike.
adoptive parents need to be willing to examine themselves in depth before bringing a child into their home.5

**Conclusion**

Emma is fortunate to have parents that will meet her needs and give her a voice, while understanding her fear of rejection and warning signs of sensory overload. She will continue her occupational therapy and family counseling until she is able to regulate her own behavior. Emma’s parents know the future will bring joys and challenges, and they have shown commitment through the challenging times.

Johnny returned to the safety of his home and the nurturing arms of his parents. He is beginning to re-learn what it means to be part of a family and to feel safe. Although Johnny will continue to have memories of harm and will need lifelong healing, his journey has started due to having good, loving parents as guides.

Sarah’s journey will be long. She has disrupted from her initial adoptive family and joined a new family and is healing in her new surroundings. She has experienced many losses and will need safety, nurturing, and structure from her new parents in order to heal.

Emma, Johnny, and Sarah have shown us many things about what children need as they are placed in homes at older ages. They have taught us that each child has a voice, and needs parents who will guide the child to use it in the right way. Each child has needs, but is not always aware of what those needs are; each child needs a parent that can teach self-awareness without shaming. Most importantly, these children’s stories have confirmed that parents are the only true guides to healing and safety for their children.

There is an awesome responsibility and obligation in the word *permanent*. If our common goal as public and private agencies is to provide permanency for children, then we must fully understand what it takes for a child to heal after an adoption. Empowering parents to be healers of their children, and bringing healing to families that are living in crisis, should be one of our primary concerns.

It is the responsibility of adoption professionals to provide children with parents who are equipped with the right tools and the right hearts for the task at hand. Permanency can only be brought to adopted older children through capable, prepared, and supported adoptive parents. Only then will our children and parents be happy and whole.
Sources

The Life-Changing Decisions in Adoption: Advice to those Considering Adopting a Child

Kathleen Whitten

Introduction

The decision about which child to choose is almost too big to make, and that’s one reason adoption decisions are so difficult. Once you decide to build your family through adoption, let yourself sit with that decision for a while, as long as you need to. Celebrate your commitment to becoming a parent. That little respite will nurture and strengthen you for all the decisions to come.

This article is designed to help you with your decision by outlining four major considerations as you determine which type of adoption is right for you. You need to consider:

- Your child’s age
- Your child’s ethnicity
- Your child’s health status
- Your comfort level in having a relationship with your child’s biological family

Each major decision section includes three parts: one for the heart, one for the brain, and one for practical considerations.

In the information presented below, the “brain” sections—real information you need—comes from peer-reviewed, published papers in the fields of medicine, psychology, and social work. The age divisions mentioned are generally based on those designated by researchers, but there are no absolute age limits on any of the research reported here. Also, as you read, keep in mind that studies that generalize about all adopted children might not necessarily apply to your child. This might be good or bad, depending on the findings.

The “practical issues” sections explain why each decision in the process is important and what implications your choices may have. Your decisions about your child’s age, ethnicity, and health will determine which adoption agencies you can work with and whether you choose domestic or international adoption. Once you have answers to all the questions posed below, you will be in an excellent position to choose the best agency for your family. You will also be ready to respond to questionable “sales pitches” for waiting children who might not be right for you and your family.

Four Important Decisions In Your Adoption Process

1. Age: Do you see yourself adopting an infant, a toddler, or an older child?

In adoption, as in biological parenting, there are always surprises. You might envision an infant in your arms, gazing up into your eyes. But you might have an infant referred to you, and then learn that you have to wait—for her country’s government to negotiate an agreement with the U.S. Department of State, or for your birth certificate to be recertified. While you wait for her, she will develop into a toddler, without you. But you will still be her parent. Or you might envision a toddler, and be on an agency list for a little one,
only to get a call that there’s a five-year-old ready for a parent—and somehow you’ll know that you were meant for him, and he was meant for you.

The heart part
In your parenthood fantasy, how old is your child? How does it feel to imagine parenting an older or younger child? Are you comfortable with that new image, or anxious? Feeling comfortable is a good sign that you should seriously consider children of different ages. Remember that some anxiety about this is normal, not a sign to abandon the process.1

The brain piece: What you need to know
Infants, newborn to about six months, can attach to an adoptive parent more easily than older children, so their emotional transition into their new family is smoother. They have only just begun to learn a language, so if they’re adopted internationally, they will learn the adoptive parents’ language on about the same schedule as nonadopted children. With an infant, adoptive parents have the longest possible time to influence his or her development. Research shows over and over that children adopted as infants (before one year) are most like nonadopted children in all outcomes: parent/child attachment, school achievement, peer relationships, and behavior. Dutch psychologist Femmie Juffer, herself an adoptive mother, found that the age of internationally adopted children at placement had the greatest effect on their attachment to their adoptive parents, regardless of their birth weight or country of origin. It is better for children psychologically to be adopted as infants.

On the other hand, babies don’t sleep through the night. Infants adopted from orphanages may have medical, psychological, or emotional conditions that won’t become apparent until they are older. Infants need calm, warm, responsive, 24/7 care from you or from another sensitive, caring adult. When you hit your tenth night of 3 AM feedings, and you’re jet-lagged from two weeks abroad, calm, warm and responsive care might be the hardest thing you can imagine.

Older babies and toddlers, seven to 36 months, who have been securely attached to their caregivers in a foster family or orphanage, can form another secure attachment to adoptive parents who give them sensitive, responsive care. My own research with children adopted from foster care shows that the majority of them do form secure or ordered attachments with the adoptive families, even after a history of abuse. In addition, toddlers who are adopted into a “rich” educational environment—with toys, books, and a lot of talking—can overcome early deprivation and catch up to their early-adopted or nonadopted peers in cognitive development and school achievement. Children adopted from orphanages with more enriching environments and conscientious care are likely to fare even better in their adoptive homes. Still, doctors estimate that children experience one month of growth and developmental lag for every five months in an orphanage (Albers, et al., 1997).

Another issue to consider in adopting an older infant or toddler (seven to 36 months) is that by toddlerhood, many medical conditions that aren’t obvious in infancy can be more easily observed. These include autism and autistic spectrum disorders, deafness and specific language problems, and fetal alcohol syndrome.

Toddlers will have a longer transition into their adoptive families. This might require more time off work for the main caregiver. Challenges during the transition include language barriers for internationally adopted children. Most children begin their “vocabulary spurt” around 18 months, when they begin speaking in phrases of two or three words, and each day they speak one or two new words. Imagine a Chinese-born two-year-old, running through your house on her little legs, trying to tell you something important with a stream of her new Chinese words.

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1 The Parents’ Workbook sections in Labor of the Heart: A Parents’ Guide to Decisions and Emotions in Adoption include exercises to help you make these decisions.
My best advice is this: Expect the best, and at the same time prepare for anything. Most children adopted from orphanages or foster care fare very well. But some children adopted from foster care or orphanages at older ages have abnormal ways of showing they’re upset. These children may show sadness and hurt through quickly triggered tantrums that parents interpret as acting out or disrespect. Or they might hurt themselves, hitting or biting or scratching themselves. In fact, these ways of dealing with an emotional upset are a classic “miscue.” Children who react this way need comforting and reassurance from parents—comfort they learned not to expect from orphanage caregivers or birth family. So, unlike children raised from infancy with loving, responsive parents, they don’t just cry when they’re upset. They have tantrums or hurt themselves instead. This relieves their own distress by blowing off emotional steam or turning it into physical pain. Their forever parents can help them learn that they will be cared for and comforted. But tantrums and self-harming behavior can be unnerving to parents who aren’t prepared.

Cautions about outcomes for toddlers apply to older children, *preschoolers and older children (37 months and older)*, as well. In this discussion about children at various ages, though, remember that the addition of one month of age doesn’t magically change a child; it’s a convenient way to talk about various groups of children. The particular child you want to adopt may or may not adhere to generalizations about these groups.

In general, the older the child at the time of adoption, the greater the challenges for the parents. For example, the strongest predictor of cognitive achievement at age four for Romanian orphans was the child’s age at adoption. Late-adopted Romanian children were more likely to have unusual patterns of attachment, compared with non-deprived adoptees from the United Kingdom.

Children with clinical levels of Oppositional Defiant Disorder (ODD) or Attention Deficit Hyperactivity Disorder (ADHD) symptoms were more likely to have been adopted after age two, have had multiple foster home placements, and experienced abuse or neglect than adopted children with lower symptom levels (Simmel, et al., 2001). Many studies have found that an older age at placement is associated with more aggressive behavior in elementary-age children and more problem behaviors in adolescence.

Like toddlers, some older children can have a hard transition into their adoptive homes. If they are internationally adopted, they have the difficulty of learning English—and an entirely new culture, school, and family—at the same time they’re grieving the caregivers and friends they left behind at the orphanage. Their parents might need to plan for a much longer adjustment period than parents of babies and very young children.

Almost all older children adopted from the U.S. foster care system have experienced abuse or neglect. This makes them more challenging to parent. Some parents might decide to pursue this type of adoption out of altruism—certainly a worthy goal—and might imagine that all the children need is love. This is true, but proceed with caution: “love” must be defined not as starry soft-focused hugs, but as warmth, unfailing kindness, mature parental strength, and consistently firm but gentle limit-setting. You can learn the special techniques to put love into practice for these children, but be sure of your commitment.

We don’t know all of the factors that lead to problems in children adopted at older ages. We do know that empathetic, responsive parenting can help children overcome many emotional difficulties. And we also know that many so-called special physical needs in children from abroad are easily correctable with Western medicine.

**The practical considerations**

In general, “healthy” infants can be more easily adopted from other countries than from the U.S. According to the most recent data available, in the
U.S. in 2007, there were 6.1 infant adoptions out of every 1,000 abortions and births to unmarried women (Placek, 2011). Infant adoptions are often private, arranged between birthparents and adoptive parents by an agency or attorney. In most adoptions handled by an attorney, adoptive parents frequently pay expenses for birthparents, who decide after the baby is born whether to proceed with the adoption. Private agencies also arrange adoptions for U.S.-born infants. Agencies differ on their requirements for parents to adopt infants, with some requiring a religious commitment. Waiting times for a completed domestic adoption can range from months to years.

Foster-to-adopt programs are now more frequent in the U.S. through local Departments of Social Services. Infants and toddlers are sometimes placed with a foster family interested in adoption, but usually children who enter foster care are older. In 2009, children waiting to be adopted from the foster care system were, on average, eight years old and had been removed from their primary caretakers at age four (Children’s Bureau, 2010).

In addition, some states approve foster parents to adopt at the same time they’re approved to be foster parents. This means the completion of only one homestudy, and the possibility of adopting a child placed into your home as a foster child. Studies show that this form of adoption leads to reduced time in foster care and a shorter wait for adoption for some foster children. If you are interested in this type of adoption, contact your local social services agency. This program is a win-win situation, especially for the children who have continuity with the foster parents they’ve grown to love.

2. Ethnicity: Do you and your child have to match?

Political correctness has no place here—you might think you should feel a certain way about this question. But allow yourself to be absolutely honest in the privacy of your heart. Think about whether you are comfortable parenting children of a different race. Then try to imagine going outside your comfort zone. Make an effort to educate yourself about the long and controversial history of transracial adoption in the U.S. and Western Europe.

The heart part

For some people, it’s hard to imagine loving a child who doesn’t “match.” What can help you get specific? Visit children from other ethnic groups. Spend time with other multiracial families in your community, especially at a local adoptive families support group. This last part is important, because different cities offer different social and political environments for adopted children and multiracial families. Some of these might be more welcoming than others.

Theresa King, an adoption social worker and supervisor, began her career in Philadelphia 30 years ago with a private agency whose express purpose was placing African-American children in same-race homes. But for the past six years, she’s worked with some transracial placements. She has strong feelings about parents receiving solid preparation for transracial parenting. “To think you can do it with love alone—that’s just crazy, because racism is too deeply entrenched in American society,” she says.

Ms. King recommends a hard, searching look at three areas of your life, beginning with the extended family. Family reactions can be important, too, and they may not always be welcoming. Some grandparents have a difficult time imagining a grandbaby who doesn’t look like them. After the family, Ms. King says, think about your neighborhood. Many of us, especially white people, take a mostly white neighborhood for granted and don’t see it through the eyes of a person of color. Also consider your church or religious institution and the local schools. How diverse are they? How do the people get along? Is it a truly blended community, or still “separate but equal”? If they include almost no people of
your child’s race, how willing are you to seek out other settings where your child might see herself reflected in others?

On a personal level, think about what characteristics you think people of different races have. Toni Ayers, adoptive mom and adoptee herself, points out that all groups have a certain stereotype in Western society, stereotypes so woven into the fabric of our cultural myths that we’re not consciously aware of them. Our nonwhite children will fit into the racial hierarchy of the United States, and one of our many jobs as parents will be to help them deal with that.

Ayers says of transracial adoption, “Think about what this means for your whole family: If you’re white, you’re no longer a white family, you’re a multiracial family.” Even though there are some African-American and mixed-race parents who’ve adopted children of other races, most adoptive parents are white, and many adopted children are not. Until this mix changes, the advice of Toni and Theresa will hold.

The brain piece—what you need to know
Prospective adoptive parents should be informed about three aspects of transracial adoption: the long and controversial history of transracial adoption in the U.S., ethical problems in international adoption, and parenting a child of a different race.

History of transracial adoption
Transracial adoption has become more common in the U.S. and Western Europe in the past 20 years. Before about 1980, adoptive placements in the U.S. were usually made so that children could “pass” as biologically related to their adoptive parents. This practice reinforced secrecy in adoption, with parents and social workers keeping children from knowing their adoption history. Not everyone has welcomed transracial adoption, especially in the U.S. with its history of slavery and racism. Opposition to transracial adoption in the U.S. came from two main sources: institutionalized white prejudice against people of color and the National Association of Black Social Workers (NABSW), which opposed placing children of African and African-American descent with white parents. In addition, Native American tribes began to oppose the placement of Native children off the reservation with white families. Barbara Kingsolver’s superb novels The Bean Trees and Pigs in Heaven describe this dilemma eloquently and emotionally.

Ethical problems in international adoption
The economics of international adoption mean that children from impoverished, developing countries are adopted by parents in more developed—read: wealthy—countries. The potential for corrupt adoption practices exists in all developing countries, because Westerners have money and are willing to spend it on an adoption, and there have been some who are willing to break the law in order to facilitate adoptions.

In 1993, a group of countries passed The Hague Convention on the Protection of Children and Cooperation in Respect of Intercountry Adoption. The U.S. adopted it in 2000 through the Intercountry Adoption Act. Six years later, the U.S. Department of State published regulations to implement the Intercountry Adoption Act. The goal of the laws and agreements in the Hague Convention is to create safeguards to ensure that intercountry adoptions are conducted in the best interests of the child. The laws prevent abuses against children, birth families, and adoptive parents involved in adoptions in countries governed by the Hague Convention. They also provide for licensing or accrediting all agencies and all individuals providing adoption services. So all adoption agencies that are legally authorized to work in a Hague Convention country will have a valid, current license. The U.S. Department of State is responsible for keeping a list of licensed agencies, which can be accessed via their website (www.adoption.state.gov).

Parenting a transracially adopted child
Experts in transracial adoption recommend three ways to promote healthy adjustment for
children: become part of a community with people from your child’s ethnic group, learn about the experience of transracially adopted adults from your child’s ethnic group, and confront racism head-on.

Your family will encounter people who are totally mystified by the idea that you can even be a family if you all look so different. Every multiracial family has at least one story about this. The stories aren’t all pretty, but every parent has the chance to model tolerance and compassion, even to the ignorant and uninformed. Your children will watch you deal with these people, and will learn from your example.2

Practical considerations
In domestic adoptions, there are still barriers to transracial adoption. Many social workers still oppose it, although federal law forbids consideration of race or ethnicity in adoptive placements.

International adoption agencies are obviously more open to transracial placements because most adoptive western parents are white and most children to be adopted are not. Practical considerations related to ethics in international adoption mean that adoptive parents must do very careful homework to make sure they’re working with agencies that are not only licensed, but also very reliable and ethical. Check with other adoptive families, ask for their recommendations for agencies, and narrow down your list to three or four. Then post to e-mail lists and ask for people’s experiences with each agency.

3. Health: Can you take care of a child who isn’t perfectly healthy?

Your answer has to be “yes,” at least part of the time, because all children get sick. But some have chronic conditions that require more parental involvement and vigilance. When you think—and feel—through this issue and the questions below, put all your “should”s on the shelf—the ones that say, “I should be able to parent a child with any condition.” The only potential wrong step here is not being truthful.

The heart piece
Some parents find themselves drawn to children with special needs, or “waiting” children. They become informed about the kind of care their child will need, and find resources available in their areas, especially specialized surgery.

The brain piece: What you need to know
In international adoption, it’s important to remember that different countries have different rules on what constitutes “special needs.” In some, laws prohibit “healthy” children from being adopted by foreigners. Therefore, many basically healthy children in orphanages will be diagnosed as having significant medical conditions. But all countries under the Hague Convention require pre-adoption medical exams to find “excludable diseases” that would prevent a child from being admitted to the U.S.

A study comparing the pre-adoptive medical reports of 56 children adopted from the former Soviet Union and Eastern Europe with the children’s actual health status as determined by U.S. physicians (Albers, et al., 1997), found that pre-adoption reports included many unfamiliar neurologic diagnoses, but none were confirmed by the U.S. physicians. The pre-adoption reports mentioned developmental delays for half of the children, confirmed by U.S. check-ups.

Practical considerations
There are multiple practical aspects to your decision about health status. Adoption agencies will ask you to complete a very detailed application for a waiting child with special needs, so start on this early.

- Meet with a health care professional to ask about raising children with certain conditions.
- Interview parents of children with the conditions you are considering, and be as

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2 Chapter 9 of Labor of the Heart: A Parent’s Guide to Decisions and Emotions in Adoption describes some of the emotional and spiritual opportunities adoptive parents have found in this type of parenting.
thorough as possible educating yourselves. The American Academy of Pediatrics includes a group of adoption professionals who have access to the most complete and up-to-date information about the health of adopted children.

- Find a pediatrician before a child is referred to you. International adoptions may require a pediatrician with experience in international adoption, preferably a member of the “adoptmed” listserv.

- Health insurance is also a consideration. Some agencies require you to take out coverage on your child, regardless of his or her health status, before the adoption.

- Some agencies, especially public ones in the U.S., discount their agency fees for children with special needs. “Special needs” may mean anything from being older than 12 months to having multiple handicapping conditions.

- In international adoptions, you might need to specify that you’ll accept some conditions which seem more serious than they really are, given the realities of foreign laws governing which children can be adopted, and the sometimes fictional diagnoses in other countries. Your international agency and your adoption pediatrician can guide you.

- Ask your agency to give you as much information as possible about your child’s health.

4. Your Relationship with Your Child’s Birth Family

Your first thought might be, “What relationship? He’ll be mine, all mine.” He will be all yours, but he’ll always be part of his birth family, too, and they’ll be a part of him. Because they are his relatives, they will be yours, too. If you’re married, your husband’s or wife’s family became yours in law—for better or for worse. (Just think of all those mother-in-law jokes!) The same is true in adoption, but there are vastly different degrees of relationship and frequency of contact, depending on the type of adoption. The way your child thinks about birth families can be strongly influenced by you.

The heart piece

Natalie and her husband decided to pursue an open, domestic adoption because they wanted to know as much as possible about their children’s medical history. Both of their girls were adopted in the United States. “But most important,” she said, “we wanted our children to know as much as possible about their birthparents.”

Toni Ayers also wanted an open adoption, but for different reasons. “I have a relationship with my birthmother,” she says. “My parents helped me search, and I was in my mid-twenties when I found her. She’s like a distant aunt. I have a close relationship with my birth sister who’s 16 years younger and my maternal grandparents. I wanted an open adoption because the relationship with siblings is so important. Having the information is a gift.”

An adoptive parent’s worst fear is that biological parents will decide they want their child back. Media horror stories throw gasoline on that fire, although they represent only a tiny fraction of adoptions.

Many people have an idealized picture of a relationship among birthparents, adoptive parents, and children—like an all-inclusive, Norman Rockwell Thanksgiving dinner, with some extra folks related by adoption ready to dig into that turkey. Sometimes it works that way forever, sometimes only for a while. As in any relationship, adoptive parents can control only their part of it. Birthparents may live complicated lives, and some are not able to integrate their adopted children in their new lives. Many adoptive parents want an open adoption, or at least as open as possible, because they believe it’s in the best interest of their child to have as few secrets as possible. At the same time, it’s important to recognize that not
all birthparents want the same degree of openness, and not all birthparents are stable enough to continue a long-term relationship.

The brain piece: What you need to know
During the past 15 years, adoption agencies have changed their practices from confidential adoptions to actively promoting not only openness about adoption in the family, but also openness and contact between adoptive and birth families. In confidential adoptions, agencies give only minimal information about the birth family to the adoptive family and the adopted child. The information stops shortly after the adoption is finalized. The birthparents and adoptive parents never meet.

The official terms for different types of openness include “mediated” and “direct contact” or “fully disclosed.” “Mediated” means that the agency gives non-identifying information to birth families and adoptive families, and the agency workers act as go-betweens or mediators. Families might exchange photos, letters, or gifts, and may also meet occasionally. In “fully disclosed” adoptions, adoptive and birth families have direct communication and ongoing contact, and have identifying information about each other. All adoption professionals say that contact and relationships between birth and adoptive families are “subject to change.”

Very little research has been published on the outcomes for children in adoptions with different levels of openness. The definitive study in this area found that children reported being satisfied with the degree of openness in their adoptions, regardless of the level (Grotevant & McRoy, 1998). All children in the study showed similar curiosity about their birth families, regardless of the amount of information they had. All children had positive self-worth scores, indicating good self-esteem. The most important piece of the study showed that the children’s social and emotional adjustment was not related to the degree of openness in their adoptions.

A more recent study of 152 adopted adolescents by some of the same authors (2006) showed that 74 percent of teens who had contact with their birthmothers were satisfied with the contact, but those who were not satisfied wanted more contact. Among the teens who had no contact, about half wished they did have contact and half did not. The main conclusion adoptive parents should take from both studies: choosing one type of openness over another will probably not have a large impact on a child’s ultimate adjustment.

Practical considerations
If you choose a private, fully-disclosed adoption, in which you advertise for a birthmother and meet her, you’ll have the maximum amount of contact and an automatic fully-disclosed adoption. The same degree of openness through meetings is also available from some agencies for U.S. adoptions, and many agencies offer mediated contact with birthparents.

The amount of information about birthparents available in international adoptions varies dramatically. In some areas of some countries, birthparents attend ceremonies at which adoptions are finalized. In other places, birthparents must abandon their children and there is no information about them at all.

Your preference for a particular degree of openness will determine the type of agency and adoption you choose. Remember that, in the end, the degree of openness will probably not have a large impact on your child’s adjustment. It will, however, make a difference in your daily life—so think through and consider the best fit for yourself.

Balancing the Heart, Brain, and Practical Considerations
At some point in this process, you will probably experience at least one conflict between your heart’s desire, your brain’s knowledge, and what is possible in practical terms. You might need to abandon—or say a long good-bye to—one of your
heart’s desires in order to get the best for your child-to-come. Or you might need to say farewell to a certain vision you had of yourself. This could be an idealized vision of yourself as a parent, or an unhealthy view of yourself as a victim of circumstances.

On the positive side, it should be comforting to remember that your emotional work throughout this struggle will not be wasted. You will learn from it, and it will make you a better parent, because throughout your life with your child, there will be conflicts between what you want for your child and what is possible for you to give him. You can choose to embrace the decisions you’re making now about your child in the course of the adoption process, because it’s an important part of creating your family and making your family what it’s meant to be.

If you can’t seem to decide—and making these decisions can be extremely difficult—give yourself a little time. Maureen, an adoptive mom, described the “see-saw” she and her husband were on, failing to come to an agreement about certain decisions. “But then,” she said, “he turned 40, and he went into a diabetic coma. When God hits you with a brick like that, things become clear. All of the stupid stuff goes away, all the stops, the barriers. He woke up from the coma, and after he said he wanted a cannoli, he said he wanted a kid.” They began their adoptive parent training shortly after he came home from the hospital.

Finally, remember that at the end of this process you will have a child in your home, and let yourself be open to that child. As Senator Mary Landrieu has said, “Adoption has been the most wonderful thing that could have happened to me or my husband.” It will be for you, too.

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Resources and References

**Children’s Age**


- Hopkins-Best, M. (1998) *Toddler adoption: The weaver's craft*. Indianapolis, IN: Perspectives Press. Written by the mother of a boy adopted from Peru; adoptive parents recommend this as the best book on adopting toddlers. It includes adjustment and attachment issues, but does have a bias toward worst-case scenarios.


**Transracial adoption**
- Bridge Communications is a training group run by Toni Ayers, adoptee and adoptive mother, and her colleagues. See: www.bridgecommunications.org
- Rainbow Kids is a site, run by an adoptive mom, adoption advocate, and adoptee, that has excellent articles on international and transracial adoption, as well as links to agencies and waiting children. See: www.rainbowkids.com

**Children’s Health**
- National Organization on Fetal Alcohol Syndrome (www.nofas.org)
- National Library of Medicine sponsors an excellent site for peer-reviewed medical information written for lay readers. See: www.nlm.nih.gov/medlineplus
- University of Minnesota International Adoption Clinic http://www.med.umn.edu/peds/iac/

**Open Adoption**
- Homes, A.M. (2007). *The mistress’s daughter*. New York: Viking. Memoir by the critically acclaimed novelist and short-story writer; describes her experiences learning about her birth family, after her birthmother initiated contact with her. This is not about open adoption, but rather about the experience of an adoption that became open after the author reached adulthood.
- Insight: Open Adoption Resources and Support is a site of writings by birth mothers in open adoptions, maintained by Brenda Romanchik, a birthmother. See: http://www.openadoptioninsight.org/gift_of_a_child_in_open_adoption.htm
The Role of Prospective Adoptive Parents in Locating Their Future Child’s Birth Family

Hal Kaufman

Introduction

In the area of domestic infant adoption, the seeds of change have been planted and leading adoption professionals and prospective adoptive parents are taking notice. The adoption field is in the early stages of an important shift in the role required of families hoping to adopt domestically. The implication of this change is that prospective adoptive families will greatly benefit from taking a much more active role in locating expectant parents considering adoption. This is true even when the family’s adoption professional is searching for a suitable match on behalf of that family.

Consider the following facts:

- International adoptions decreased 24 percent between 2004 and 2008 and another 27 percent in 2009.¹ They dropped even further in 2010.²
- The number of women making adoption plans continues to trend slightly downward.³

With longer wait times and a decrease in the number of healthy, young children available for adoption from abroad, more prospective adoptive families will likely consider and proceed with a domestic adoption. Combining this with the fact that fewer women are making adoption plans makes it simple to conclude that, all else being equal, the length of time it will take to adopt domestically will increase. The experiences of many adoption professionals and prospective adoptive families back up this conclusion.

At the same time, some adoption professionals are noticing that expectant parents are taking a more proactive role in the process. As Susan Watson, Director for Domestic Adoptions and Birthparent Services at Spence-Chapin describes it, “More birthparents are approaching adoption professionals having already selected a family.” This is a monumental shift and is in stark contrast to the more traditional domestic adoption process, whereby the expectant family learns about adoption from the adoption professional and selects an adoptive family from candidates screened by that same adoption professional.

What Ms. Watson and others are observing matches what one might expect from those from the Millennial Generation. People in their teens and 20s, sometimes dubbed “Millennials,” are characterized as optimistic, inventive, and individualistic. They rewrite the rules and don’t see the relevance of most institutions. They are

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also masters of technology and social media.\(^4\)

It is reasonable to assume that this generation will continue to leverage technology to find ways to both learn about adoption and locate adoptive families.

So, if more families are hoping to adopt domestically, fewer women are making adoption plans, and more expectant parents who choose adoption are finding prospective adoptive families on their own, then prospective adoptive families must explore additional means of matching with expectant parents beyond what they have traditionally explored. Those families who continue to follow the traditional process and wait for their adoption professional to facilitate a match with expectant parents will be at a disadvantage compared with those who work hard to find and be found by expectant parents considering adoption.

Adoption Outreach

Adoption outreach, adoption networking, and adoption advertising are terms used to refer to the actions that prospective adoptive families take to “find and be found.” Many prospective adoptive families spread the word of their adoption plans through e-mails to friends and family, holiday letters, and social networking websites such as Facebook. They purchase business cards and a toll-free number, and advertise in newspapers and online adoption profile listing services such as ParentProfiles.com.

In many respects, personal adoption outreach is similar to searching for a new job. Many job seekers partner with professionals, such as headhunters and resume writers, but the most successful job seekers simultaneously do their own networking and advertising to increase their chances of finding the right job as quickly as possible.

Few if any job seekers would post their resume on an employment website such as Monster.com and then just wait for the phone to ring, yet many prospective adoptive families choose a similar, mostly passive approach when trying to build their family through adoption. Adoption outreach is something that families can do to complement what their adoption professional may already be doing. Just as in the job search, the key is to create as many opportunities as possible to find the right match.

From the Perspective of the Pre-Adoptive Family

There are benefits and risks associated with adoption outreach. For some families the risks may outweigh the benefits, but many families carefully choose certain outreach activities over others while simultaneously mitigating the risks.

Benefits

Faster Placement
The most obvious benefit for prospective adoptive families of complementing their adoption professional’s outreach with their own personal adoption outreach is a faster placement. When a family adds their own outreach efforts to the work that their adoption professional is doing, there can only be one of two outcomes:

1) The match occurs through the adoption professional just as it would have without personal adoption outreach (a neutral outcome).

2) The match occurs more quickly because the personal adoption outreach resulted in a match (a positive outcome).

Personal outreach cannot lengthen a prospective adoptive family’s wait time, and that is why those who do outreach, as a general population, will adopt more quickly than those who choose to wait.

More Control
Many families feel a greater sense of control over the adoption process and its outcome when they are doing their own networking and advertising to

match with expectant parents. Those families who harbor anxiety about why expectant parents would choose them to parent over other qualified families are likely to feel an even greater sense of control.

The additional control is also important for families who are more likely to wait longer for a match should they follow the traditional approach. For example, many adoption professionals report longer wait times for single and same-sex prospective adoptive parents compared to heterosexual, married couples. Similarly, the prospective adoptive family’s age and their expectations regarding gender, race, and openness can also play a role in how long they wait.

**Cautions**

**Adoption Law**

For adoption outreach purposes it is critical that prospective adoptive families understand adoption laws, such as the use of advertising, interstate adoption, and reimbursable birthparent expenses. The best way for prospective adoptive families to mitigate the risk of making a poor legal decision is to partner closely with adoption professionals who have experience in adoption law in the state in which they reside. In fact, the decision to do personal adoption outreach actually increases the need to build a strong relationship with your adoption professional.

It is also important for prospective adoptive families to remember that public advertising is only one of several components of adoption outreach. Even when advertising is prohibited, one can still network with friends and family, use business cards and a toll-free number, leverage Facebook, and pursue many other outreach activities.

**Fraud**

Unfortunately, there are some people who will attempt to defraud prospective adoptive families. Sometimes the prospective birth family “promises” their child to multiple families at the same time in the hopes of extracting money from as many families as they can before ultimately making a placement. Sometimes they may never make a placement or even be pregnant.

Families who do outreach are more likely to be defrauded when they lack adequate support from experienced adoption professionals. Adoption attorneys and social workers who have worked with hundreds of birth families and are less emotionally involved in the adoption than the prospective adoptive family are best suited to identify early warning signs of fraud and provide counsel on appropriate protective measures.

**Emotional Stress**

The goal of adoption outreach is to find or be found by expectant parents considering adoption. The more expectant parents the prospective adoptive family identifies, the more likely it is they will find a good match. That being said, it is also true that the more expectant parents they identify, the more times they may experience not matching. The recurring sense of “failure” may have an emotional impact on the prospective adoptive family and may dissuade some from doing adoption outreach at all.

One alternative approach for limiting the emotional stress is for prospective adoptive families to use their adoption professional to screen expectant parents. Families can network and advertise as the law allows, but can share their adoption professional’s contact information instead of their own. This approach not only reduces the risk of fraud as previously stated, but it also decreases the number of interactions between expectant parents and prospective adoptive families that do not result in a match.

**Implications for Adoption Professionals**

The decision to promote adoption outreach to families can have an impact on the type of

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5 The American Academy of Adoption Attorneys is a national association of over 300 attorneys who practice or have otherwise distinguished themselves in the field of adoption law. The Academy provides a membership listing on their website at http://www. adoptionattorneys.org
Relationships Between Families and Professionals

Adoption professionals who expect their families to network and market themselves create a different type of relationship with their families than those who do not. They create more of an equal partnership in the process instead of an outsourcing arrangement.

The language used by adoption professionals is an important element in developing the desired relationship. For example, first consider the adoption professional who believes that families do not want to do any outreach. This professional may be communicating something to the effect that: “You pay the fees and we take care of the whole process. We’ll call you when a prospective birth family shows interest in your profile.”

Contrast this approach with an adoption professional who expects families to take a greater role in the process and uses language such as this: “Here is what we will do and what you can expect from us, and here is what you can do, how we will support you, and what you can expect from your efforts.”

As you can see from these two simplified examples, even the language adoption professionals use to describe their philosophy, approach, and services is critical in creating the desired partnership that can achieve success.

Domestic Program Models

Adoption outreach initiatives create an opportunity to revisit existing service and pricing models. For example, some professionals offer two programs based on whether the adoption professional or the adoptive family finds the birth family. Some programs require the family to decide which program to enter at the beginning of the process, whereas other programs simply determine the final fee based on who identifies the birth family.

Adoption Connection in Cincinnati, Ohio, has embraced outreach training as a fundamental part of their services. Their fee structure requires families to pay a low monthly fee for outreach training and comprehensive support. “Providing outreach training aligns with our agency’s overall philosophy of empowering our families,” says Beth Schwartz, agency director. “The monthly fee provides even greater motivation for our families to do outreach. The sooner they match with a birth family, the fewer monthly payments they pay and the lower their overall adoption costs.”

Training and Support

Adoption professionals who believe that families should take an active role in finding their future child’s birth family must consider whether they are providing adequate training and support to enable their families to succeed.

Many adoption professionals simply provide families with a list of outreach ideas. This approach is insufficient for three primary reasons:

- Providing a “to-do” list to a family who does not appreciate its role in the process and is not empowered or motivated will not yield satisfactory results.
- Adoption outreach is about creating opportunities for expectant parents and
prospective adoptive families to find each other, but it is also necessary to simultaneously prepare for exactly that to happen. Adoption outreach training that excludes topics such as how to talk with birth families and assess risk is like a career coach teaching someone how to network to find a job while ignoring the need to prepare for interviews.

Although technology makes adoption outreach easier in many ways, it is also intimidating and a barrier for many.

The most complete and successful training programs will motivate and empower families to take action, help them develop their personal outreach plan, and provide them with the necessary support for a simple and smooth implementation.

**Conclusion**

Technology, the role that expectant parents increasingly play in the adoption process, the rise in the number of prospective adoptive families, and the drop in the number of international adoptions are just a few of the driving factors that are creating change in the adoption field. The question that both adoption professionals and prospective adoptive families need to ask is: Are we doing all that we can to achieve success in this changing world?

Personal adoption outreach refers to the networking and advertising activities that prospective adoptive families can do to find their future child’s birth family. It is something that families can do and adoption professionals can encourage and support to achieve success for all stakeholders. Adoption outreach may result in a faster placement. It also gives families greater control over the process, while simultaneously requiring them to partner closely with adoption professionals to ensure that they adhere to adoption laws, minimize the risk of fraud, and manage emotional stress.

Not all adoption professionals agree that prospective adoptive families should pursue their own adoption outreach, and in a limited number of cases, adoption outreach may not make sense. However, when either the adoption professional believes that he or she needs to offer additional support to their clients to either stay in business or meet their clients’ needs, or when prospective adoptive families want to increase their chances for a faster adoption, adoption outreach is a valuable strategy worth exploring.
Health Insurance for Adopted Children

Mark McDermott with Elisa Rosman

Background of Legal Rights

As a result of federal and state legislation established several years ago, discrimination by health insurance carriers against adopted children is prohibited in most situations. Prior to 1993, however, numerous problems existed. For example, insurance carriers could delay coverage until an arbitrary date, such as the finalization of the adoption in court. Carriers would also refuse to cover adopted children based on pre-existing conditions.

The Omnibus Budget Reconciliation Act of 1993 (OBRA), Public Law 103–66, amended the Employee Retirement Income Security Act of 1974 (ERISA) to require any group health plan providing coverage for dependent children to provide adopted children with the same benefits and coverage given to biological children of a plan participant. OBRA specifically eliminated any requirement that the adoption be finalized in court before coverage could begin. The new law also prohibited carriers from restricting coverage of adopted children on the basis of a preexisting condition.

The changes implemented by OBRA apply to the medical benefit plans of all employers subject to ERISA. Since ERISA covers almost all employers except government employers, OBRA provided broad coverage to families with adopted children.

Even the gap in coverage for federal employees has been closed. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-91, which also amended ERISA, extended the prohibition against discrimination to governmental employers. As a result, health insurance coverage for adopted children is now available to all families covered by group health plans as soon as those families assume financial responsibility for the children. HIPAA included several other important reforms. For example, HIPAA mandates that group health plans must offer the employee the right to enroll an adopted child in the plan immediately. Under prior law, immediate enrollment was not always possible if the adopted child joined the family at a time when the employee was not eligible to elect for or alter coverage; i.e., when it was not “open season.”

With the exception of a small number of states that have special new laws, adoptive parents cannot purchase insurance to cover the birthmother’s medical expenses because she is not one of their dependents. The insurance coverage discussed in this article only applies to the separate medical expenses of the child. If the adopted child is a newborn, he or she will incur medical charges separate from the birthmother’s for hospital care from the time of birth until discharge from the hospital, and these are the expenses eligible for coverage by the adoptive parents’ carrier.

Under the law, as amended by OBRA and HIPAA, coverage does not commence until the time of “placement.” The term “placement,” however,
is defined in the statute as the time when the adoptive parent assumes financial responsibility for the child.

Non-employer-sponsored health insurance plans (i.e., individual plans) are not subject to federal regulation; instead, they are regulated by state law. Fortunately, many states have their own laws that prohibit health insurance discrimination against adopted children. According to the Council for Affordable Health Insurance, there are mandates in 45 states requiring health insurance plans to cover adopted children. The states that lack such statutes are Alabama, Delaware, Michigan, Missouri, New Jersey, and the District of Columbia.¹ If you are covered by an individual plan, you should check the laws of your own state to determine your rights. (See below for a list of state resources.)

Nuts and Bolts

As soon as you have made the decision to adopt, contact your health plan administrator to find out how to enroll your child. To make sure you are eligible for HIPAA's protections, apply for health insurance for your child within 30 days of your child’s adoption or placement for adoption. As long as you apply within 30 days, your child cannot be excluded based on a pre-existing condition.²

If your insurance company denies your child coverage, Deborah Ghose, offers the following advice via the website www.adopting.org: “In 1995, Mr. Melbinger wrote to the Department of Labor on behalf of [Adoptive Families of America] AFA, requesting specific guidance from the Department on various questions that had arisen following the introduction of 609(c). In response, the Department issued a 6-page Advisory Opinion that addressed in detail such questions as: How is "placement for adoption" defined? Must a plan cover the birth expenses of the mother or the hospitalization expenses of a premature baby? A copy of this letter would go a long way with an employee benefits person who was questioning the eligibility of an adoptive child for health coverage.” The letter Ms. Ghose references can be found at: http://www.dol.gov/ebsa/programs/ori/advisory95/95-18a.htm

If your insurance company denies payment for post-adoptive lab work (required for many internationally adopted children), the Adoptive Families magazine website has a letter that your pediatrician can customize to send to your insurance company. This can be found at: http://www.adoptivefamilies.com/medical under “Insurance Coverage for Medical Screening Tests.”


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New Jersey
New Jersey Department of Banking & Insurance
http://www.state.nj.us/dobi/index.html

New Mexico
New Mexico Public Regulation Commission, Insurance Division
http://www.nmprc.state.nm.us/id.htm

New York
New York State Insurance Department
http://www.ins.state.ny.us/

North Carolina
North Carolina Department of Insurance
http://www.ncdoi.com/

North Dakota
North Dakota Insurance Department
http://www.nd.gov/ndins/

Ohio
Ohio Department of Insurance
http://www.insurance.ohio.gov/Pages/default.aspx

Oklahoma
Oklahoma Insurance Department
http://www.ok.gov/oid/

Oregon
Oregon Insurance Division
http://www.cbs.state.or.us/ins/

Pennsylvania
Insurance Department
http://www.insurance.pa.gov/

Rhode Island
Rhode Island Department of Business Regulation
http://www.dbr.state.ri.us/

South Carolina
South Carolina Department of Insurance
http://www.doi.sc.gov/

South Dakota
South Dakota Division of Insurance
http://www.state.sd.us/drr2/reg/insurance/

Tennessee
Tennessee Department of Commerce and Insurance
http://www.state.tn.us/commerce/index.shtml

Texas
Texas Department of Insurance
http://www.tdi.state.tx.us/

Utah
Utah Insurance Department
http://www.insurance.state.ut.us/

Vermont
Vermont Department of Banking, Insurance, Securities & Health Care Administration, Insurance Division
http://www.bishca.state.vt.us/InsurDiv/insur_index.htm

Virginia
Virginia State Corporation Commission Bureau of Insurance
http://www.scc.virginia.gov/division/boi/

Washington
Washington State Office of the Insurance Commissioner
http://www.insurance.wa.gov/

West Virginia
West Virginia Offices of the Insurance Commissioner
http://www.wvinsurance.gov/

Wisconsin
Wisconsin Office of the Commissioner of Insurance
http://oci.wi.gov/oci_home.htm

Wyoming
Wyoming Insurance Department
http://insurance.state.wy.us/
Introduction

Adoption is a long and often emotionally laborious process. One of the many stressors for families is the financial challenge of adopting. Since its inception in 1997, the adoption tax credit has helped many thousands of middle-income American families defray the high costs of adoption, making adoption a reality and providing loving, permanent families for millions of children who might have otherwise languished in foster care or institutions.

History

After years of advocacy by adoption organizations, including the National Council For Adoption (NCFA), the Federal Adoption Tax Credit went into effect for tax year 1997. This initial adoption assistance program was part of the 1996 Small Business Job Protection Act and set the maximum credit at $5,000 per child ($6,000 per child with special needs), and allowed for the credit to sunset (expire) on December 31, 2001.

In 2001, Congress passed parts of President Bush’s tax incentive package, the Economic Growth and Tax Relief Reconciliation Act of 2001.¹ This act extended the adoption tax credit until December 31, 2010 and increased the initial maximum credit to $10,000 per child (for both special needs and non-special needs adoptions) and also indexed this amount for inflation annually. The process of indexing the credit allows for adjusting the maximum allowed amount annually for inflationary factors as they pertain to adoption and the economy. The credit for adopting a child with special needs was made permanent with this act. For 2010, the indexed tax credit maximum was $13,170 per child.²

The Way Things Currently Stand

The adoption tax credit as provided for in the 2001 legislation was set to sunset in tax year 2010 unless it was renewed by Congress. The Patient Protection and Affordable Care Act of March 2010 temporarily increased the adoption expense credit and fringe benefit exclusion limit for adoption assistance programs and made the credit refundable. The changes are effective for tax years beginning after December 31, 2009.

This extension allows for the maximum adoption credit to be increased to $13,170 per eligible child. This increase applies to both non-special needs adoptions and special needs adoptions. Also, the adoption credit is made refundable, meaning that

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families will realize the full benefit regardless of taxes paid. The scheduled sunset relating to the adoption credit is delayed for one year (i.e., the sunset becomes effective for tax years beginning after December 31, 2011).

On December 17, 2010 the 2010 Tax Relief Act was signed into law which extended the Bush era tax cuts through tax year 2012. The extension for tax year 2012 is not refundable as it is with the Patient Protection and Affordable Care Act which applies only for tax years 2010 and 2011.

If the adoption tax credit is allowed to expire after this current extension, the maximum tax credit for the adoption of children with special needs would decrease to $6,000 per child, with the credit for adoptions of non-special needs children expiring altogether.

**Adoption Tax Credit**

For the tax year 2010, the maximum adoption tax credit was $13,170 per child for qualified adoption expenses. The tax credit phase-out began for taxpayers with a modified adjusted gross income (AGI) in excess of $182,180, and was completely phased out for taxpayers with a modified AGI of $222,180 or higher.

The Internal Revenue Code §23(a)\(^3\) defines the adoption tax credit as follows: “In the case of an individual, there shall be allowed a credit against the tax imposed by this chapter the amount of the qualified adoption expenses paid or incurred by the taxpayer.”

Furthermore, the Code defines “Qualified Adoption Expenses” to be “reasonable and necessary adoption fees, court costs, attorney fees, and other expenses which directly relate to, and the principle purpose of which is for, the legal adoption of an eligible child by the taxpayer.” Examples of qualified expenses include fees paid to an adoption agency, legal fees, travel-related expenses, all official costs, and any other reasonable cost associated with adopting the identified child. Excluded expenses include any expenses deemed illegal by State or Federal Statute, expenses for surrogate parenting arrangements, expenses related to step-parent adoption, or expenses reimbursed through grants or employer assistance programs.

The Code further defines an “eligible child” to be “an individual who has not attained age 18 or is physically or mentally incapable of caring for himself.” To apply for the credit, married couples must file a joint return and the maximum credit limits are the same for both married couples and single adoptive parents.

The adoption tax credit differs from a deduction, exclusion, or exemption in that it actually reduces, dollar-for-dollar, the taxpayer’s tax liability by subtracting the amount from taxes owed. A tax credit is specifically different from a deduction, in that while a tax credit offsets a taxpayer’s tax liability, a deduction offsets income from a taxpayer’s adjusted gross income to come to taxable income (the amount of income taxable). Therefore, a tax credit is much more advantageous than a deduction, because the tax credit is a refund of applicable taxes to offset the cost of adoption. More simply, an adoptive parent’s tax dollars go to fund approved adoption expenses rather than the federal government.

With the exceptions of tax years 2010 and 2011, the adoption tax credit has historically been nonrefundable, allowing for a five-year carry-forward for those portions within the maximum allowed amount not able to be utilized in the taxable year in which the credit arose. The carry-forward is applicable for future tax years even if the taxpayer’s modified AGI in those years exceeds the amount allowable or extends into the phase-out range. The carry-forward credit must be used within four subsequent years of the taxable year in which the adoption occurred.

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\(^3\) For a copy of the tax code referenced throughout this document, see: http://www.law.cornell.edu/uscode/26/23.html
For tax years 2010 and 2011, the tax credit was made refundable by The Patient Protection and Affordable Care Act of March 2010, meaning that regardless of the taxes paid, families will be able to receive the maximum allowed benefit in the year of finalization.

Furthermore, for taxpayers who has finalized adoptions before tax year 2010, yet had applicable carryforwards from previous credits, these taxpayers remaining credit will be fully refundable in tax year 2010.

The IRS Code also defines in which tax year the credit becomes applicable, which differs slightly for domestic and some international adoptions. If the child is “a United States Citizen or a child who is foreign born, but who is a resident at the time the adoption commences,” the taxable year for which the adoption tax credit can be claimed is the year in which the adoption became finalized. Simply put, once you have received the final adoption decree from the court, you may claim the credit in that tax year. Any expenses paid prior to this filing are eligible as if incurred in the tax year the decree is entered. This is also applicable for those families who adopt their child on a legal guardianship decree from the country of origin or any family whose child enters the country on an IR-4 visa. The credit is applicable once an adoption is finalized in the United States.

In the case of adoptions for which the Hague Convention determines the finality of the adoption, the IRS will accept that declaration of finality for the purposes of allowing the tax credit. For those international adoptions not under the auspices of the Hague Convention, finality is determined when the competent authority in the sending country enters a decree of adoption or the adoption is finalized in the home state of the adopting parents.

For additional expenses that may occur in subsequent years pertaining to an adoption that occurred in a previous tax year, the taxpayer may claim those expenses in the tax year they are incurred, as long as the total amount claimed is within the maximum allowable amount per child. For families who are adopting multiple children, it is important to understand that the maximum amount is per child; therefore, families are able to claim a credit for each child adopted, even if such adoptions take place in the concurrent tax year.

An example of the application of the tax credit: John and Jane Doe adopt a child in 2009. John and Jane incur $20,000 in eligible adoption expenses. In 2009 their tax liability on their Form 1040 was $15,000, and they had $13,500 withheld from their paychecks during the year. In a normal year, without the adoption tax credit, they would expect to pay $1,500 to the Federal government before April 15. However, with the maximum adoption tax credit they are permitted to take ($12,150), their tax liability is reduced to $2,850, which means they will receive a refund of taxes withheld of $10,650. Instead of paying the government in taxes, their tax dollars were applied to their adoption.

The tax credit and subsequent carry-forward is especially beneficial to lower-income and middle-income families, in that any part of the credit not taken in year one may be carried forward for five years. This helps families plan their adoption expenses with loans that can be repaid as taxes are offset during subsequent years. Families can thus make lump-sum payments towards the loans, in effect paying them off faster, while reducing the amount of interest paid.

An example of application of the carry-forward: John and Jane Doe adopt a child in 2009. John and Jane incur $15,000 in eligible adoption expenses. In 2009 their tax liability on their Form 1040 was $6,000, and they had $5,000 withheld from their paychecks during the year. In a normal year, without the adoption tax credit, they would expect to pay $1,000 to the Federal government before April 15. However, with the adoption tax credit they are permitted to take, their liability is reduced to $0, which means they will receive a refund of taxes withheld of $5,000. Instead of
Adopting a Child with Special Needs

The designation of “Child with Special Needs” only applies to children who are U.S. citizens. A child qualifies as a “Child with Special Needs” if the taxpayer adopts a child who has been deemed by the State to qualify for adoption subsidy assistance (State assistance or SSI). The taxpayer may claim the entire credit after adopting a child from U.S. foster care or a child who is a U.S. citizen who has been deemed to have special needs by a competent American authority, even if the expenses they incurred were less than the maximum amount ($12,150 for 2009).

An example of this special needs application: John and Jane Doe adopt a child from foster care in 2009. John and Jane incur $2,500 in eligible adoption expenses. In 2009 their tax liability on their Form 1040 was $14,000, and they had $13,000 withheld from their paychecks during the year. Although their qualified adoption expenses were only $2,500, John and Jane are still eligible to take the entire $12,150 tax credit, reducing their tax liability to $1,850. John and Jane will receive a refund of taxes withheld of $11,150.

Adoption Tax Exclusion

As previously stated, the taxpayer must exclude amounts reimbursed via an employer program or otherwise when determining qualified adoption expenses for the purpose of the adoption tax credit. There is, however, a provision in the Code (IRC §137)\(^4\) that provides an exception for income received through an employer adoption assistance program. It states: “gross income of an employee does not include amounts paid or expenses incurred by the employer for qualified adoption expenses in connection with the adoption of a child by an employee if such amounts are furnished pursuant to an adoption assistance program.”

The definition for qualified adoption expenses is the same as that used for the adoption tax credit, and the maximum exclusion amount and phase-out limits apply as those set forth for the credit. With the costs associated with adoption and the varied companies supplying adoption assistance programs to their employees, this exclusion can potentially save a family as much as $3,500 in taxes.

Failed Adoptions

The Code does not include specific language to indicate that taking a credit is allowable for a failed adoption attempt. It also does not specify that the credit be taken only for successful adoption efforts. The only direct recognition of failed adoption attempts is found in the filing requirements, which note that the taxpayer may or may not know the name and age of the child for whom the credit is claimed. Furthermore, in the instructions for filling out Form 8839, the form that accompanies the 1040, on which the taxpayer claims the adoption tax credit, it states, “Complete all columns that apply to the eligible child you adopted or tried to adopt.”

Currently there are no clear requirements and no clear guidelines from the IRS that make it clear the adoption effort must have been successful to be eligible for the credit. If a taxpayer has experienced an unsuccessful adoption of an identified child and incurred qualified adoption expenses, it is highly recommended that they seek professional help from a local CPA for guidance on how to best claim the credit for the qualified adoption expenses.

\(^4\) See: http://www.taxalmanac.org/index.php/Internal_Revenue_Code:Sec._137:_Adoption_assistance_programs
Other Tips for Adoptive Parents, Forms, and Suggestions

Once the taxpayer(s) have experienced a successful adoption, they should claim their child as a dependent on their tax return for the tax year the child entered the home. The child will need a Taxpayer Identification Number, which can be either the child’s Social Security Account Number or an Adoption Taxpayer Identification Number (ATIN) (this can be applied for by using Form W-7A). This form requires approximately four to eight weeks for processing and expires on the two-year anniversary of its issuance or the issuance of the Social Security Account Number, whichever comes first. It is a good idea for the taxpayer to obtain the ATIN in situations where it appears that a Social Security Number will not be issued in time to file tax returns in a timely manner.

To take the adoption credit or exclusion, the taxpayer must complete Form 8839, entitled “Qualified Adoption Expenses,” which is used to itemize qualifying adoption-related expenses. Form 8839 is then attached to either the Form 1040 or Form 1040A, whichever is applicable.

The credit is also reported as a subtraction to taxes owed on the applicable form. Other applicable forms are the Form SS-5, which is used to apply for a Social Security Number for your child, and Form W-7A, mentioned above.

Adoptive parents should make sure to keep all applicable records, receipts, journals, and invoices from their adoption journey and retain this information for at least three years after the credit has been used in full. It is also a good idea for them to either consult a tax professional or their employer’s human resources representative to plan for withholdings from their pay in the tax years that the adoption credit is applicable; otherwise, the availability of the funds released to the taxpayer through the tax credit will only be available annually at tax filing time.

While all families may not be able to recoup the entire tax credit in some years, a personal accountant or adoption agency representative can help the family estimate how much they should be able to receive within the allowable time period.

The IRS tax topic can be viewed at:

Forms referenced in this document can be accessed at:
http://www.ssa.gov/online/
Love and Practicality: Adoption Financing

Ellen Wilson

Introduction

A lifelong journey begins with the decision to build a family through adoption. In addition to the hope, joy, and anticipation, this decision brings with it many emotional and practical details to attend to along the way. Which car seat is safest? Which name will be best? What color to paint the child’s room? How to decide on a pediatrician… and, how will we afford this?

Whether adopting domestically or internationally, expenses related to adoption can present a big hurdle to families. Fortunately, there are a growing number of resources available to families to help them manage the cost of adoption, including tax benefits, grants, employer assistance, and more.

The Federal Tax Credit

The federal tax credit\(^1\) is a good place to start for most families. This tax credit is available to many families for qualified adoption expenses. Everything from adoption fees and attorney’s fees to court costs and travel expenses incurred as part of an adoption are covered. As long as the costs are “reasonable and necessary” and their principle purpose is for a legal adoption of a child under age 18, they can be included.

On March 23, 2010, President Obama signed Public Law 111-148, the Patient Protection and Affordable Care Act. This is good news for the adoption community, as this act preserved the adoption tax credit for another year and increased it to $13,170. Specifically, here are the provisions contained in the health care bill relating to the tax credit:

- The current adoption tax credit has been extended until the end of 2011.
- The new dollar limit and phase-out of the adoption credit are adjusted for inflation in tax years beginning after Dec. 31, 2010.
- The value of the adoption tax credit has been increased from $12,150 to $13,170 for both non-special needs adoptions and special needs adoptions.
- The increase is retroactive, meaning that any adoption occurring after January 1, 2010 is eligible for this higher credit.
- The credit is now refundable. This means that even families that owe zero taxes can receive the full tax credit in the form of a tax refund to help with their adoption-related expenses.

An expanded federal tax credit offers substantial assistance for families. Credits are much more valuable than deductions to most families because they come right off the top of the tax bill.

As with many tax credits, there is an income limit on the adoption credit. This information is updated or revised each year. For 2010, the limit was based on modified adjusted gross income (modified AGI).

\(^1\) Like many things related to the United States Tax Code, there are specific requirements and details for families to consider. Detailed information on the tax credit is available in NCFA’s Adoption Advocate #21, Tax Benefits for Adoption: The Adoption Tax Credit, available at: https://www.adoptioncouncil.org/images/stories/documents/adoptionadvocate21.pdf
For Families with modified AGI for 2010 of:  

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<td>$182,521 to $222,520</td>
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**Employer Assistance**

Employer assistance is more widely available than many people realize. A 2009 study by Hewitt Associates\(^2\) finds that more and more companies—of different sizes, industries and states—offer adoption benefits. While a recent survey by the Society for Human Resource Management found that the percentage of employers offering adoption benefits had decreased as a result of the economic downturn,\(^3\) growth over the past 20 years is impressive. The Hewitt study shows that in 1990, 12 percent of companies offered adoption benefits, increasing to 51 percent in 2008. Nearly 60 percent of these companies extend benefits to part-time employees as well.

Despite the increasing prevalence of adoption benefits, utilization is very low. Hewitt estimates that only about 0.1 percent of employees use the benefits each year. Many employer adoption plans qualify under IRS Code section 137 as “adoption assistance programs,” which means that employers can reimburse qualified adoption expenses free of federal income taxes.

The federal tax credit and employer assistance can work together to help reduce the cost of adoption. Families may claim employer-provided assistance and the tax credit in the same year, provided they are used to cover different expenses. It is worth noting that “double-dipping” is not allowed. Families cannot take a tax credit for expenses that have already been reimbursed by employers.

**Military Benefits**

Active-duty military personnel\(^4\) may be reimbursed for up to $2,000 in qualified adoption expenses per adoptive child. Most of the costs covered by employers or eligible for the federal tax credit would be covered under the military benefit; however, travel expenses are not covered. Reimbursement is made after the adoption is finalized and only if the adoption was completed through a state adoption agency or a non-profit private agency. Additional assistance may be available for military families adopting a child with special needs. Further, the military’s Exceptional Family Member Program is designed to ensure that the adoptive families of children with special needs are assigned to duty stations at which the child’s needs can be met.

**Adoption Grants**

Adoption grants are available through a wide variety of organizations. While grants rarely cover the entire cost of adoption, the appeal of a grant (versus a loan) is that it does not require repayment (although it is reported as income to the recipients). There are many granting organizations, some of which offer need-based grants, while others offer general adoption grants. A large number of organizations focus specifically on certain types of adoptions (international or domestic), or even on certain countries. When looking into grants, families should consider the requirements the organization has for applicants, such as religious affiliation, adopting a child with special needs, adopting internationally, etc. It is also important to take into consideration the grant review process and submission deadlines.

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\(^4\) There are specific qualifications for reimbursement under the Military Adoption Reimbursement program including active-duty status, timing of reimbursement, qualified adoption agencies, etc. Details are available at http://www.militaryfamily.org/assets/pdf/Qualifications-for-Reimbursement.pdf
Conclusion

In addition to the assistance and grant programs mentioned above, there are many other conventional financing avenues available for families, including various types of loans and assistance from religious and civic organizations.

Adoption is a journey of many steps. While the challenge of financing an adoption may seem significant, with a little legwork, families can find the resources that match their needs. With hearts that pull them forward, and practical steps along the way, families can make their dreams of adoption a reality.
Section 3

Foster Care
Finding Permanence for Kids: NCFA Recommendations for Immediate Improvement to the Foster Care System

Elisa Rosman and Chuck Johnson, with Marc Zappala

Introduction

In 2008, the most recent year for which statistics are available, there were 463,000 children in foster care, of which 123,000 were waiting to be adopted. That year, 285,000 children exited foster care: 52 percent were reunified with a parent or caregiver, 19 percent were adopted, eight percent went to live with other relatives, 10 percent were emancipated, seven percent moved into a guardianship setting, two percent were transferred to another agency, and one percent ran away. The number of children emancipated from the system—who “age out” of foster care without ever having been placed with a permanent family—has increased steadily over time, reaching a record of 29,516 in 2008.1

As Bass and colleagues state in their introduction to The Future of Children, “Foster care is intended to serve as a temporary haven for abused or neglected children who cannot safely remain with their families...even in the best situations, foster care is inherently fraught with uncertainty, instability, and impermanence” (p. 6). Bass’ review of the research finds that children in foster care are at high risk for poor educational outcomes, demonstrate low levels of engagement at school, and are less likely to be involved in extracurricular activities. Children in foster care are also more likely to have physical and mental health problems than children who do not grow up in foster care.2

“Aging out” of foster care before one is ready for adulthood and independence also has a detrimental effect on children. As Courtney and colleagues explain, “Too old for the child welfare system, but often not yet ready to live as independent young adults, the…foster youth who ‘age out’ of care each year are expected to make it on their own long before the vast majority of their peers” (p. 5).3 As part of the Midwest Evaluation of the Adult Functioning of Former Foster Youth, Courtney used data from Illinois, Iowa, and Wisconsin to determine how foster youth were functioning as they made the transition to adulthood. In the most recent report from the study, surveying the youth at age 21, the researchers found negative outcomes in multiple domains. Compared to a National Longitudinal Study of Adolescent Health (“Add Health”) sample of 21-year-olds who had not aged out of foster care, the foster care youth:

- were more than twice as likely to not have a high school diploma or GED;
- were less likely to be employed;

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reported a median income of $5,450 from employment over the previous year (compared to $9,120 for their Add Health peers);

were more likely to describe their health as being fair or poor;

were less likely to have health insurance;

were more likely to have been pregnant;

were more likely to have belonged to a gang (males only);

were more likely to have pulled a gun or knife on someone; were more likely to report ever being arrested, convicted, and ever being arrested as an adult;

were more likely to report being cut or stabbed by someone (males only);

were less likely to report performing any unpaid volunteer or community service work in the past twelve months; and

were less likely to report maintaining a positive relationship with an adult since age 14 (60 percent versus 77 percent).

The research is clear: remaining in foster care is not good for children. Children’s advocates, foster care alumni, policymakers, and other stakeholders are all calling for reform of the current foster care system. On May 27, 2009, the White House hosted a summit to discuss needed reforms, and the National Council For Adoption (NCFA) drew from this and many previous discussions with child welfare advocates to develop the recommendations presented in this issue of the Adoption Advocate. These suggestions for improving the foster care system have found broad support among child welfare advocates. They should be implemented immediately to ensure that more children currently residing in the foster care system find a safe permanency option.

Issues and recommendations are presented for the following areas of reform:

Foster and adoptive parent recruitment and retention

Increasing adoptions out of foster care

Getting more families involved in the lives of foster children

Support/training for frontline child welfare workers

Encourage states to provide care until age 21

Focus on permanency

Court-related changes

Policy/legislative changes

Parent Recruitment and Retention

Issues

It must be the goal of the foster care system to move more children into permanency quickly, whether that permanency is achieved by safely returning the child to his or her biological family or by the child’s adoption out of foster care into a new, loving family. For the latter—those children who will not be returning to their biological families—the most direct way to ensure permanency is to recruit more foster and adoptive parents. Sixty percent of children adopted out of foster care are adopted by their foster parents.4

Fortunately for children waiting to be adopted, American culture is strongly pro-adoption, and surveys show that Americans’ pro-adoption sentiments specifically apply to adoption from foster care. For example, a nationally representative survey released by the Dave Thomas Foundation for Adoption in 2007 found that 72 percent of Americans viewed adoption favorably, and 69 percent thought the government should do more to encourage adoptions out of foster care. Additionally, 30 percent had considered adoption, and 71 percent of these had considered foster care adoption specifically. In short, over 20 percent of Americans have considered adopting a child out of foster care.5 Furthermore, a team of researchers at the Urban Institute, using data from the National


Survey of Family Growth, found that women’s interest in adopting increased by 38 percent between 1995 and 2002. This includes an increase of 35 percent among Black women, 29 percent among Hispanic women, and 50 percent among lower-income women.\textsuperscript{6}

Unfortunately, too often Americans’ enthusiasm for foster care adoption does not translate into actual adoptions from foster care, largely because prospective adoptive parents either do not know where to begin the process or they do not receive the outreach and support they need from the public or private agency once they apply. In one nationally representative survey conducted by Harris Interactive on behalf of NCFA, only 29 percent of respondents who had considered adopting or foster-parenting a child actually inquired with their state agency about doing so.\textsuperscript{7} In the Urban Institute study cited above, while the percentage of women who expressed interest in adoption and actually took steps toward that end was 16 percent in 1995, it had decreased to only 10 percent by 2002.

Parent recruitment is only half of the equation. Once recruited, foster parents must be supported to ensure they remain in the system, and there is considerable evidence that this is not happening. Research has consistently found high yearly turnover rates among foster parents. According to adoption advocate and author Jayne Schooler, 50 percent of foster parents drop out within a year of their first placement, citing three main reasons: lack of respect, lack of effective support, and lack of relevant training.\textsuperscript{8} Similarly, in an analysis of data from the 1991 National Survey of Current and Former Foster Parents, 40.5 percent of former foster parents listed lack of support from their agency as a reason for exiting the system.\textsuperscript{9}

Many potential foster parents are lost before they even make it through the front door. Julie Wilson and colleagues from Harvard’s Kennedy School of Government analyzed data from four sources: the Adoption and Foster Care Analysis and Reporting System (AFCARS); a survey of state adoption directors from 43 states; case studies of adoption practices in Boston, Miami, and San Jose; and an analysis of adoption applicant case records in those three cities. They found that only one in 28 people who contact a child welfare agency actually adopts a child from foster care. Many of the individuals in the three cities complained that it was difficult to find the right person to call, there was no answer when they first called, they left voicemail messages but got no return call, or they got bounced around from person to person before locating the correct staff member.\textsuperscript{10}

\textbf{Solutions}

There are multiple documented strategies for increasing parent recruitment and retention.

For an excellent overview, see the study by the Urban Institute previously cited. Below are specific examples of recruitment and retention strategies that NCFA believes will make a crucial difference in the lives of children waiting to be adopted from foster care.

\textbf{Public service announcements (PSAs).} PSAs represent one method by which a difference can be made quickly. In the Wilson study, many of the individuals who participated in Boston, Miami and San Jose reported hearing about foster care adoptions through electronic and print media, such as \textit{Wednesday’s Child} segments on television,

\begin{itemize}
  \item \textsuperscript{7} Atwood, T.C. & Zappala, M. (2007). Public attitudes regarding the federal child welfare system’s financing and performance. \textit{Adoption Advocate}, 3.
\end{itemize}
billboards (in Miami, one billboard slogan read “Adoption has been made easier”), PSAs, and booths at community festivals.

NCFA has attempted to increase foster care and adoption awareness and adoption by developing radio and television public service announcements featuring country music recording artist and NCFA National Adoption Spokesperson Rodney Atkins. NCFA’s PSAs are designed to educate listeners and viewers on the nation’s need for more adoptive and foster parents. To date, the radio PSA has been released to 1,250 country music radio stations and 125 Christian radio stations, and been broadcast over 20,000 times. The television PSA was distributed to more than 200 television stations nationwide and has aired on the ABC-TV network, CNN, and the USA Network and its cable subsidiaries, and was the first PSA shown by Wal-Mart’s in-house television network during National Foster Care Month in May 2009.

Another example of an effective PSA is the “You don’t have to be perfect to be a perfect parent” campaign, created by the Advertising Council and sponsored by the U.S. Department of Health and Human Services. A series of these ads, run in Spanish, prompted a huge influx of calls to AdoptUsKids. Another campaign targeting African American families was unveiled in early August of this year.11

Child-specific campaigns. Research also suggests that campaigns may be most effective when they are “child-specific”; that is, featuring specific children, as the Wednesday’s Child campaigns do. The efforts made by Children Unlimited, a private adoption agency in South Carolina, are highlighted in a paper on recruitment from the National Center for Resource Family Support.12 Children Unlimited reported that 22 percent of their inquiries and 10 percent of finalized adoptions over a nine-month period came from child-specific print media campaigns. Another example of a child specific focus is the AdoptUsKids.org website, sponsored by the Children’s Bureau, Administration for Children & Families, and the Department of Health and Human Services. With the mission of recruiting and connecting foster and adoptive families with children across the country, AdoptUsKids provides a national photolisting of children waiting to be adopted out of foster care.

Successful first contact. Public service campaigns are only useful if the people responding to them receive the answers and support they need. Wilson and her colleagues recommend that agencies establish specialized adoption hotlines to ensure that individuals who call receive a timely, professional response. Agencies should also have a very clear road map of the adoption process ready and available for potential adopters. Finally, Wilson’s report recommends that the emphasis be placed on recruitment, and not on screening out prospective parents who may not be appropriate, when the initial contact is made.

Use of more federal dollars for recruitment. States should use more federal dollars for parent recruitment. According to NCFA’s recent analysis of states’ Child and Family Services (CFS) 101 forms, while 22 percent of children in foster care are waiting to be adopted, states are only spending an average of 1.2–1.3 percent of available federal funds on parent recruitment and training ($102 million out of an available $7.9–8.5 billion). As NCFA states in its report, the decision of states “to allocate relatively paltry amounts of federal funding toward parent recruitment and training services results in children aging out of the system unnecessarily.

Increased emphasis among the states on parent recruitment and training is necessary to build on the success of ASFA and improve outcomes for

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11 To view the campaign, see: http://www.adcouncil.org/default.aspx?id=17
Spending more money is only useful if the money is spent productively; more research is required immediately to determine what types of parent recruitment efforts are most effective. On a long-term basis, researchers need to examine the factors that motivate relatives to adopt or serve as guardians for their kin.

**Public-private partnerships.** Public-private partnerships have shown promising results in reaching prospective adoptive parents as well as keeping them in the system. In public-private partnerships, state and private agencies work together to recruit, train, and retain foster and adoptive parents. For example, the One Church, One Child program works to increase the number of African American children adopted out of foster care by actively recruiting permanent adoptive homes (see: [http://nationalococ.org](http://nationalococ.org)). In Maryland, as just one example, One Church, One Child works directly with local social service departments. This strategy may be especially important for recruiting minority families. In the Wilson study, the authors review research which finds that it is especially difficult to recruit and retain minority families and that public agencies are increasingly contracting with “minority-controlled agencies” to reach these families.

Private agencies also possess the ability to provide a “seamless system” of support services, including post-placement services, for adoptive and foster parents. They are also well regarded for their record of making adoptive and foster parents feel valued throughout the process. For example, Bethany Christian Services, one of the nation’s largest private adoption agencies, involves foster and adoptive parents in its recruitment efforts and provides financial rewards to families who successfully recruit other foster families. By involving foster and adoptive parents in the agency’s important work, Bethany Christian Services sends parents the message that they are equal partners in the important work of finding families for children. Expanding the role of public-private partnerships in recruiting, training, and retaining adoptive and foster parents will help alleviate the high caseloads with which public agencies typically struggle, allow more targeted recruitment efforts, and ultimately lead to more children being adopted out of foster care.

**Make sure agency staff know what works for retaining families.** The National Resource Center for Family-Centered Practice and Permanency Planning identifies multiple factors that increase the likelihood of foster parent retention. Agencies that work with families must be aware of and embrace these principles, ensuring that foster parents:

- Maintain a positive relationship with agency, characterized by sharing information, support, and mutual respect
- Understand their rights and responsibilities and what is expected of them
- Have access to training
- Receive support from caseworkers and more experienced foster parents

**Training.** Agencies, programs, and governments must make appropriate training available to foster and adoptive parents. Children often enter foster care as a result of abuse and neglect that leave them scarred and emotionally fragile. One example of the type of training that can make a huge difference in the success of a foster care/adoption placement is Trauma Informed Assessment and Preparation (TIAP). Jayne Schooler describes TIAP as a “purposeful, therapeutic approach to the assessment and preparation process for foster and adoptive parents” to help close the gap between expectations and reality.

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Trauma-competent adoptive and foster parents understand:

- the impact that childhood trauma can have
- the unique needs and strengths of the child who has survived the trauma
- the impact on the family of parenting/being a sibling to these children
- the demands of the relationship
- what services are needed

Increasing Adoptions Out of Foster Care

Issues

Beyond parent recruitment and retention, it is vital to know what factors successfully predict adoption in order to further promote and increase adoptions out of foster care. Hansen and Hansen, economists at the University of Mary Washington and American University, used foster care data from across the United States to determine the most important predictors of adoptions out of foster care. They found that “the size of the adoption assistance payment is the only policy variable that is clearly and positively correlated with success in achieving adoption for waiting children” (p. 3). In fact, using a linear model to predict the number of adoptions out of foster care, they found that an increase of $36 in the adoption assistance subsidy correlated with ten additional adoptions.16

Solutions

Adoption subsidies. There are several strategies for increasing the number of adoptions out of foster care. The first, as suggested by the above research, is to make adoption subsidies for families adopting out of foster care uniform and standardized in all states throughout the country. A survey of almost 250 families conducted by Children’s Rights in 2005 found that 81 percent of parents said the availability of adoption subsidies was important in their decision to adopt, and 58 percent said they could not adopt without a subsidy.17

Funding for pre-and post-adoption support. A second solution is to increase funding for pre- and post-adoption support services. Families must not feel that they are on their own in deciding to adopt out of foster care. The 2008 Congressional interns at the Congressional Coalition on Adoption Institute (CCAI) provided an excellent list of services that would promote adoption out of foster care, including:

- support groups for parents, adopted children, and other children in the home
- professional counseling services
- respite care services
- educational conferences for adoptive families.18

The need for support services was highlighted by a recent news story from the United Kingdom, in which a survey found that the number of disrupted adoptions had doubled in the past five years, from 26 to 57. The advocacy group Adoption UK is quoted as saying that they believe the increase in the number of disruptions indicates insufficient support and preparation for adoptive families.19

Getting More Individuals Involved in the Lives of Foster Children

Issues

Americans should be encouraged to simply get involved in the lives of children in foster care.


19 Bennett, R. (2009, July 10). Number of adopted children returned to care has doubled in five years. The Times. Retrieved from http://women.timesonline.co.uk/tol/life_and_style/women/families/article6675966.ece
As the Urban Institute report on foster parent recruitment and retention cited above states, “There are many ways to support the foster care adoption process other than by adopting. With so many individuals interested in adopting but not taking steps, the field might consider strategies to encourage these individuals to support foster care adoption in other ways” (p. 24).20

**Solutions**

One example of a national campaign working toward this goal is Raise Me Up (http://www.raisemeup.org), funded by Casey Family Programs. With the motto, “You just have Raise Your Hand/Raise Awareness/Raise Your Voice and say you’ll help,” Raise Me Up is committed to giving individuals a concrete way to make a difference in the lives of children in their communities. The approach is three-pronged:

- “Raise Your Hand” links individuals to opportunities to volunteer, mentor, or make a donation;
- “Raise Awareness” connects people to local events designed to strengthen children and families and increase public awareness about foster care; and
- “Raise Your Voice” helps individuals get involved with efforts to lobby elected officials at the local, state, and national levels to support children in foster care.

In their report on strategies for improving the foster care system, the 2009 Congressional interns at CCAI also stress the importance of mentoring. They argue for two federal policy changes to promote mentoring: allowing foster care maintenance payments to be used for extracurricular and social activities, and giving foster parents the authority to allow youth in their care to participate in extracurricular activities.21

Legislation such as the Foster Care Mentoring Act described below would further promote the role of mentors in foster children’s lives.

**Support/Training for Frontline Child Welfare Workers**

**Issues**

A strong child welfare staff is crucial in order to support children and families in the foster care system and help facilitate transitions out of foster care. However, the situation is dire among child welfare and social service workers in the foster care system, largely due to high vacancy rates and high turnover rates.

In a survey of 42 states conducted in 2004, the American Public Human Services Association (APHSA) found that, for child protective service workers, the average vacancy rate was 8.5 percent and the average turnover rate was 22.1 percent. These high rates are no doubt largely due to low wages. The average salary for child protective service workers was $35,553, which is lower than salaries for nurses, public school teachers, police officers, and firefighters.22

In the most extreme cases, these deficits in the child welfare workforce result in true tragedy. For example, according to a recent article in *The Miami Herald*, it was discovered in July 2009 that more than 70 child welfare workers in Florida falsified records over the course of two years. As a result, 14 children were left in unsafe homes, and six children were lost track of temporarily. When questioned, workers blamed the falsifications on unduly high caseloads. While the Child Welfare League of America recommends that case workers have no more than 15 foster care cases at any one time, the Department of Children and Families in

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Florida does not cap caseloads. They reported that the average caseload in Florida is 14-22 cases per caseworker.23

In all but the most extreme cases, these challenges with the workforce are not insurmountable. If the reasons for high vacancies and high turnovers can be identified, then they can be addressed and fixed. In the APHSA survey cited above, state administrators reported that the two biggest problems in recruitment and hiring were the perceived imbalance between the demands of the job and the compensation, and the fact that starting salaries were not competitive with comparable positions. Furthermore, when asked about factors contributing to turnover, the most common and severe problem reported was the high, demanding workload.

**Solutions**

**Additional funds to improve conditions for workers.** The issues of insufficient salary and too high workload can be addressed, but doing so requires federal leadership and funding. In the APHSA study, states reported that they could not implement any strategies that required new resources, which means that additional funds must be directed toward child welfare workforce issues. With additional funds, money could be allocated to steps that have been identified as making a difference in retaining workers: reducing caseloads, increasing salaries, improving supervision, creating career ladders and opportunities for professional growth, and improving training.

**Different hiring practices.** A report from the Annie E. Casey Foundation highlights a change in hiring practices in Michigan that translated to lower caseloads for caseworkers; which, in turn, translated to better care for children and families. In 2001, the Michigan Family Independence Agency (FIA) instituted a central hiring and training system. As a result, vacancies among child welfare workers that had previously taken four months to fill were filled in two weeks. This meant that caseworkers no longer had to take on the caseloads of workers that had left for the four months it used to take for a replacement to be hired. Michael Downer, the director of personnel for FIA's human services office, explained why the new system worked: “The key to the whole process was having a centrally managed pool of extra staff that we could hire, put through training, and manage from here in Lansing…So, if we knew that someone is needed in Alpena County, we could ship a person to Alpena County” (p. 20). They found that, as a result of the reforms, not only were vacancies being filled faster, but FIA was also attracting stronger applicants than ever before. There is also a new training facility tied in with the hiring pool, meaning that new hires are not only starting more quickly, they are also starting better trained and more prepared.24

**Federal workforce initiatives.** The changes listed above are local, although they are dependent on federal dollars. But there are also federal initiatives that could make a difference. The CCAI 2008 Foster Youth Interns made a series of suggestions to increase the number of qualified social workers and professionals who are working in the foster care system, which include:

- Establishing a National Foster Care Services Corps to help communities that have a large number of job openings find qualified workers;
- Using federal funding for states to provide bonuses for child welfare workers who serve for 5, 10, 20, etc. years of service; and
- Encouraging states to include actual foster care youth in child welfare workforce trainings.25


Similarly, in the introduction to *The Future of Children* special issue on foster care, the authors recommend a federal loan forgiveness program for social work students. As with established loan forgiveness programs in other disciplines (e.g., health professionals who participate in health disparities research; lawyers who practice public interest law), students who graduate and work for a child welfare agency for a specific amount of time would have their loans forgiven.26

**Encourage States to Provide Care Until Age 21**

**Issues**

As reviewed in the introduction, youth who age out of foster care at age 18 show significant negative outcomes, as compared to nationally representative samples of their peers.

**Solutions**

Recent legislation has begun to address this issue. The Fostering Connections to Success and Increasing Adoptions Act of 2008 amends Title IV-E of the Social Security Act to give states the option of covering children in foster care, as well as certain children in an adoption or guardianship placement, after age 18 (for full text, see http://www.govtrack.us/congress/billtext.xpd?bill=h110-6893).

Using data from the Midwest Study described in the introduction, Courtney and colleagues “find strong evidence that allowing foster youth to remain in care past age 18 promotes the pursuit of higher education, and more qualified evidence that extending care may increase earnings and delay pregnancy” (p. 2). For example, 67 percent of 19-year-olds who were still in care were enrolled in a school or training program, compared to 31 percent for those who were not in care. Furthermore, 37 percent of the 19-year-olds still in care were enrolled in a two- or four-year college, compared to 12 percent for those not in care. Young women who remained in care were also 38 percent less likely to become pregnant by age 19.27

There is also a cost–benefit argument to be made for extending care to age 21. According to Amy Dworsky of Chapin Hall, the average annual cost in Illinois of extending foster care to age 21 is $38,000 per youth. However, the average increase in lifetime earnings that can be expected from youth remaining in care and completing post-secondary education is $72,000. This translates to a 2:1 benefit–to–cost ratio.28

**Focus on Permanency**

**Issues**

The passage of the Adoption and Safe Families Act of 1997 (ASFA) increased the focus on permanency for children; that is, achieving reunification or adoption for children in a timely fashion. The landmark report from the Pew Commission on Foster Care states permanency as one of the guiding principles of its work: “All children must have safe, permanent families in which their physical, emotional and social needs are met” (p. 12).29

**Solutions**

Agencies need to adopt programs and practices that promote permanency. For example, researchers at Chapin Hall recently evaluated the Legal Aid’s Foster Children’s Project (FCP) in Palm Beach County, FL. The program was designed to expedite the exit of children to permanency (reunification or adoption) by providing legal representation to those aged three and under that entered shelter care.

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The evaluation found that children who were represented by FCP exited to permanency at a much higher rate than children not represented by FCP.30

Following the model of the cost-benefit analysis described above related to keeping children in care until age 21, there also needs to be more research demonstrating the true cost savings when a child finds permanency as compared to aging out.

### Court-Related Problems

#### Issues

A report from the GAO clearly identifies issues within the court system as a barrier in moving children from foster care into permanent homes. In a survey of all 50 states, the GAO found that the barriers were due to insufficient numbers of judges and attorneys to handle the caseload, a lack of cooperation between courts and child welfare agencies, and inadequate training of judges and attorneys in child welfare cases.31

In our policy priorities, NCF A states that “[o]ne of the greatest problems with foster care today is dysfunctional family courts that trap children in a lengthy process of hearings and legal technicalities, resulting in children growing older in foster care and becoming less and less likely to be adopted.”32 Clearly, this is an area where change is necessary and could have meaningful impacts.

#### Solutions

**Following the "15 of 22" provision of ASFA.**

The 1997 Adoption and Safe Families Act requires that parental rights be terminated for children who have been in foster care for 15 of the previous 22 months. This is intended to move children out of unsafe situations and into positions where they can be eligible for adoption. However, a GAO report in 2003 found that states exempt a large number of children from the “15 of 22” provision, especially children who may be more difficult to place, such as adolescents. (This information was based on data from only nine states, as the other states did not even collect data on use of the 15 of 22 provision.)33 Officials in the six states that the GAO visited as part of the report, however, reported that the establishment of specific timeframes, such as the 15 of 22 provision, does help states focus their priorities on finding permanent placements for children. This indicates that this is an important tool, which, if used appropriately and on a more widespread basis, could help move children out of foster care in a timelier manner.

Using flexibility in adoption incentive payments to increase the number of people working on child welfare cases. Consider this example from the GAO report:

> …[W]e found that some states are taking advantage of the flexibility allowed in the use of adoption incentive payments to increase the number of people working on child welfare cases. During our site visit to Oregon, child welfare officials told us that the lack of legal resources has inhibited the state’s ability to quickly pursue court cases against birth parents to terminate their parental rights and thereby free a child for adoption. To address this issue, Oregon has used its adoption incentive payments to contract for additional lawyers to litigate these cases. According to our survey results, 6 states have used the incentive payments to

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hire or contract additional legal staff and 13 states have used these funds to hire or contract additional social workers (p. 39).

This creative use of funds to increase the legal staff working on cases could prove to be an important solution. According to findings from the Fostering Results project from a survey of 2,241 judicial officers nationwide, among judges for whom abuse and neglect cases make up more than 25 percent of their docket, 52 percent say that overcrowded court dockets delay safe, permanent placements for children in foster care. That percentage goes up to 64 percent for judges for whom abuse and neglect cases make up more than 75 percent of their docket. Furthermore, 46 percent of the judges reported that the lack of available services for children and families in need was their greatest frustration with the child welfare system. Clearly, this is an area in which an infusion and/or redistribution of resources could make a significant difference.

Legislation

Issues

There are numerous pending legislative bills that, if passed, could greatly improve the lives and outcomes of children in foster care in this country. There is also a need to set up mechanisms to ensure that passed legislation is uniformly enforced across the country.

Solutions

Fostering Connections to Success and Increasing Adoptions Act of 2008. States should take advantage of the opportunity provided by the recently passed Fostering Connections to Success and Increasing Adoptions Act to increase the age at which youths legally exit the system from 18 to 21. This would give youths in foster care more time to form family connections and prepare for life as an independent adult.

Tax credits. Research has shown that government financial support for adoptive parents leads to higher adoption rates for children in foster care, however some of this support is scheduled to disappear. Improvements to the Adoption Tax Credit made under the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) must be reauthorized prior to their scheduled sunset in 2011. EGTRRA increased the amount parents of children adopted out of foster care were eligible to claim under the tax credit from $6,000 per special needs child (and $0 per non-special needs child) to $10,000 for any child. EGTRRA also mandated that parents of children adopted from foster care do not have to document their adoption-related expenses in order to claim the credit, thus eliminating a large amount of confusing paperwork from the process and increasing the number of adoptive parents claiming the tax credit. If these improvements are allowed to expire in 2011, adoptive parents will receive far less government support than they are currently receiving, and fewer children will be adopted from foster care. It is vital that legislation be passed to keep the tax credit provisions of EGTRRA from expiring.

ICPC. The Interstate Compact on the Placement of Children (ICPC) establishes uniform legal and administrative procedures to govern the interstate placement of children. It was originally designed in 1960 to make it easier to place children across state lines. However, over time, the flaws in the ICPC became apparent; the ICPC suffered from lack of accountability, poor enforcement, and outdated bureaucratic processes, all of which resulted in long delays in private agency adoptions. As a result of these problems, the Association of Administrators of the ICPC (a subgroup of APHSA) proposed regulations to reform the ICPC in 2007, but critics of the ICPC believe


the reforms did not go far enough. For example, NCFA recommended removing private placements by licensed child placement agencies from ICPC. This would allow states to focus more on children in public care, who were the intended beneficiaries of the ICPC initially. Not only did this not occur, NCFA believes that, in fact, the new ICPC actually gives the receiving states increased authority for supervising a private agency that arranged an adoption. As NCFA argued in 2007, “The ICPC was a broken system long before APHSA accepted responsibility for drafting new standards, but the new proposed regulations make a bad system potentially even worse.”\(^{37}\) According to APHSA, as of July 15, 2009, 10 states (Ohio, Alaska, Delaware, Florida, Indiana, Maine, Minnesota, Missouri, Nebraska, and Oklahoma) have enacted the new ICPC. (Information obtained from Carla Fults, via personal communication, July 15, 2009.)\(^{38}\)

**Foster Care Mentoring.** For children remaining in foster care, having a mentor can make a huge difference. An example of legislation encouraging mentorship is Sen. Mary Landrieu’s Foster Care Mentoring Act, introduced in May 2009. The bill provides $15 million to establish statewide foster care mentoring programs, as well as an additional $4 million to establish a national public awareness campaign to recruit mentors. It also allows for up to $20,000 in federal student loan forgiveness for volunteers who mentor a foster child (see: http://landrieu.senate.gov/priorities/adoption.cfm). In the press release introducing the bill, Sen. Landrieu’s office cites research indicating that children who are mentored are 45 percent less likely to use illicit drugs, 59 percent more likely to succeed in school, and 73 percent more likely to attain higher life achievement goals.\(^{39}\)

**Putative Father Registry.** Largely resulting from two high-profile cases in the 1990s in which biological fathers disputed adoptions, there has been increased attention paid to the role and rights of biological fathers. Some potential adoptive families might worry that, even after an adoption is finalized, the biological father could surface and contest the adoption. The Protecting Adoption and Promoting Responsible Fatherhood Act of 2009 addresses this issue. Introduced by Sen. Landrieu on April 30, 2009, the act provides for the creation of a National Putative Father Registry, gives states grants to create individual state registries that feed into the national registry, and establishes a national media campaign to inform individuals of the existence of the registry and of the role that the registry could play in pending adoptions. (Several states already have state registries, the most recent being South Carolina, which was signed into law in June of 2009.) If a putative father registry exists, men who are having extramarital sexual relations with a woman have the option of submitting their names and contact information, as well as the names of their sexual partners, to the registry. If a private or public agency or attorney is facilitating an adoption, the registry can first be checked to ensure that the putative father is contacted and notified. Not only would this bill allow men the opportunity to waive their parental rights to children conceived out of wedlock, it would also help reduce the number of adoptions disrupted by men who may not have even been aware that they fathered a child.\(^{40}\)

**Resource Family Recruitment and Retention Act of 2009.** This bill, introduced by Sen. Blanche Lincoln in February 2009, is one example of legislation designed to address the issues of family recruitment and retention. Among other things, it would amend Title IV-B to allow for awarding grants to states that are implementing innovative programs in the areas of foster parent recruitment, training, retention, and support. This would allow states to engage in more of the objectives highlighted in the recruitment and retention section above.

\(^{37}\) Ibid.

\(^{38}\) Subsequent revisions to the ICPC proposal by APHSA have addressed several of NCFA’s initial concerns, but NCFA suggests additional revisions are necessary before NCFA could fully endorse the proposed new ICPC.


Conclusion

There is no excuse for the foster care system in this country to languish in its current state, far from what children and families deserve. Surveys consistently show support for and interest in foster care adoption that is more than adequate to ensure loving, permanent families for every child in state care. But problems persist in multiple areas: insufficient and ineffective parent training and recruitment efforts, a lack of focus on increasing adoptions out of foster care, a shortage of individuals and families involved in the lives of children in foster care, inadequate support and training for child welfare workers, states that are unable to provide care until age 21, a lack of focus on permanency, problems with the courts that serve families and children in foster care, and promising legislation that has yet to be passed.

The recommendations and solutions outlined in this Adoption Advocate were chosen because they can be implemented relatively quickly, yielding almost immediate results. It is NCFA’s hope that individuals, agencies, local governments, and the federal government will begin to implement these solutions in order to live up to our responsibility as a compassionate nation that cares for its children.
Benefits and Challenges of Adopting Children from Foster Care: Insights from a National Survey of Children’s Health
Nicholas Zill

Introduction

A visitor from another planet who gazed upon the situation regarding adoption of children in the contemporary United States would think that he had arrived in what the ancient Greek playwright Aristophanes called, “Cloud Cuckoo Land.” On the one hand, interest in adopting children has increased because many middle-class couples delay having children and then have difficulties conceiving because of fertility issues. On the other hand, the number of adoptable children has declined, partly because of widespread use of contraceptives and abortion and partly because parenting their babies has become a more frequent choice of unmarried women. In addition, teen mothers, the age group historically most likely to place their infants for adoption, have become less common since 1970 (Bachrach, London, & Maza, 1988; Jones, 2008).

At the same time, there are thousands of American children who are available for adoption but who do not get adopted (Committee on Ways and Means, 2009). These tend to be children born to substance-abusing or mentally-ill women, or youngsters who have been neglected or abused in the homes of their birthmothers. Prospective adoptive parents may be more hesitant to adopt from foster care, fearing they won’t be capable of helping children cope with the possible long-term effects of the traumatic early experiences they have endured in addition to the unknown genetics that adoption always brings.

Despite the risks involved, sizable numbers of families are prepared to adopt children who have experienced abuse and neglect. However, their efforts to adopt are often frustrated by federal laws and child welfare agency practices that require time-consuming efforts to “preserve” and “reunify” biological families, and give preference to the placement of foster children with relatives (Bartholet, 1999; Jones, 2008). As a consequence, families who are eager to adopt an unrelated foster child may find themselves turned down by social workers in favor of a grandmother, aunt, or cousin of the child. This can occur even though the relative is reluctant to adopt and/or lacks the financial and other parenting resources to provide for the child.

Such obstacles, plus the limited number of adoptable infants and children who are not in foster care, have led increasing numbers of prospective parents in the U.S. to look to foreign countries like China, Russia, and Guatemala for youngsters to adopt (Hollingsworth & Ruffin, 2002). Although information about the origins and health status of these foreign national children may be incomplete or faulty, there is often the perception that an American family can complete an international adoption in less time and with fewer complications than adopting a child from foster care in the U.S. And, at least until recently, families had a better chance of obtaining an adoptive daughter or son near the time of the child’s birth or within the first year or two of the child’s life. (This is becoming less true with the recent increases in older-child adoptions internationally.)
For reasons spelled out below, there would appear to be benefits for the children in this country who await adoption and for U.S. society as a whole, if adoption of children in foster care by qualified nonrelatives were made easier, faster, and more frequent. Yet advocates of “family preservation” have resisted efforts to make it so. Provisions of federal law whose intent is to promote adoption of foster children by nonrelatives have often been undermined by the practices and prejudices of officials in state child welfare agencies (Bartholet, 1999). This is not to say that keeping children with kin is a bad choice; it only becomes so when leaving children with less-than-qualified relatives takes priority over the best interest of the child.

Much of the controversy over adoption of children from foster care has gone on without the benefit of statistically reliable comparisons of how children fare if they are adopted from foster care as opposed to remaining in foster care or being reunited with their birthparents. Although definitive answers to this question can only be obtained through longitudinal studies and random-assignment social experiments, there is useful information to be gleaned from a recent federal survey called the National Survey of Adoptive Parents (Bramlett et al., 2010). The purpose of this paper is to summarize the results of a special analysis of data from this survey.\(^1\) The analysis was aimed at shedding as much light as possible on the life situations and wellbeing of children who had been adopted from foster care as well as those who were currently in foster care.

The paper begins by presenting data from state agencies on the size of the population of foster care children in the United States, as well as information about where children who have been maltreated are placed when they are removed from their birth families, how many become eligible for adoption, and how many actually get adopted. It then describes reasons for believing that adoption might be in the best interests of a child in foster care, as well as reasons why adoption might not resolve all the difficulties that such children encounter. A presentation of the survey analysis results follows, along with a discussion of what the results imply for child development theories and child welfare policies.

### Basic Facts About Children in Foster Care

Children enter foster care because their parents find themselves unable to care for the child or adolescent, or because the parent(s) is found to be sufficiently neglectful or abusive to warrant removal of the child from the parental home. During the first decade of the 21st century, close to a half-million children in the United States were in foster care at any one time—i.e., they were under the care and control of state-run child welfare agencies. According to state agency records submitted to the federal Adoption and Foster Care Analysis and Reporting System (AFCARS), nearly 275,000 more entered the foster care “system” each year, and an equal or greater number left the system annually (National Data Archive on Child Abuse and Neglect, 2009). Thus, about 750,000 children, or more than one percent of the total child population of the nation, spent at least some time in foster care each year (Committee on Ways and Means, 2009).

Children removed from their birth families under court authority are placed in the temporary care of foster parents until they can be safely returned to their families, or, if necessary, placed with relatives or in a longer-term foster care situation, or legally adopted. AFCARS records show that, of the 423,773 U.S. children in foster care on September 30, 2009, 48 percent were being cared for in a foster family home with foster parents who were not related to the child by blood, marriage, or adoption. Twenty-four percent were placed with foster parents who were related to the child by blood or marriage. Sixteen percent were residing in an institution or group home. Five percent were back with their parents on a trial home visit, and four percent were in a pre-adoptive home (Administration for Children & Families, 2010).

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\(^1\) The analysis was carried out with the assistance of Matthew Bramlett of the National Center for Health Statistics.
Some children are in foster care for only a brief period of days or weeks before being returned to their birthparent or parents. But some 245,000 children in 2009 have been in foster care for 12 months or more. And around 11 percent—or 48,088 in 2009—have been in foster care five years or more. Some 30,000 youth per year remain in foster care until they reach adulthood. These young people represent about 10 percent of those leaving foster care each year (Administration for Children & Families, 2010).

Only about 10 percent of all children in foster care will be adopted (Committee on Ways and Means, 2009). There were 55,684 children adopted from foster care during fiscal year 2009, but there were 114,556 waiting to be adopted on September 30th of that year (Administration for Children & Families, 2010). (That is, adoption was the agency’s case goal for the child and the parental rights of the biological parents had been legally terminated.)

Congress has passed a series of laws with provisions aimed at facilitating and encouraging adoption of foster children, such as by providing financial incentives including the adoption tax credit, subsidized medical care, and regular support payments for less affluent adoptive parents. There was an initial upward jump in the annual number of children adopted from foster care following the passage of the federal Adoption and Safe Families Act in 1996, from a base-period level of around 28,000 children per year to a level of around 51,000 children per year in 2000. Since then, however, the number of children adopted from foster care has fluctuated between 51,000 and 55,000, with only a small upward trend. Likewise, the proportion of foster children waiting to be adopted who actually are adopted has hovered around 40 percent (Administration for Children & Families, 2009).

Among the things that state agencies do that impede the adoption process and result in fewer foster children being adopted are:

- persisting in efforts to reunite foster children with birthparents after overwhelming evidence shows that the birthparents are likely to pose continuing risks to the child’s health and safety;
- delaying the termination of parental rights so that adoption of children in infancy becomes almost impossible;
- keeping children in foster care even though suitable adoptive parents are available, because the potential adopters are not of the same race or social class as the child’s birthparents; and,
- encouraging reluctant relatives to adopt children in their care rather than allow the children to be adopted by willing, unrelated adults with greater resources (Bartholet, 1999).

Although children in foster care represent only a small fraction of the total child population of the United States, they represent a much bigger portion of the young people who go on to struggle with concerning behaviors, including: creating serious disciplinary problems in schools, dropping out of high school, becoming unemployed and homeless, bearing children as unmarried teenagers, abusing drugs and alcohol, and committing crimes. For example, a recent study of a Midwest sample of young adults aged 23 or 24 who had “aged out” of foster care found extremely high rates of arrest and incarceration among these young adults. Eighty-one percent of the long-term foster care males had been arrested at some point, and 59 percent had been convicted of at least one crime. This compares with 17 percent of all young men in the U.S. who had been arrested, and 10 percent who had been convicted of a crime. Likewise, 57 percent of the long-term foster care females had been arrested and 28 percent had been convicted of a crime. The comparative figures for all female young adults in the U.S. are four percent and two percent, respectively (Courtney, Dworsky, Lee & Rapp, 2010).

Former foster youth are over-represented among inmates of state and federal prisons. In 2004, for example, there were almost 190,000 inmates
of state and federal prisons in the U.S. who had a history of foster care during their childhood or adolescence. These foster care “alumni” represented nearly 15 percent of the inmates of state prisons and almost eight percent of the inmates of federal prisons (Bureau of Justice Statistics, 2009). The cost of incarcerating former foster youth was approximately $5.1 billion per year. If their rate of imprisonment could be reduced by even 10 percent, it would result in savings of $513 million per year (author’s calculations from Bureau of Justice Statistics data tables).

Increased adoption of young people from foster care is one way of decreasing the number of young people who must spend much of their youth in unstable and less than ideal living arrangements. It may also be a way of preventing the long-term detrimental consequences of such an upbringing.

**The Case for Adoption**

**Reasons Why Adoption May Be Beneficial for Foster Children**

The reasons for believing that adoption may be in the best interests of a foster child grow out of the commitment that adoptive parents must make in order to become the primary caretakers of the child, as well as the human capital and family resources they bring to the job of parenting. Adoptive parents have to go through a trying qualification process and make a legal commitment to raise the child as their own, which foster parents or relatives may not have to go through to the same extent. This process not only works to select couples who are highly motivated and well qualified to become parents, but the argument can be made that it also produces motivation for the parent to work harder to promote the child’s welfare than foster parents, social caseworkers, or nonadoptive relatives might work (Hamilton, Cheng, & Powell, 2007; Hartman & Laird, 1990). Indeed, some theorists believe that adoptive parents compensate for not being the biological parents of the child by being extra-vigilant to the child’s needs and seeking to get the most assistance possible from medical and educational bureaucracies (Case & Paxson, 2001; Kirk, 1984). They may even work harder at this than many biological families would.

The commitment that adoptive parents make can provide the adopted child with a sense of security and family identity and the assurance of a stable, continuous relationship with one set of parent figures. Such a relationship is likely to be better for the child’s emotional wellbeing and socialization than an impermanent custodial arrangement or series of arrangements with foster parents or relatives. Prior research has shown that the “turbulence” of having multiple or unstable living arrangements is associated with lower achievement and child wellbeing (Haveman, Wolfe, & Spalding, 1991; Vandivere, Malm & Radel, 2009).

Human capital and family resources theory (Becker, 1981; Blau & Duncan, 1967; Coleman, 1988) holds that the more parents can provide in the way of knowledge, skills, money, property, and social connections, the better for the health, development, achievement and wellbeing of the children they raise. Families with more physical, intellectual, and social resources are better able to furnish their children with a stable home environment, safe neighborhood, high-quality health care and schooling, positive peer influences, and job opportunities than families with less capital and fewer resources (Mayer, 1997; Schneider & Coleman, 1993; Thomson, Henson, & McLanahan, 1994).

Because potential adoptive parents are carefully screened by child welfare agencies, those that are permitted to adopt foster children are likely to have college educations, adequate incomes, and stable housing arrangements (Bachrach, 1983; Bramlett, Radle, & Blumberg, 2007). They are unlikely to be alcohol or drug abusers or to have psychiatric conditions or criminal records. The same cannot be said for many of the birth families from which foster children come (Bartholot, 1999; Committee on Ways and Means, 2009; Needell
& Barth, 1998). Foster parents are also screened by agencies, but standards for approval as a foster parent are generally more lenient than those for adoptive parents (Bartholet, 1999). And when children are informally taken in by relatives, outside of the foster care system, there is no screening at all involved.

There may also be a very practical reason for favoring adoption of children from foster care, namely, that adoption costs the public less than either maintaining a child in foster care or returning the child to a high-risk birth family (Barth, 1997; Hansen & Hansen, 2005). If adoptive families have sufficient financial resources, they would not require regular subsidy payments or public assistance such as Food Stamps, Medicaid, and cash welfare in order to support their children. Many formal and informal foster families—and many high-risk birth families—do need these forms of public assistance in order to make ends meet (Barth, 1997; Needell & Barth, 1998). On the other hand, subsidy payments for families that adopt children from foster care are available and made use of by most - though not all - adoptive families. Despite this, there is ample reason to believe that adoption is generally cheaper for the public than maintaining a child in foster care (Committee on Ways and Means, 2009; Hansen & Hansen, 2005).

**Factors to Consider in Making Adoption Succeed for Children in Foster Care**

While there are good theoretical reasons for believing that adoption might be beneficial for foster children, it is also vital to understand that children from difficult backgrounds bring with them special needs. A better understanding of these needs can help ensure that families are prepared and supported when adopting a child from foster care. In order to further understand these needs, we turn to attachment theory, traumatic stress theory and behavior genetics.

Attachment theory (Ainsworth, 1969, 1973; Bowlby, 1951, 1969; Rutter, 1981) holds that it is essential for their mental health that infants and young children experience warm, intimate and continuous relationships with at least one adult, usually their mothers. The relationship creates an attachment to the parent which makes the parent a potent agent of socialization and helps nurture feelings of trust and empathy towards the mother and others. The period between six months of age and two-and-a-half years is a “sensitive” period for the formation of such bonds. Many children who do not develop a stable and secure bond during this period, or have the bond disrupted, are subject to both short-term distress reactions and longer-term difficulties in their feelings and behavior toward other people. Children adopted from foster care are often adopted at ages three or older, and are older at adoption, on average, than international or private domestic adoptees (Vandivere et al., 2009). This highlights the need for making timely decisions to ensure that children are placed as early as possible.

Many foster children have experienced unresponsive or neglectful treatment by birthmothers who are addicted to drugs or have mental illness. They may also have experienced the disruption of early attachments to birthparents (Bartholet, 1999; Strijker, Knorth, & Knot-Dickscheit, 2008). According to state agency records submitted to the federal Adoption and Foster Care Analysis and Reporting System (AFCARS) (National Data Archive on Child Abuse and Neglect, 2009), 54 percent of children entering foster care in the United States in 2007 experienced severe parental neglect. For nearly 30 percent, parental drug or alcohol abuse was a circumstance associated with the child’s removal from the home. For almost 17 percent, the parent’s inability to cope was a reason for removal (Committee on Ways and Means, 2009).

According to attachment theory, not having a stable maternal bond is apt to produce long-lasting deficits in the child’s social development, deficiencies that are not easily remedied by a new home environment, no matter how favorable. Children adopted from foster care are more likely than other adopted children to experience
attachment problems, due to their older average age at adoption. The lack or disruption of an early attachment can make it difficult for the child to form strong bonds with the adoptive parents, and may lead to later erratic or delinquent behavior that strains the adoptive parents’ commitment to the child (Howe & Fearnley, 2003; Hughes, 1999; van den Dries, Juffer, van IJzendoorn & Bakermans-Kranenburg, 2009; Verhulst, Althaus & Versluis-Den Bieman, 1990). AFCARS records indicate that for 17 percent of young persons entering foster care in 2007, the adolescent’s own problem behavior was a circumstance associated with his or her removal from the home (Committee on Ways and Means, 2009).

On the other hand, if the adoption of a foster child occurs at birth or early in the child’s life, so that the relationship with the adoptive parents is the first or one of the first that the child experiences, attachment theory would predict that a loving and supportive adoptive family would be perfectly capable of forming a mutual bond with the child and nurturing positive social development. Again, this argues for the timely placement of children to ensure that attachment can occur.

Some foster children have experienced abusive treatment by boyfriends of the birthmother, incompetent babysitters, or by birthmothers or birthfathers themselves (Daly, 1998; Daly & Wilson, 1996). AFCARS records show that for nearly 16 percent of children entering foster care in 2007, physical abuse of the child was a circumstance associated with the child’s removal from the home, and for six percent, sexual abuse was a reason for removal (Committee on Ways and Means, 2009). Early abuse can also have long-lasting effects on a child’s development, effects which a supportive adoptive family may only partly ameliorate. According to traumatic stress theory, the likelihood of long-term emotional scars depends on the intensity and duration of the abuse. The more severe and long-lasting the abuse, the greater the likelihood of long-lasting behavioral disturbances, and the more problems the adoptive family is likely to face (Brodzinsky, Hitt, & Smith, 1993; Coon, Carey, Corley & Fulker, 1992; Simmel, Brooks, Barth, & Hinshaw, 2001). A family preparing to adopt a child from foster care needs to be prepared for these possible realities and have the tools to provide the child the necessary love and support.

According to the behavior-genetics perspective (Daly, 1998; Dawkins, 1976; Hamilton, 1964; Pinker, 2002), a child in foster care is not a “blank slate” to be “written on” by parental preferences, peer pressures, and cultural conventions. Each child has a genetic endowment that not only shapes his height and hair color, but also his intellectual capacity and temperamental disposition. As mentioned above, parents of foster children are likely to have a history of drug or alcohol abuse, mental illness, child neglect or abuse, or criminal conduct. Thus, children in foster care may be burdened not only by a traumatic early history, but also by a genetic legacy that may incline them toward emotional instability (Verhulst et al., 1990) or learning challenges (Deutsch et al., 1982; Hamilton, Cheng, & Powell, 2007). Adoptive parents who are not aware of “the limits of family influence” (Rowe, 1994) may find themselves with unrealistic expectations of their children. Again, preparation and support become crucial for the child and family’s success.

An Opportunity to Learn How Adopted Children Are Faring

Despite the important scientific questions and pressing policy issues surrounding the topics of foster care and adoption of foster children, there has been a paucity of reliable information on the life circumstances and wellbeing of foster children and children adopted from foster care. In particular, there has been a lack of data derived from standard measurement methods and based on large, probability samples of the child population (as opposed to samples of convenience) (Bramlett, Radel & Blumberg, 2007; Miller, Fan, Christensen, Grotevant & van Dulmen, 2000; Sun, 2003; Zill, 1990). Administrative records on foster and adopted children vary in measure
definition and quality from state-to-state, despite federal efforts to make them more uniform. Moreover, administrative data cannot be used to compare the wellbeing of children who remain in foster care with that of children who were adopted from foster care.

In 2007, as a result of a collaboration among several federal agencies, the first national survey of adopted children was conducted by the National Center for Health Statistics. The National Survey of Adoptive Parents (NSAP) was the first large-scale survey to obtain nationally-representative information about the characteristics and experiences of adopted children and their families in the U.S., as well as information on the health and wellbeing of the adopted children. The survey sample of 2,089 represented children under age 18 who were adopted and living with neither biological parent. It included children adopted from foster care and other domestic sources, as well as from other countries. The information collected was based on reports by the children’s adoptive parents (Bramlett et al., 2010).

Because the NSAP was conducted as a follow-up study to the 2007 National Survey of Children’s Health (NSCH), comparable information was available about children in the general population, including children living with foster parents or relatives. This information included indicators of child health, achievement, and behavior, as well as demographic characteristics of the children and social and economic circumstances of their families (Blumberg et al., 2010).

The aim of the study summarized in this report was to use the NSAP/NSCH sample to compare the life circumstances and wellbeing of children adopted from foster care with those of children who were in foster care at the time of the survey. The study also involved comparing the children adopted from foster care with two other groups: children living in “traditional” families with both their birthmother and birthfather, and children living with birthmothers who had never married. The latter group provided an approximation of the kind of birth family from which most foster children come (Committee on Ways and Means, 2009; Needell & Barth, 1998) and to which many foster children return when they are “reunited” with birthparents.

**Results of the Comparative Analysis**

**Analysis Plan**

After separating children in the NSAP/NSCH sample into those adopted from foster care and those currently in foster or relative care, we examined the demographic characteristics of the groups to see if there was evidence that adopted children were a select group that may have had more favorable prospects than those who remained in formal or informal foster care. We examined the distribution of the study groups by age, sex, race and Hispanic origin, to test for the presence of significant differences that would have to be taken into account in subsequent analyses.

We then carried out analyses to examine whether children adopted from foster care had home environments with more resources and more favorable conditions than children remaining in foster care. Were the adoptive parents more likely to be legally-married two-parent couples? Did they have higher education and income levels than the foster parents? Were the adopted children more likely to live in safe and supportive neighborhoods? Were they more likely to have health insurance coverage?

The next set of analyses addressed the question of whether children adopted from foster care tended to cost the public less money than children remaining in foster care. Were adoptive households more likely to have at least one adult who worked on a year-round basis? Were adoptive households less likely to have incomes that were below the official poverty level? Were they less likely to be receiving Food Stamps, cash welfare payments, and subsidized school meals? Was the health insurance coverage that adopted children had more likely to be through the parents’ employers or from other private sources?
and less likely to be solely from public programs like Medicaid and the State Children’s Health Insurance Program (SCHIP)?

The final set of analyses examined how the adopted and foster care children were faring on indicators of child health, achievement, and behavior. How did the groups compare on overall health status and special health care needs? What proportion in each group was making normal progress in school and what proportion was exhibiting achievement or conduct problems? How many in each group were engaging in problem behavior, such as depressed, withdrawn behavior, or aggressive, defiant actions? And how many had received psychological counseling or therapy for their problems during the last year?

Children Adopted From Foster Care and Children in Care Have Similar Demographic Profiles

Of the 91,642 children of ages 0-17 in the 2007 NSCH national sample, there were 801 who had been adopted from foster care. There were 2,439 children who were either in nonrelative foster care \( (n = 259) \) or being cared for by relatives \( (n = 2,180) \) who had not adopted them.\(^2\) There were 61,364 children living in families with both their birthmother and birthfather, and 5,326 children living with birthmothers who had never married.

In order to develop composite statistics on children currently in foster care, the mean values from the nonrelative foster care subgroup and the relative care subgroup were combined into weighted averages, with each group being weighted according to its frequency in the foster-care population. AFCARS data on foster children in family households show that two-thirds live with nonrelative foster parents and one-third live with foster parents who are related to them by blood or marriage (Administration for Children & Families, 2009). Thus, in deriving the composite foster care means, the mean of the nonrelative foster care subgroup received a weight of two-thirds, and the mean of the relative care subgroup received a weight of one-third. In addition to the composite foster care means, the subgroup means for children in nonrelative foster care and relative care are shown separately in Tables 1b, 2b, and 3b. Foster children who lived in group homes or institutions were outside of the sampling frame of the NSCH, and thus are not represented in the study.

Comparing the demographic characteristics of children adopted from foster care with those of children in foster care showed that there was a significant age difference between the groups, with the adopted group being more than a full year older, on average, than the foster care group (10.6 versus 9.0). The majority of the foster care children were females (53 percent), while the majority of the children adopted from foster care were males (57 percent). The gender difference was not statistically significant, however (Table 1a).

The two groups did not differ significantly in their racial-ethnic composition. Both showed an under-representation of white children and an over-representation of African-American children, compared to the overall U.S. population under 18 years of age.\(^3\) Hispanic children were represented in about the same proportion as in the overall youth population. Thirty-four percent of the adopted children were white, 35 percent black, 19 percent were Hispanic, and 12 percent were from other racial or ethnic groups, including Asian, American Indian or Alaskan Native, and biracial or multiracial children. Of the children currently in foster care, 39 percent were white, 32 percent black, 12 percent Hispanic, and eight percent were from other racial or ethnic groups.

In sum, the demographic profiles of the adopted and foster care groups were quite similar, except

\(^2\) In response to the survey questionnaire, foster parents who were related to the child by blood or marriage typically identified themselves as relatives rather than as foster parents. Thus, it was necessary to broaden the definition of the “foster care” comparison group to include children living with relatives other than their biological parents, whether or not the children were formally under the supervision of a state child welfare agency.

\(^3\) Wherever the term “white” children is used in this report, the reference is to non-Hispanic white children. Likewise, the terms “African-American” or “black” children refer to non-Hispanic African-American children.
that children in the adopted group were a year and a half older, on average. This simplifies matters with respect to comparing the life circumstances and wellbeing of children in the two groups. But both study groups differed considerably with respect to age and racial-ethnic makeup from children living with both biological parents and those living with never-married mothers. The adopted group was considerably older, on average, than children living with both biological parents (mean age of 7.9 years) and children living with single mothers who had never married (7.3 years).

Children adopted from foster care were five times more likely to be black than children living with both biological parents (35 percent versus seven percent of those in two-parent families). They were only about half as likely to be white (34 percent versus 63 percent of those in two-parent families). On the other hand, children adopted from foster care were less likely to be black than children living with never-married single mothers (35 percent versus 49 percent), and more likely to be white (34 percent versus 20 percent). These differences must be taken into account when comparing the wellbeing of children in adoptive, foster care, and biological parent groups.

Adopted Children Have More Favorable Home Environments

Data from the comparative survey analysis show that children adopted from foster care have home environments that are more favorable for child development and wellbeing than children who remain in foster care. Compared to children currently in foster care, adopted children are:

- More likely to be living with a mother and father who are legally married to one another (as opposed to with a single parent or two cohabiting parents): 71 percent of the adopted children were in two-parent families, compared with 56 percent of the foster care children (Table 1a);
- Twice as likely to have at least one parent who is a college graduate: 43 percent of the adopted children had such a parent, compared with 21 percent of the foster children (Table 1a);
- Three times as likely to be in a financially-secure household (one whose annual income is at least 400 percent of the official poverty level): 28 percent of the adopted children were in such a household, as opposed to 10 percent of foster care children (Table 1a);
- More likely to be living in a safe and supportive neighborhood: 81 percent of the adopted children lived in such a neighborhood, compared with 68 percent of the foster children (Table 1a).

Each of these factors—two-parent family, higher parent education level, higher family income level, safe and family-friendly neighborhood—has been found to be associated with more favorable outcomes for children and youth (Bramlett & Blumberg, 2007; Coiro, Zill, & Bloom, 1994; McLanahan & Sandefur, 1994; Zill, 1996; Zill and Nord, 1994).

Children adopted from foster care are not quite as well off as children who are growing up with both their birthmother and their birthfather with respect to these family resource factors. U.S. children living with both birthparents are more likely than adopted children to have two married parents (93 percent versus 71 percent), to have at least one college-educated parent (52 percent versus 43 percent) and to be living in a financially-secure household (36 percent versus 28 percent). But they are no more likely to be living in a safe and supportive neighborhood (76 percent versus 81 percent); and they are slightly less likely than adopted children to have current health insurance (91 percent versus 98 percent).

On the other hand, children adopted from foster care are substantially better off in terms of family resources than children who live with their birthmothers only, particularly single mothers who have never married. Children living with never-married biological mothers are only one-fourth as likely to have a parent with a college degree (10 percent versus 43 percent) or live in a financially-secure household (six percent versus 8 percent). Only a minority of children with never-married
Adopted mothers live in safe neighborhoods (48 percent versus 81 percent of adopted children). And fewer of them have current health insurance (91 percent versus 98 percent).

Adopted Children Are Less Costly to the Public

Children adopted from foster care cost the public less money than children living in foster care families. This is because adoptive parents are more likely than foster parents to be working outside the home on a full-time basis and less likely to be heavily reliant on welfare, Food Stamps, and government-sponsored health care. Compared to the households in which foster children live, the households of adopted children are (Table 2a):

- Half as likely to be one where no adult works 50 or more weeks per year: 10 percent of the adopted children lived in such households, as opposed to 22 percent of the foster care children;
- Half as likely to be a household whose annual income was below the official poverty level: 15 percent of the adopted children lived in a poverty-level household, as opposed to 28 percent of the foster children;
- One-half as likely to be a household that received TANF or other cash welfare benefits: eight percent of the adopted children lived in a welfare-dependent household, compared with 17 percent of the foster children;
- One-third as likely to be a household that received Food Stamps: eight percent versus 24 percent; and
- Half as likely to be a household where some or all children received reduced-price meals at school: 34 percent of the adopted children lived in a household receiving subsidized school lunches, compared with 62 percent of the foster children.

Children adopted from foster care were less likely to have their health care subsidized by public programs like Medicaid or SCHIP: 62 percent of adopted children, compared with 80 percent of foster children, had their health care covered by Medicaid or SCHIP. On the other hand, 35 percent of adopted children, versus only 12 percent of foster children, had private health insurance. And only two percent of adopted children, as opposed to eight percent of foster children, had no current health insurance coverage.

Children adopted from foster care cost the public substantially less money than children living with birthmothers who have never married. Children in households headed by never-married mothers are (Table 2a):

- Three times more likely to not have a full-year adult wage-earner in the household (31 percent versus 10 percent);
- Three times more likely to be poor (53 percent versus 15 percent);
- Three times more likely to be receiving TANF or other cash welfare payments (21 percent versus eight percent);
- Six times more likely to be receiving Food Stamps (53 percent versus eight percent);
- Twice as likely to be getting subsidized school lunches (63 percent versus 34 percent);
- More likely to have their health care covered by Medicaid or SCHIP (70 percent versus 62 percent);
- Less likely to have it covered by private health insurance (21 percent versus 35 percent); and
- Four times more likely to have no current health insurance coverage (nine percent versus two percent).

Obviously, children adopted from foster care cost more to the public treasury than children being raised by both of their biological parents. However, households with adopted children differ little from those with both parents and their biological children with respect to the proportion that do not have at least one adult working year-round (10 percent versus seven percent) and the proportion of children in poverty (15 percent versus 12 percent). Neither difference is statistically significant. Areas where adoptive
households clearly rely on public funds more often than two-parent families are with respect to medical insurance (62 percent versus 19 percent receive Medicaid or SCHIP benefits), subsidized school lunches (34 percent versus 20 percent), and TANF or other cash welfare payments (eight percent versus two percent). In addition, three-quarters of children adopted from foster care are in households that receive a monthly adoption subsidy payment. However, these payments are typically modest in magnitude (with a median value of about $445 per month in 2007) and considerably smaller than the maintenance payments the family would receive if the child were in foster care (Committee on Ways and Means, 2009).

Adopted Children Have More Developmental Problems Than Children Living with Both Birthparents

A majority of children adopted from foster care—55 percent—have special health care needs, meaning that they have ongoing limitations in their ability to perform activities that other children of the same age can perform, or an ongoing need for prescription medications, specialized therapies, or more medical, mental health, or educational services than are usual for most children of the same age. This is more than three times higher than the frequency of special health care needs among children living with both biological parents (16 percent) (Table 3a). This difference is not surprising, given the troubled family backgrounds and the traumatic early experiences that many of the children from foster care have endured. Many of these needs are associated with diagnosed emotional disorders or learning disabilities, such as a reactive attachment disorder (RAD), attention deficit disorder (ADD/ADHD), or conduct disorder. Nearly half of young people adopted from foster care—46 percent—have received psychological treatment or counseling at some point since their adoption. And nearly a third—32 percent—have an Individualized Education Plan (IEP/IFSP) and receive special education services at school. This is nearly five times higher than the frequency of special education IEPs among children living with both biological parents (6.5 percent).

Despite these continuing health or mental health issues, most children adopted from foster care appear to be doing reasonably well on indicators of child development and well-being. For example, eight in ten adopted children are in “excellent” or “very good” overall health (83 percent); “often” show empathic behavior and other positive social skills (81 percent); and have progressed normally and not had to repeat grades in school (79 percent).

Nonetheless, it is clear that the proportion of children adopted from foster care who have developmental problems is significantly larger than that for children being raised by both of their biological parents. Compared to children living with both biological parents, children adopted from foster care are (Table 3a):

- Six times more likely to have received psychological counseling or therapy within the last year: 31 percent versus five percent;
- Three times more likely to have shown signs of depression “sometimes” or “often”: 29 percent versus 10 percent;
- Three times more likely to have “often” engaged in aggressive or defiant behavior: 20 percent versus six percent;
- Three times more likely to have repeated a grade in school: 21 percent versus seven percent;
- Twice as likely for parents to have been contacted by the child’s school because of behavior or learning problems the child was having: 56 percent versus 23 percent; and
- Less likely to have shown interest and engagement in their schoolwork: 64 percent versus 86 percent.
Frequency of Developmental Problems Similar for Children in Foster Care and Children Adopted from Foster Care

The proportion of children with developmental problems among children adopted from foster care is not significantly smaller (statistically speaking) than that for children who remain in foster care, despite the more favorable home environments in which the adopted children live. Compared to children currently in foster care, children adopted from foster care are (Table 3a):

- About as likely to have shown signs of depression “sometimes” or “often”: 29 percent versus 25 percent;
- About as likely to have “often” engaged in aggressive or antisocial behavior: 20 percent versus 15 percent;
- About as likely to have repeated a grade in school: 21 percent versus 25 percent;
- About as likely for parents to have been contacted by the school because of the child’s behavior or learning problems: 56 percent versus 55 percent; and
- Equally likely to have shown interest and engagement in their schoolwork: 64 percent for both groups.

The proportion of youngsters with special health care needs among children adopted from foster care is larger than the equivalent proportion for children currently in foster care (55 percent versus 42 percent). In addition, children adopted from foster care are more likely to have IEPs and be receiving special education services in school (32 percent versus 20 percent). These figures are noteworthy for two reasons. First, they indicate that the children adopted from foster care have not been selected because they have fewer apparent problems or more favorable prospects than the children who remain in foster care. Second, they support the notion that adoptive parents are more energetic and effective at obtaining needed medical, educational, and social services for their charges than foster parents, relative caretakers, or social workers are.

Also on the positive side, it appears that the proportion of adopted children who were in “excellent” or “very good” health is somewhat larger than the equivalent proportion for children currently in foster care (83 percent versus 76 percent). The apparent difference is not statistically significant, however. Although nearly half of adopted children had received psychological therapy at some point in their lives, the proportion who received counseling within the last year is smaller than that for children in foster care (31 percent versus 42 percent).

Implications of the Findings

A comparative analysis of data from a large national health survey of children under 18 years of age supports the argument that adoption brings a number of advantages to children who have experienced neglect or abuse and spent time away from their birthparents and in foster care. As expected, children adopted from foster care have more favorable home environments. They are more likely to be in the care of two married parents. Those parents typically have higher education and income levels than the foster parents or relatives who would care for the children if they remained in foster care. Adopted children are more likely to live in safe and supportive neighborhoods and to have health insurance coverage.

The survey analysis also found evidence consistent with the notion that adoption is less costly to the public than having children remain in foster care or returning them to their high-risk birth families. Compared to both foster households and households of never-married birthmothers, adoptive households were less dependent on Food Stamps, cash welfare, subsidized school meals, and publicly-financed health insurance programs like Medicaid and SCHIP. It is true that a majority of adoptive households receive government-provided adoption support payments and subsidized medical care for their adopted children. But these supports are less costly than those provided to households with foster children.
Though less direct and more open to dispute, the survey findings suggest that adoptive parents do indeed do more to obtain needed medical, educational, and social services for their charges than do foster parents, relatives, single mothers, or even married biological parents. In particular, the high proportion of school-aged adopted children—nearly one third—who have Individualized Education Plans and receive special education services at school seems supportive of this notion.

What the survey findings did not show is that the favorable home environments that adopted children enjoy are associated with fewer child health, achievement, or behavior problems than foster children experience. Children adopted from foster care experienced such problems with about the same high frequency as children in foster care, and at a far higher rate than children living with both biological parents. This is not surprising given the early trauma and family disruption that these children have experienced. In this respect, the survey findings reinforce the significant roles that attachment, genetics, and previous trauma may have in the child’s development and adoptive experiences. The findings also point to the importance of supports, training, and preparation for families adopting from foster care.

On the other hand, the full beneficial effects of an improved home environment have not yet been fully studied. Perhaps if we returned to these young people when they reach adulthood, more dramatic differences in favor of the adopted group would be apparent. It is also important to remember that previous research has shown that the foster children who show the worst achievement and behavior problems are those who reside in group homes and institutions (Rosenfeld, 2010) and those who remain in foster care for the entirety of their childhoods (Courtney et al., 2010). Foster children in group homes and institutions fell outside of the sample frame of the National Survey of Children’s Health. And it is not possible in a cross-sectional snapshot survey to identify those foster children who will spend much of their childhood in foster care.

As mentioned earlier, definitive answers to the questions posed here must rely on longitudinal studies of child development and random-assignment social experiments.

A sobering set of survey findings is the inauspicious developmental status of children who were living with their never-married biological mothers. These children were included in the study as a comparison group because their family situations are most like the ones in which neglect or abuse often occurs and foster children emerge: uneducated, low-income, single-parent families. The children in the never-married mother group had not experienced officially-recognized neglect, abuse, or family disruption. Yet they exhibited nearly as many health, achievement, and behavior problems as children in foster care. These families were also very costly to the public, with low levels of parental employment and self-sufficiency, and extensive reliance on Food Stamps, cash welfare payments, and publicly-subsidized health insurance and medical care.

There was also evidence in the survey findings that children who lived with never-married biological mothers or with other biological relatives were not receiving as much of the medical, psychological, and educational services that they may have needed, compared to adopted and foster children. This conclusion emerges from the observations that the never-married mother and relative children showed high rates of problem behavior and grade repetition, but comparatively low rates of receiving psychological counseling or therapy and special education services. The former groups also had lower rates of consistent health insurance coverage. On the positive side, the never-married mothers and relatives were more likely to report close relationships with their children and less likely to complain of parenting stress than were adoptive and foster parents.

Despite their limitations, the 2007 National Survey of Children's Health and the National Survey of Adoptive Parents provide important
insights that can inform and clarify scientific discussions and policy debates about how to improve the lives of children who have suffered neglect or abuse and family disruption. The surveys show that adoption can make more extensive family resources and supportive care available to children who have been maltreated and removed from their birthparents. At the same time, the findings demonstrate that turning improved resources and services into better outcomes for young people is not a simple matter.

References


Table 1a: Child and household demographic and socioeconomic characteristics for children living with two biological parents, children in foster care, children adopted from foster care, and children living with never-married biological mothers: United States, 2007

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Children Living with Two Biological Parents</th>
<th>Children in Foster Care</th>
<th>Children Adopted from Foster Care</th>
<th>Children Living w/ Never-married Biological Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child-level</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Age (years)</td>
<td>7.9 (0.05)</td>
<td>9.0 (0.39)*</td>
<td>10.6 (0.30)* §</td>
<td>7.3 (0.14)* §†</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>51.6 (0.53)</td>
<td>47.1 (3.72)</td>
<td>57.0 (4.13)</td>
<td>49.4 (1.53)</td>
</tr>
<tr>
<td>Female</td>
<td>48.4 (0.53)</td>
<td>52.9 (3.72)</td>
<td>43.0 (4.13)</td>
<td>50.6 (1.53)</td>
</tr>
<tr>
<td>Race/ethnicity</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>20.2 (0.53)</td>
<td>21.4 (3.31)</td>
<td>19.0 (4.01)</td>
<td>21.7 (1.52)</td>
</tr>
<tr>
<td>Non-Hispanic white</td>
<td>63.3 (0.55)</td>
<td>39.2 (3.65)*</td>
<td>34.4 (3.46)*</td>
<td>20.2 (1.15)* §†</td>
</tr>
<tr>
<td>Non-Hispanic black</td>
<td>7.4 (0.26)</td>
<td>31.6 (3.88)*</td>
<td>35.0 (4.41)*</td>
<td>49.3 (1.51)* §†</td>
</tr>
<tr>
<td>Non-Hispanic other</td>
<td>9.1 (0.37)</td>
<td>7.9 (1.45)</td>
<td>11.7 (2.75)</td>
<td>8.8 (0.77)</td>
</tr>
<tr>
<td>Child was born in the US</td>
<td>95.7 (0.24)</td>
<td>97.6 (1.07)</td>
<td>99.8 (0.15)* §</td>
<td>98.0 (0.42)*</td>
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<tr>
<td><strong>Household (HH)-level</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean # of children in HH</td>
<td>2.3 (0.01)</td>
<td>2.9 (0.11)*</td>
<td>2.6 (0.09)*</td>
<td>2.2 (0.04)* §</td>
</tr>
<tr>
<td>Caregiver Marital Status</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>93.0 (0.33)</td>
<td>55.6 (3.85)*</td>
<td>71.0 (3.82)* §</td>
<td>0.0 (0.00)* §†</td>
</tr>
<tr>
<td>Cohabiting</td>
<td>6.6 (0.32)</td>
<td>10.7 (2.78)</td>
<td>3.5 (1.48)* §</td>
<td>12.6 (1.09)* §†</td>
</tr>
<tr>
<td>Neither</td>
<td>0.4 (0.08)</td>
<td>33.7 (3.67)*</td>
<td>25.5 (3.67)*</td>
<td>87.4 (1.09)* §†</td>
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<tr>
<td>Household Income</td>
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</tr>
<tr>
<td>&lt;50% Fed. Poverty Level</td>
<td>4.1 (0.27)</td>
<td>12.5 (3.21)*</td>
<td>5.1 (2.85)</td>
<td>28.4 (1.43)* §†</td>
</tr>
<tr>
<td>50-&lt;100% FPL</td>
<td>7.7 (0.36)</td>
<td>15.4 (2.90)*</td>
<td>9.6 (1.99)</td>
<td>24.7 (1.44)* §†</td>
</tr>
<tr>
<td>100-&lt;200% FPL</td>
<td>18.6 (0.48)</td>
<td>31.4 (3.59)*</td>
<td>30.1 (4.28)*</td>
<td>24.8 (1.41)* §†</td>
</tr>
<tr>
<td>200-&lt;400% FPL</td>
<td>33.2 (0.49)</td>
<td>30.9 (3.58)</td>
<td>27.6 (3.80)</td>
<td>16.1 (1.12)* §†</td>
</tr>
<tr>
<td>400% FPL and up</td>
<td>36.4 (0.49)</td>
<td>9.9 (2.21)*</td>
<td>27.7 (3.45)* §</td>
<td>5.9 (0.69)* §†</td>
</tr>
<tr>
<td>Highest Parent Education</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;High school (HS)</td>
<td>6.3 (0.32)</td>
<td>12.8 (2.01)*</td>
<td>8.3 (3.04)</td>
<td>19.1 (1.29)* §†</td>
</tr>
<tr>
<td>HS/equivalent</td>
<td>18.2 (0.46)</td>
<td>31.3 (3.66)*</td>
<td>19.5 (2.82)</td>
<td>42.1 (1.58)* §†</td>
</tr>
<tr>
<td>&gt;HS, &lt;College Grad</td>
<td>23.6 (0.45)</td>
<td>34.6 (3.59)*</td>
<td>29.5 (4.20)</td>
<td>28.9 (1.26)*</td>
</tr>
<tr>
<td>College Grad or more</td>
<td>51.8 (0.53)</td>
<td>21.4 (3.36)*</td>
<td>42.8 (4.20)* §</td>
<td>9.9 (0.69)* §†</td>
</tr>
<tr>
<td>Metropolitan Statistical Area (MSA) Status</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>In MSA</td>
<td>85.5 (0.27)</td>
<td>79.0 (2.75)*</td>
<td>83.2 (2.14)</td>
<td>83.9 (1.11)</td>
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<td>Not in MSA</td>
<td>14.5 (0.27)</td>
<td>21.0 (2.75)*</td>
<td>16.8 (2.14)</td>
<td>16.1 (1.11)</td>
</tr>
<tr>
<td>Primary language in HH is English</td>
<td>85.1 (0.48)</td>
<td>93.8 (2.30)*</td>
<td>95.2 (2.98)*</td>
<td>89.4 (1.31)* §†</td>
</tr>
<tr>
<td>Sample Size</td>
<td>61,364</td>
<td>2,439</td>
<td>801</td>
<td>5,326</td>
</tr>
</tbody>
</table>

* Estimate differs from that of children living with two biological parents at the 0.05 level
§ Estimate differs from that of children in foster care at the 0.05 level
† Estimate differs from that of children adopted from foster care at the 0.05 level
Table 1b: Means and percent distributions of child and household demographic and socioeconomic characteristics for children in nonrelative foster care and children living with nonadoptive relatives: United States, 2007

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Children in Nonrelative Foster Care</th>
<th>Children Living with Relatives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child-level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Age (years)</td>
<td>8.6 (0.57)†</td>
<td>9.3 (0.26)*</td>
</tr>
<tr>
<td>Gender</td>
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<td>Male</td>
<td>46.4 (5.42)</td>
<td>48.5 (2.44)</td>
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<td>Female</td>
<td>53.6 (5.42)</td>
<td>51.5 (2.44)</td>
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<tr>
<td>Race/ethnicity</td>
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<tr>
<td>Hispanic</td>
<td>25.0 (4.86)</td>
<td>14.0 (1.84)*</td>
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<tr>
<td>Non-Hispanic white</td>
<td>40.4 (5.32)</td>
<td>36.6 (2.37)</td>
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<td>Non-Hispanic black</td>
<td>27.0 (5.68)</td>
<td>41.0 (2.36)*</td>
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<td>Non-Hispanic other</td>
<td>7.6 (2.08)</td>
<td>8.5 (1.17)</td>
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<tr>
<td>Child was born in the U.S.</td>
<td>97.8 (1.57)</td>
<td>97.3 (0.67)†</td>
</tr>
<tr>
<td><strong>Household (HH)-level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean # of children in HH</td>
<td>3.2 (0.16)†</td>
<td>2.2 (0.06)*†</td>
</tr>
<tr>
<td>Caregiver Marital Status</td>
<td></td>
<td></td>
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<tr>
<td>Married</td>
<td>57.7 (5.62)†</td>
<td>51.3 (2.43)†</td>
</tr>
<tr>
<td>Cohabiting</td>
<td>13.8 (4.14)</td>
<td>4.4 (0.69)*</td>
</tr>
<tr>
<td>Neither</td>
<td>28.5 (5.34)</td>
<td>44.3 (2.43)†</td>
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<td>Household Income</td>
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<tr>
<td>&lt;50% Federal Poverty Level</td>
<td>10.1 (4.69)</td>
<td>17.5 (1.94)†</td>
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<tr>
<td>50–&lt;100% FPL</td>
<td>14.8 (4.25)</td>
<td>16.7 (1.66)†</td>
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<tr>
<td>100–&lt;200% FPL</td>
<td>33.2 (5.25)</td>
<td>27.6 (2.22)</td>
</tr>
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<td>200–&lt;400% FPL</td>
<td>33.2 (5.21)</td>
<td>26.1 (2.36)</td>
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<tr>
<td>400% FPL and up</td>
<td>8.8 (3.21)†</td>
<td>12.2 (1.52)†</td>
</tr>
<tr>
<td>Highest Parent Education in HH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;High school (HS)</td>
<td>7.8 (2.83)</td>
<td>22.9 (2.04)*†</td>
</tr>
<tr>
<td>HS/equivalent</td>
<td>28.0 (5.33)</td>
<td>37.9 (2.43)†</td>
</tr>
<tr>
<td>&gt;HS, &lt;College Grad</td>
<td>38.4 (5.26)</td>
<td>26.8 (2.02)*</td>
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<td>College Grad or more</td>
<td>25.9 (4.95)†</td>
<td>12.4 (1.70)†</td>
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<td>Metropolitan Statistical Area (MSA) Status</td>
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<tr>
<td>In MSA</td>
<td>78.5 (4.04)</td>
<td>80.1 (1.44)</td>
</tr>
<tr>
<td>Not in MSA</td>
<td>21.5 (4.04)</td>
<td>19.9 (1.44)</td>
</tr>
<tr>
<td>Primary language in HH is English</td>
<td>92.8 (3.39)</td>
<td>95.7 (1.09)</td>
</tr>
<tr>
<td>Sample Size</td>
<td>259</td>
<td>2,180</td>
</tr>
</tbody>
</table>

NOTE: Estimates for Children in Foster Care in Table 2a calculated from (.67) times mean for Children in Nonrelative Foster Care plus (.33) times mean for Children Living with Relatives

* Estimate differs from that of children in foster care at the 0.05 level
† Estimate differs from that of children adopted from foster care at the 0.05 level

Table 2a: Indicators of public costs for children living with two biological parents, children in foster care, children adopted from foster care, and children living with never-married biological mothers: United States, 2007

<table>
<thead>
<tr>
<th>Indicator (age group)</th>
<th>Children Living with Two Biological Parents</th>
<th>Children in Foster Care</th>
<th>Children Adopted from Foster Care</th>
<th>Children Living with Never-married Biological Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child characteristic</td>
<td>Percent (standard error)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of health insurance</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Public (Medicaid/SCHIP)</td>
<td>19.0 (0.47)</td>
<td>80.2 (2.06)*</td>
<td>62.4 (3.90)*§</td>
<td>69.8 (1.38)*§†</td>
</tr>
<tr>
<td>Nonpublic</td>
<td>72.2 (0.52)</td>
<td>11.8 (1.29)*</td>
<td>35.3 (3.82)*§</td>
<td>20.7 (1.11)*§†</td>
</tr>
<tr>
<td>None</td>
<td>8.8 (0.32)</td>
<td>8.0 (1.69)</td>
<td>2.4 (1.00)*§</td>
<td>9.4 (1.02)*†</td>
</tr>
<tr>
<td>Household (HH) characteristic</td>
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<td></td>
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</tr>
<tr>
<td>HH at or below poverty level</td>
<td>11.8 (0.41)</td>
<td>27.9 (3.57)*</td>
<td>14.7 (3.26)*§</td>
<td>53.2 (1.56)*§†</td>
</tr>
<tr>
<td>HH receives TANF/other cash welfare</td>
<td>2.4 (0.21)</td>
<td>17.1 (3.21)*</td>
<td>7.7 (1.96)*§</td>
<td>21.1 (1.26)*†</td>
</tr>
<tr>
<td>Any child in HH receives Food Stamps</td>
<td>8.5 (0.34)</td>
<td>23.5 (3.81)*</td>
<td>7.8 (3.17)*§</td>
<td>53.0 (1.55)*§†</td>
</tr>
<tr>
<td>Any child in HH receives reduced-price school lunch</td>
<td>20.2 (0.50)</td>
<td>61.6 (3.58)*</td>
<td>33.5 (4.22)*§</td>
<td>62.6 (1.51)*†</td>
</tr>
<tr>
<td>No one in HH works 50+ weeks/year</td>
<td>7.1 (0.29)</td>
<td>21.8 (3.36)*</td>
<td>10.3 (1.83)*§</td>
<td>30.8 (1.58)*§†</td>
</tr>
</tbody>
</table>

* Estimate differs from that of children living with two biological parents at the 0.05 level
§ Estimate differs from that of children in foster care at the 0.05 level
† Estimate differs from that of children adopted from foster care at the 0.05 level

Table 2b: Indicators of public costs for children in nonrelative foster care and children living with relatives: United States, 2007

<table>
<thead>
<tr>
<th>Indicator (age group)</th>
<th>Children in Nonrelative Foster Care</th>
<th>Children Living with Relatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child characteristic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of health insurance</td>
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<td></td>
</tr>
<tr>
<td>Public (Medicaid/SCHIP)</td>
<td>88.6 (2.82)*†</td>
<td>63.2 (2.50)*</td>
</tr>
<tr>
<td>Nonpublic</td>
<td>5.3 (1.53)*†</td>
<td>25.0 (2.35)*†</td>
</tr>
<tr>
<td>None</td>
<td>6.1 (2.39)</td>
<td>11.9 (1.68)*†</td>
</tr>
<tr>
<td>Household (HH) characteristic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HH at or below poverty level</td>
<td>24.9 (5.21)</td>
<td>34.1 (2.26)*†</td>
</tr>
<tr>
<td>HH receives TANF/other cash welfare</td>
<td>13.4 (4.62)</td>
<td>24.7 (2.52)*†</td>
</tr>
<tr>
<td>Any child in HH receives Food Stamps</td>
<td>21.4 (5.58)*†</td>
<td>27.7 (2.19)*†</td>
</tr>
<tr>
<td>Any child in HH receives reduced-price school lunch</td>
<td>64.8 (5.20)*†</td>
<td>55.1 (2.48)*†</td>
</tr>
<tr>
<td>No one in HH works 50+ weeks/year</td>
<td>18.5 (4.91)</td>
<td>28.6 (2.00)*†</td>
</tr>
</tbody>
</table>

NOTE: Estimates for Children in Foster Care in Table 2a calculated from (.67) times mean for Children in Nonrelative Foster Care plus (.33) times mean for Children Living with Relatives.
* Estimate differs from that of children in foster care at the 0.05 level
† Estimate differs from that of children adopted from foster care at the 0.05 level
Table 3a: Indicators of health, mental health and behavior, health care, academic performance, and family environment for children living with two biological parents, children in foster care, children adopted from foster care, and children living with never-married biological mothers: United States, 2007

<table>
<thead>
<tr>
<th>Indicator (age group)</th>
<th>Children Living with Two Biological Parents</th>
<th>Children in Foster Care</th>
<th>Children Adopted from Foster Care</th>
<th>Children Living with Never-married Biological Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child's Health</td>
<td>Percent (standard error)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex/VG Overall Health</td>
<td>87.2 (0.41)</td>
<td>75.5 (3.21)*</td>
<td>82.9 (3.30)</td>
<td>75.3 (1.53)*</td>
</tr>
<tr>
<td>Special Health Care Needs</td>
<td>15.8 (0.36)</td>
<td>41.8 (3.70)*</td>
<td>55.1 (4.11)*‡§</td>
<td>23.3 (1.31)*†</td>
</tr>
<tr>
<td>BMI Obese (10-17)</td>
<td>13.3 (0.54)</td>
<td>18.1 (3.16)</td>
<td>16.9 (4.89)</td>
<td>28.5 (2.64)*§†</td>
</tr>
<tr>
<td>Missed &gt;10 days of school due to illness/injury (6-17)</td>
<td>4.2 (0.23)</td>
<td>5.1 (1.26)</td>
<td>6.4 (3.21)</td>
<td>8.0 (0.88)*</td>
</tr>
<tr>
<td>Child's Mental Health (MH) &amp; Behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes shows 2+ signs of depression (6-17)</td>
<td>9.9 (0.39)</td>
<td>25.2 (3.42)*</td>
<td>28.7 (4.63)*</td>
<td>21.0 (1.98)*</td>
</tr>
<tr>
<td>Often shows 2+ aggressive behaviors (6-17)</td>
<td>6.0 (0.36)</td>
<td>14.5 (2.79)*</td>
<td>19.5 (4.47)*</td>
<td>16.0 (1.49)*</td>
</tr>
<tr>
<td>Often shows 2+ positive social skills (6-17)</td>
<td>96.4 (0.25)</td>
<td>78.9 (4.17)*</td>
<td>81.0 (4.02)*</td>
<td>86.8 (1.51)*</td>
</tr>
<tr>
<td>Receives MH counseling (2-17)</td>
<td>4.7 (0.20)</td>
<td>42.4 (4.13)*</td>
<td>30.5 (3.83)*§</td>
<td>10.4 (0.98)*§†</td>
</tr>
<tr>
<td>Child's Health Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently insured</td>
<td>91.3 (0.32)</td>
<td>92.2 (1.65)</td>
<td>97.7 (0.99)*§</td>
<td>90.7 (1.01)*†</td>
</tr>
<tr>
<td>Consistently insured</td>
<td>86.3 (0.41)</td>
<td>86.0 (1.98)</td>
<td>93.6 (2.91)*§</td>
<td>81.2 (1.31)*§†</td>
</tr>
<tr>
<td>Gets care in Medical Home</td>
<td>62.5 (0.53)</td>
<td>53.0 (3.90)*</td>
<td>55.9 (4.39)</td>
<td>44.0 (1.53)*§†</td>
</tr>
<tr>
<td>Academic Performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents ever contacted about school problems (6-17)</td>
<td>23.4 (0.55)</td>
<td>55.1 (4.48)*</td>
<td>55.7 (4.74)*</td>
<td>47.2 (2.00)*</td>
</tr>
<tr>
<td>Child repeated grade (6-17)</td>
<td>6.6 (0.34)</td>
<td>25.3 (4.62)*</td>
<td>21.0 (4.36)*</td>
<td>21.6 (1.88)*</td>
</tr>
<tr>
<td>Child has IFSP/IEP</td>
<td>6.5 (0.24)</td>
<td>19.5 (2.81)*</td>
<td>31.7 (4.21)*§</td>
<td>12.0 (1.13)*§†</td>
</tr>
<tr>
<td>Child usually engaged in school (6-17)</td>
<td>86.1 (0.47)</td>
<td>64.0 (4.57)*</td>
<td>63.5 (4.67)*</td>
<td>69.7 (2.05)*</td>
</tr>
<tr>
<td>Family Environment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents/child can talk/share ideas together very well (6-17)</td>
<td>72.5 (0.58)</td>
<td>57.5 (4.52)*</td>
<td>55.8 (4.73)*</td>
<td>70.4 (1.95)*§†</td>
</tr>
<tr>
<td>Parent usually feel stressed</td>
<td>7.8 (0.34)</td>
<td>20.6 (3.27)*</td>
<td>24.2 (4.11)*</td>
<td>16.0 (1.23)*</td>
</tr>
<tr>
<td>Neighborhood safe, supportive</td>
<td>76.4 (0.47)</td>
<td>67.8 (3.68)*</td>
<td>81.3 (2.57)*§</td>
<td>48.0 (1.58)*§†</td>
</tr>
</tbody>
</table>

* Estimate differs from that of children living with two biological parents at the 0.05 level
§ Estimate differs from that of children in foster care at the 0.05 level
† Estimate differs from that of children adopted from foster care at the 0.05 level

Table 3b: Indicators of health, mental health and behavior, health care, academic performance, and family environment for children in nonrelative foster care and children living with nonadoptive relatives: United States, 2007

<table>
<thead>
<tr>
<th>Indicator (age group)</th>
<th>Children in Nonrelative Foster Care</th>
<th>Children Living with Relatives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child’s Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex/VG Overall Health</td>
<td>75.7 (4.69)</td>
<td>75.0 (1.95)</td>
</tr>
<tr>
<td>Special Health Care Needs</td>
<td>46.8 (5.40)</td>
<td>31.5 (2.39)*†</td>
</tr>
<tr>
<td>BMI Obese (10-17)</td>
<td>15.2 (4.54)</td>
<td>23.9 (2.61)</td>
</tr>
<tr>
<td>Missed &gt;10 days of school due to illness/injury (6-17)</td>
<td>4.2 (1.82)</td>
<td>7.0 (0.97)</td>
</tr>
<tr>
<td><strong>Child’s Mental Health (MH) &amp; Behavior</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes shows 2+ signs of depression (6-17)</td>
<td>25.7 (4.99)</td>
<td>24.2 (2.19)</td>
</tr>
<tr>
<td>Often shows 2+ aggressive behaviors (6-17)</td>
<td>15.9 (4.09)</td>
<td>11.6 (1.63)</td>
</tr>
<tr>
<td>Often shows 2+ positive social skills (6-17)</td>
<td>76.5 (6.15)</td>
<td>83.8 (1.94)</td>
</tr>
<tr>
<td>Receives MH counseling (2-17)</td>
<td>55.3 (6.11)†</td>
<td>16.4 (1.72)*†</td>
</tr>
<tr>
<td><strong>Child’s Health Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently insured</td>
<td>94.1 (2.32)</td>
<td>88.4 (1.64)*†</td>
</tr>
<tr>
<td>Consistently insured</td>
<td>89.7 (2.77)</td>
<td>78.6 (2.06)*†</td>
</tr>
<tr>
<td>Gets care in Medical Home</td>
<td>56.5 (5.68)</td>
<td>45.8 (2.52)†</td>
</tr>
<tr>
<td><strong>Academic Performance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents ever contacted about school problems (6-17)</td>
<td>59.2 (6.54)</td>
<td>46.7 (2.83)</td>
</tr>
<tr>
<td>Child repeated grade (6-17)</td>
<td>27.8 (6.82)</td>
<td>20.2 (1.97)</td>
</tr>
<tr>
<td>Child has IFSP/IEP</td>
<td>22.9 (4.13)</td>
<td>12.6 (1.44)*†</td>
</tr>
<tr>
<td>Child usually engaged in school (6-17)</td>
<td>60.6 (6.73)</td>
<td>70.9 (2.28)</td>
</tr>
<tr>
<td><strong>Family Environment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents/child can talk/share ideas together very well (6-17)</td>
<td>55.1 (6.60)</td>
<td>62.4 (2.81)</td>
</tr>
<tr>
<td>Parent usually feel stressed</td>
<td>24.0 (4.82)</td>
<td>13.7 (1.57)*†</td>
</tr>
<tr>
<td>Neighborhood safe, supportive</td>
<td>70.2 (5.35)</td>
<td>62.8 (2.46)†</td>
</tr>
</tbody>
</table>

NOTE: Estimates for Children in Foster Care in Table 3a calculated from (.67) times mean for Children in Nonrelative Foster Care plus (.33) times mean for Children Living with Relatives.
* Estimate differs from that of children in foster care at the 0.05 level
† Estimate differs from that of children adopted from foster care at the 0.05 level

Outcomes During the Transition to Adulthood for Former Foster Youth

Mark E. Courtney, Amy Dworsky, JoAnn S. Lee and Melissa Raap

Introduction

For most young people, the transition to adulthood is a gradual process. Many continue to receive financial and emotional support from their parents or other family members well past age 18. This is in stark contrast to the situation confronting youth in foster care. Too old for the child welfare system but often not yet prepared to live as independent young adults, foster youth who “age out” of care each year are expected to make it on their own long before the vast majority of their peers.

The federal government recognized the need to help prepare foster youth for this transition to adulthood by amending Title IV-E of the Social Security Act three times since 1986 to create services and supports for foster youth and former foster youth. The John Chafee Foster Care Independence Program provides $140 million per year to states for services to prepare foster youth for adulthood, and gives states the option of extending Medicaid coverage until age 21 for youth who age out of foster care. Federally-funded vouchers for post-secondary education and training are also available to eligible current and former foster youth making the transition to adulthood.

More recently, the Fostering Connections to Success and Increasing Adoptions Act of 2008 amended Title IV-E to extend the age of Title IV-E eligibility from 18 to 21. Beginning in federal FY2011, states will be able to claim federal reimbursement for the costs of foster care maintenance payments made on behalf of Title IV-E eligible foster youth until they are 21 years old. This change in federal policy was informed by findings from the Midwest Evaluation of the Adult Functioning of Former Foster Youth (the “Midwest Study”). This report provides information on the transition to adulthood for foster youth participating in the Midwest Study.

Overview of the Midwest Study

The Midwest Study is the largest longitudinal study of young people aging out of foster care and transitioning to adulthood since the passage of the John Chafee Foster Care Independence Act in 1999. Youth were eligible to participate in the study if they were in the care of the public child welfare agency in Illinois, Iowa, or Wisconsin at age 17, if they had entered care prior to their sixteenth birthday, and if the primary reason for their placement was abuse, neglect, or alcohol and/or substance dependency. Youth with developmental disabilities or severe mental illnesses that made it impossible for them to participate in the initial interviews and youth who were incarcerated or in a psychiatric hospital were excluded from participation. Youth were also ineligible to participate if they were “on the run” or otherwise missing from their out-of-home care placement over the course of the field period for the initial interviews, or if they were placed out of state.

1 For a full description of the baseline sample see Courtney, M. E., Terao, S., & Bost, N. (2004). Midwest evaluation of the adult functioning of former foster youth: Conditions of youth preparing to leave state care. Chicago, IL: Chapin Hall at the University of Chicago.
Figure 1. Trends in young women’s educational attainment

Figure 2. Trends in young men’s educational attainment
Baseline interviews were conducted with 732 (96 percent) of the eligible youth (63 from Iowa, 474 from Illinois, and 195 from Wisconsin) between May 2002 and March 2003. Three additional waves of survey data have since been collected. Of those from the baseline sample, 82 percent \((n = 603)\) were re-interviewed between March and December 2004 when most of the study participants were 19 years old, and 81 percent \((n = 590)\) were re-interviewed between March 2006 and January 2007 when nearly all of the study participants were age 21.

This report is based on the fourth wave of survey data from the Midwest Study. These data were collected from 82 percent \((n = 602)\) of the baseline sample between July 2008 and April 2009. Study participants were 23 or 24 years old at the time. Since we have been tracking the outcomes of the Midwest Study participants since they were 17 or 18 years old, as they move into their mid-twenties we can begin to identify trends in the directions that their lives have taken across different domains. Here we describe trends in key outcomes during the transition to adulthood: educational attainment, employment, family formation, and criminal justice system involvement.\(^2\) We restricted our analysis to the 472 young adults (64 percent of the original sample) who were interviewed in all four waves of the study, and examined the trends for males and females separately.

**Trends in Educational Attainment and School Enrollment**

The percentage of study participants who had a high school diploma or GED rose substantially between age 17 or 18 and age 21, but remained stable after that. Although males and females began at about the same starting point (i.e., 15 percent), females experienced a larger increase over time. By the time they were interviewed at age 23 or 24, 81 percent of the young women and close to three-quarters of the young men had a high school diploma or a GED.

We see a somewhat similar trend in the percentage of study participants who had ever attended college. Following a substantial increase between


![Figure 3. Trends in current employment by gender](image-url)
Figure 4. Trends in marriage and cohabitation among females

Figure 5. Trends in marriage and cohabitation among males
age 17 or 18 and age 21, the percentage of young women who had ever attended college leveled off, and the percentage of young men who ever attended college rose modestly. Nevertheless, 38 percent of the young women had ever attended college by age 23 or 24, compared with only 28 percent of the young men.

A very different picture emerges if we look at the percentage of study participants who had a college degree. Only a handful of study participants had either an associate’s or bachelor’s degree by the age of 21. That had risen to a mere 8 percent of the young women and 5 percent of the young men at age 23 or 24. These college graduates represent just 21 percent of the young women and 18 percent of the young men who had ever attended college.

**Trends in Current Employment**

The percentage of young men who were currently employed grew steadily from age 17 or 18 to age 21, but did not increase thereafter. By contrast, the percentage of young women who were currently employed increased between age 19 and age 21 but fell between age 21 and age 23 or 24. Although there was no point at which even half of the males had jobs, female employment peaked at 57 percent.

**Trends in Family Formation**

Because nearly all of the study respondents were still in foster care at age 17 or 18, few were cohabiting and none reported being married, so our analysis of marriage and cohabitation focuses on trends since age 19. The percentage of young women who were married or cohabiting rose to 40 percent by age 23 or 24. However, most of this growth was due to an increase in cohabitation. The trend was similar among young men, although young women were consistently more likely to be married or cohabiting.

Although the percentage of study participants who were parents increased steadily over time regardless of gender, parenthood was much more common among young women than among young men at every wave of data collection. In fact, the young women were more likely to have given birth to child by age 21 than the young men were to

![Figure 6. Trends in parenthood among females](image)

- **Gave birth to at least one child**:
  - Age 17 or 18: 20.7%
  - Age 19: 33.3%
  - Age 21: 54.8%
  - Age 23 or 24: 67.4%

- **Lives with at least one child**:
  - Age 17 or 18: 31.0%
  - Age 19: 50.6%
  - Age 21: 61.7%
Figure 7. Trends in parenthood among males

<table>
<thead>
<tr>
<th>Age 17 or 18</th>
<th>Age 19</th>
<th>Age 21</th>
<th>Age 23 or 24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fathered at least one child</td>
<td>6.2</td>
<td>12.3</td>
<td>29.9</td>
</tr>
<tr>
<td>Lives with at least one child</td>
<td>2.8</td>
<td>11.8</td>
<td>18.0</td>
</tr>
</tbody>
</table>

Figure 8. Trends in criminal justice system involvement among females

<table>
<thead>
<tr>
<th>Age 17 or 18</th>
<th>Age 19</th>
<th>Age 21</th>
<th>Age 23 or 24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrested since last interview</td>
<td>39.6</td>
<td>20.3</td>
<td>19.2</td>
</tr>
<tr>
<td>Convicted since last interview</td>
<td>13.5</td>
<td>7.0</td>
<td>6.7</td>
</tr>
<tr>
<td>Incarcerated since last interview</td>
<td>23.8</td>
<td>11.3</td>
<td>16.7</td>
</tr>
</tbody>
</table>
have fathered a child by age 23 or 24. The gender difference is even starker if we look at the percentage of study participants who were living with one or more of their biological children. At each wave of data collection, the vast majority of young women who had given birth to at least one child were living with one or more of their children, compared with only one-third to one-half of the young men who had fathered a child.

**Trends in Criminal Justice System Involvement**

Examining trends in criminal justice system involvement is complicated by changes in the questions that were asked. At the time of their baseline interview, when they were 17 or 18 years old, study participants were asked whether they had ever been arrested, convicted, or incarcerated. By contrast, at each of the subsequent wave of data collection, study participants were asked whether they had ever been arrested, convicted, or incarcerated since their most recent interview. For this reason, we focus on trends in criminal justice system involvement since age 19. However, as can be seen in Figures 8 and 9, many of these young people had already been involved with the juvenile or criminal justice system prior to their baseline interview. In fact, they were more likely to have been arrested, convicted, or incarcerated prior to their baseline interview than during any of the follow-up periods.

The percentage of study participants who reported that they had been arrested since their most recent interview remained relatively stable over time, although males were always nearly twice as likely as their female counterparts to report an arrest. Similarly, the percentage of study participants who reported that they had been convicted of a crime since their most recent interview remained fairly constant, and males were consistently more than twice as likely to report a conviction as their female counterparts.

A different pattern emerges when we turn to incarceration. The percentage of young men who reported that they had been incarcerated since their most recent interview was higher at each subsequent wave of data collection. Although the percentage of young women who reported that they had been incarcerated since their most recent interview increased between age 19 and age 21, it remained about the same through age 23 or 24.

![Figure 9. Trends in criminal justice system involvement among males](image-url)
Discussion

Although these 23- or 24-year-olds still have much of their lives ahead of them and their circumstances could change in significant ways, to the extent that self-sufficiency is a marker of a successful transition to adulthood, these young people, as a group, are not faring well. While 79 percent of the young women and nearly three-quarters of the young men had a high school diploma or a GED, only seven percent of the young women and five percent of the young men had even an associate’s degree. Not only is this considerably lower than the percentage of young people in the general population who are college graduates, but, in addition, it represents only a small fraction of the Midwest Study participants who had pursued post-secondary education. Moreover, it seems unlikely that significantly more Midwest Study participants will graduate from college in the near future, given that only 17 percent of those sampled were still enrolled in school.

Equally troubling was the study participants’ lack of economic wellbeing. Less than half of these 23- and 24-year-olds currently had a job, and most of those who were working were not earning a living wage. In fact, more than one-quarter of these young people reported no income from employment during the past year, and half of those who had worked reported annual earnings of $8,000 or less. Their lack of self-sufficiency was also reflected in their receipt of means-tested benefits: most notably, two-thirds of the females and more than one-quarter of the males had been recipients of Food Stamps during the past year.

No less disconcerting were some of the other outcomes we observed. Far too many of these young men have been incarcerated, and far too many of the young women are raising children alone. Lack of stable housing also remains a significant problem; nearly 40 percent of these young people have been homeless or “couch surfed” since leaving foster care.

This is not to say that the outcomes for these young people are uniformly poor, or that youth aging out of care have no reason to be hopeful. On the contrary, despite whatever obstacles and setbacks they may have faced, some have managed to “beat the odds” and make significant progress toward self-sufficiency. Many expressed satisfaction with their lives and optimism about their futures. Moreover, although the child welfare system failed to find them permanent homes, most of these young people have maintained close ties to members of their family of origin. It is also important to keep in mind that young people participating in the Midwest Study, like young people aging out of foster care generally, spent many years in troubled homes before entering state care; the outcomes observed here should not be considered an “effect” of foster care per se.

Nevertheless, our data provide compelling evidence that current efforts are not enough. More than a decade after the creation of the Chafee Independent Living Program, far too many foster youth are not acquiring the life skills they will need if they are to become productive, self-sufficient young adults. Although there is little research demonstrating that providing independent living services significantly improves the outcomes of young people transitioning out of foster care, more than one-third of the young people in our study wished that they had received more training or assistance while they were in foster care. In addition, efforts should be redoubled to ensure that young people making the transition to adulthood from foster care have the enduring support of responsible adults, preferably through a legally-permanent family connection.

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Aging Out of Foster Care—
Societal Costs and Individual Wellbeing

Lauren Kelley

Introduction

Although foster care is intended to be a temporary arrangement, approximately 29,471 children aged out of foster care in 2009.¹ Unlike many youth raised in intact homes, youth who age out of foster care must make an abrupt transition into adulthood without the support of a family. Allowing children to age out of foster care is detrimental to their wellbeing and costly to society. Research estimates that that for each dollar spent on the adoption of a child from foster care, society reaps approximately three dollars in benefits.²

This report examines the costs associated with aging out of foster care. Table 1 compares the life course outcomes of former foster youth and the general population. The remainder of the report elaborates on the findings outlined in Table 1.

Experiences of Homelessness

Individuals who age out of foster care are at heightened risk of experiencing homelessness. The “Midwest Study” found that 24.3 percent of 23- and 24-year-olds who aged out of foster care had experienced homelessness.³ Comparatively, a nationally representative study found that 4.6 percent of the general population of 22-year-old adults has experienced homelessness.⁴ Not only are those who aged out of foster care at increased risk of homelessness, but among those who do experience homelessness, individuals who age out of care remain homeless for longer periods than do homeless individuals in the general population. Twenty-three/twenty-four year-olds who aged out of care and experience homelessness do so for an average of 66 days.⁵ Same-aged adults in the general population do so for 22 days.⁶

According to conservative estimates, homeless shelters cost $26.71 per person, per day.⁷ Of the 29,000 youth who aged out of foster care in 2007, the expense of sheltering the 24.3 percent who are anticipated to experience homelessness by age 23 or 24 is around $12.4 million. If those who aged out experienced homelessness at the same rate and for the same length of time as the general population, taxpayers could save nearly 94 percent on sheltering those who aged out.

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³ Courtney, M., Dworsky, A., Lee, J., & Raap, M. (2009) Midwest evaluation of the adult functioning of former foster youth: Outcomes at age 23 and 24. Chicago, IL: Chapin Hall at the University of Chicago. Calculated by taking the midpoints of each “length of longest homeless spell” and weighing by its frequency and weighing the “number of times homeless” by their probability and summing.
⁵ Courtney, M., Dworsky, A., Lee, J., & Raap, M. (2009) Midwest evaluation of the adult functioning of former foster youth: Outcomes at age 23 and 24. Chicago, IL: Chapin Hall at the University of Chicago. Calculated by taking the midpoints of each “length of longest homeless spell” and weighing by its frequency and weighing the “number of times homeless” by their probability and summing.
Table 1. Life course outcomes: individuals who aged out and the general population*  

<table>
<thead>
<tr>
<th>Experience(s) of Homelessness</th>
<th>Midwest Study (Study of Former Foster Youth)</th>
<th>Adolescent Health (Nationally Representative Study)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Females</td>
<td>Males</td>
</tr>
<tr>
<td>Received Unemployment Insurance, Workers’ Compensation, or SSI in last year</td>
<td>23.6%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Received Food Stamps in last year</td>
<td>67.7%</td>
<td>26.8%</td>
</tr>
<tr>
<td>Receipt of Public Housing/ Rental Assistance in last year</td>
<td>12.4%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Receipt of TANF in last year**</td>
<td>12.2%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Institutionlized for Mental Health Reasons</td>
<td>6.5%</td>
<td>1.95%c</td>
</tr>
<tr>
<td>Ever Convicted of a Crime</td>
<td>42.43%</td>
<td>6.05%</td>
</tr>
<tr>
<td>Graduation from a 2-Year College</td>
<td>3.2%</td>
<td>19.4%</td>
</tr>
<tr>
<td>Graduation from a 4-Year College</td>
<td>2.5%</td>
<td>9.4%</td>
</tr>
</tbody>
</table>

* With the exception of the teen parenthood measure, which is reported at age 19, all measures are taken at ages 23-24.  
** Among custodial parents.  
*** Among parenting females; comparable data is not available for the Adolescent Health Sample.  

**Receipt of Unemployment Insurance, Workers’ Compensation, or Supplemental Security Income (SSI)**

Women aged 23 or 24 who aged out of foster care are 4.3 times more likely than their same-aged peers in the general population to receive unemployment insurance, workers’ compensation, or SSI. Similarly, 23- and 24-year-old men who aged out of foster care are approximately 3.3 times more likely than their same-aged peers to receive these same benefits (see Table 1).

On average, unemployment insurance benefits compensate 50 percent of wages for 26 weeks. According to the “Midwest Study,” 23- and 24-year-old males who age out of foster care worked an average of 38.6 hours per week and earned $11.12 per hour. Females who aged out of care worked an average of 34.1 hours per week and earned $9.37 per hour. Males receiving unemployment benefits anticipate

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10 Ibid.
annual maximum benefits of $5,580.02. Females receiving unemployment benefits anticipate annual maximum benefits of $4,153.72.

Approximately 29,000 foster youth aged out of care nationwide in 2007.11 Since males represent 52 percent of children in and exiting foster care,12 approximately 15,080 males aged out in 2007. Of males who aged out, eight percent will likely receive unemployment insurance benefits.13 Therefore, approximately 1,206 males who aged out are likely to receive unemployment insurance by age 23 or 24 at a cost to Americans of $6,729,504.12.

Approximately 13,920 females aged out in 2007.14, 15 Among females who aged out, 7.5 percent will likely receive unemployment insurance.16 Therefore, approximately 1,044 females who aged out are likely to receive unemployment insurance benefits by age 23 or 24 at a cost of $4,336,483.68. The total cost to Americans in unemployment benefits for both young men and women who aged out of foster care is $11,065,987.80.

In most states, worker’s compensation entitlements replace two-thirds of pre-injury wages.17 Only male foster care alumni reported receiving workers’ compensation benefits, and they received these benefits at a rate of 1.1 percent.18 The average weekly income for 23- and 24-year-olds who aged out is $492.23.19 Therefore, the average entitlement per eligible male former foster youth is 0.66666 X $492.23, or $328.15 per week.

Approximately 15,080 males aged out of foster care nationwide in 2007.20,21 Further, 1.1 percent of 23- and 24-year-old foster care alumni (166 individuals) reported receiving workers’ compensation. This creates an annual nationwide cost of $2,832,590.80 in order to provide workers’ compensation to 23- and 24-year-olds who aged out of foster care.

In 2010, the monthly SSI benefit rate is $674.00.22 Approximately 15.1 percent of 23 and 24 year olds who aged out report receiving SSI during the previous year.23 Given that approximately 29,000 youth aged out of care nationwide in 2007, 4,379 of these individuals are expected to receive SSI benefits at age 23 or 24.24 The annual cost of providing SSI to 23- and 24-year-olds who aged out is $35,417,352.00.

16 Ibid.
19 Ibid.
Given these three cost calculations, the federal government spends an estimated $49,315,930.60 per year to provide unemployment insurance, workers’ compensation, and SSI benefits for the approximate 29,000 youth who age out each year. If individuals who aged out of foster care received unemployment insurance, workers’ compensation, and/or SSI at the same rate as the general population, the government could spend approximately 73 percent less on the provision of these services for foster care alumni.

**Receipt of Food Stamps**

Women aged 23 or 24 who aged out of foster care are over nine times more likely to receive Food Stamps than their same-aged peers in the general population; similarly, 23- and 24-year-old men who aged out are nearly 18 times more likely to receive Food Stamps than their same-aged peers in the general population (see Table 1).

The per capita average monthly Food Stamp entitlement in 2008 was $101.00.25 Able-bodied adults without dependents can receive Food Stamps for a maximum of three months.26 A survey of 23- and 24-year-old former foster care youth indicates that the vast majority of adults who were not employed at the time of survey were physically able to work and would thus be subject to the three month eligibility limitation.27 Approximately 29,000 youth aged out of foster care nationwide in 2007.28 Of 23- and 24-year-olds who aged out, 49.4 percent reported receiving Food Stamps during the last 12 months.29 Therefore, 14,326 are expected to receive Food Stamps for a period of three months. This creates an annual nationwide cost of $4,340,778.00 to provide Food Stamp benefits to eligible 23- and 24-year-old foster care alumni. If individuals who aged out of foster care received Food Stamps at the same rate as their same-aged peers in the general population, the government could spend approximately 91.9 percent less on providing Food Stamps to the population of young adults who aged out of foster care.

**Receipt of Public Housing/Rental Assistance**

Young women who aged out of foster care are nearly four times more likely to receive public housing or rental assistance than their same-aged peers in the general population; young men who aged out are 3.4 times more likely to receive public housing or rental assistance than their peers in the general population (see Table 1).

The costs of these housing programs are high. The Department of Housing and Urban Development allocated $2.244 billion for the Public Housing Capital Fund in 2010.30 An additional $4.6 billion was allocated for the operation and management of public housing.31 Approximately 1.1 million families benefit from public housing.32 Therefore, the annual expense per household living in public housing is $6,221.81.

There are two forms of rental assistance: Tenant-Based Rental Assistance and Project-Based Rental Assistance. Tenant-Based Rental Assistance granted housing assistance to approximately two

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31 Ibid.

32 Ibid.
million families at a cost of $16.2 billion in 2009. Therefore, the annual expense per household receiving Tenant-Based Rental Assistance is $8,100.00. Additionally, approximately 1.3 million families received Project-Based Rental Assistance at a cost of $7.5 billion in 2009. The annual expense per household receiving Project-Based Rental Assistance is $5,769.23.

Three times as many households receive rental assistance than public housing. Within households that receive rental assistance, households are 1.538 times more likely to receive Tenant-Based Rental Assistance than Project-Based Rental Assistance (2 million households receive Tenant-Based Rental Assistance; 1.3 million households receive Project-Based). Of foster care alumni surveyed in the “Midwest Study”, 8.4 percent reported receiving either rental assistance or public housing. It follows that 2.1 percent of former foster youth age 23 and 24 received Public Housing assistance, and 6.3 percent receive Rental Assistance. Specifically, 3.82 percent of former foster youth receive Tenant-Based Rental Assistance and 2.48 percent receive Project-Based Rental Assistance. The annual nationwide societal cost associated with providing public housing and rental assistance to qualifying 23- and 24-year-olds who aged out of care is approximately $16,911,958.66. If individuals who aged out of foster care received public housing and rental assistance at the same rate as the general population, the government could spend 72 percent less on providing public housing and rental assistance for the population of young adults who aged out of foster care.

Receipt of Governmental Assistance to Parents: Temporary Assistance for Needy Families (TANF) and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

The United States government provides assistance programs such as TANF and WIC to struggling parents. Young parents who aged out of foster care receive these benefits at high rates. At age 23 or 24, 12.2 percent of mothers and 7.8 percent of fathers who aged out report recent TANF receipt; at the same age, 58.2 percent of mothers who aged out report recent WIC receipt (see Table 1). In order to understand the societal cost associated with providing benefits to young parents who aged out of foster care, we must first examine the parenting rate of former foster youth. Table 2 compares the parenting rates of young adults who aged out of foster care and young adults in the general population.

33 Ibid.
34 Ibid.
35 Ibid.
36 Ibid.
37 Ibid.
38 Ibid.
39 Ibid.
Table 2. Parenting in young adulthood

<table>
<thead>
<tr>
<th></th>
<th>Midwest Study (Age 23/24)</th>
<th>Adolescent Health Study (Age 23/24)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Study of Youth who Aged Out)</td>
<td>(Nationally Representative Study)</td>
</tr>
<tr>
<td></td>
<td>(N=601, N_female=321, N_male=280)</td>
<td>(N=1,488, N_female=762, N_male=726)</td>
</tr>
<tr>
<td>Biological parent of at least one child</td>
<td>215 (67.0%) 124 (44.3%) 56.4%</td>
<td>229 (30.1%) 133 (18.3%) 24.3%</td>
</tr>
<tr>
<td>Custodial parent of at least one child</td>
<td>197 (61.4%) 51 (18.2%) 41.3%</td>
<td>224 (29.4%) 87 (12.0%) 20.9%</td>
</tr>
</tbody>
</table>


Among 23/24 year-old parenting foster care alumni, we find the following:

Table 3. Number of resident children among 23- and 24-year-old parents who aged out of care

<table>
<thead>
<tr>
<th></th>
<th>Females (N=215)</th>
<th>Males (N=124)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of &quot;resident&quot; children</td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>0</td>
<td>18 (8.4%)</td>
<td>73 (58.9%)</td>
<td>26.8%</td>
</tr>
<tr>
<td>1</td>
<td>99 (46.0%)</td>
<td>36 (29.0%)</td>
<td>39.8%</td>
</tr>
<tr>
<td>2</td>
<td>68 (31.6%)</td>
<td>11 (8.9%)</td>
<td>23.3%</td>
</tr>
<tr>
<td>3 or more</td>
<td>30 (14.0%)</td>
<td>4 (3.2%)</td>
<td>10.0%</td>
</tr>
<tr>
<td>Mean number of &quot;resident&quot; children</td>
<td>1.55</td>
<td>0.59</td>
<td>1.2</td>
</tr>
</tbody>
</table>

It follows that foster care alumni parent at the following rates:

Table 4. Parenting among all foster care alumni (aged 23 or 24)

<table>
<thead>
<tr>
<th></th>
<th>Females</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living with no children</td>
<td>38.65%</td>
<td>81.80%</td>
</tr>
<tr>
<td>Living with one child</td>
<td>30.81%</td>
<td>12.84%</td>
</tr>
<tr>
<td>Living with two children</td>
<td>21.17%</td>
<td>3.94%</td>
</tr>
<tr>
<td>Living with three or more children</td>
<td>9.37%</td>
<td>1.41%</td>
</tr>
</tbody>
</table>

Table 5. Distribution of TANF benefits by 23- and 24-year-old parents who aged out

<table>
<thead>
<tr>
<th></th>
<th>Females Receiving TANF</th>
<th>Females Receiving WIC</th>
<th>Males Receiving TANF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Parenting</td>
<td>38.7%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Parenting 1 child</td>
<td>30.8% 3.8%</td>
<td>17.9% 12.8%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Parenting 2 children</td>
<td>21.2% 2.6% 12.3%</td>
<td>3.9% 0.3%</td>
<td></td>
</tr>
<tr>
<td>Parenting 3+ children</td>
<td>9.4% 1.1% 5.6% 1.4%</td>
<td>0.1%</td>
<td></td>
</tr>
</tbody>
</table>
In Tables 2, 3 and 4 we calculated the parenting rate among former foster youth. With that information and the finding in the “Midwest Study” that 12.2 percent of young mothers and 7.8 percent of young fathers who aged out of foster care receive TANF, and that 58.2 percent of young mothers who aged out receive WIC (see Table 1), it is possible to calculate the total rate of benefit receipt by foster care alumni, as shown in Table 5.

Next, we calculate the anticipated annual societal cost of providing TANF and WIC benefits for the approximately 29,000 foster youth who aged out in 2007. Since males represent 52 percent of children in foster care, approximately 13,920 females and 15,080 males aged out in 2007.

Table 6. TANF receipt by 23- and 24-year-olds who aged out of care nationwide

<table>
<thead>
<tr>
<th>TANF: 1 child</th>
<th>Female %</th>
<th>Female #</th>
<th>Female Cost per Month</th>
<th>Male %</th>
<th>Male #</th>
<th>Male Cost per Month</th>
<th>Total #</th>
<th>Total Cost per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>TANF: 2 children</td>
<td>3.8%</td>
<td>523</td>
<td>$164,222</td>
<td>1.0%</td>
<td>151</td>
<td>$47,414</td>
<td>674</td>
<td>$211,636</td>
</tr>
<tr>
<td>TANF: 3+ children</td>
<td>2.6%</td>
<td>359</td>
<td>$140,010</td>
<td>0.3%</td>
<td>47</td>
<td>$18,330</td>
<td>406</td>
<td>$158,340</td>
</tr>
<tr>
<td>Total</td>
<td>1.1%</td>
<td>159</td>
<td>$73,935</td>
<td>0.1%</td>
<td>17</td>
<td>$7,905</td>
<td>176</td>
<td>$81,840</td>
</tr>
</tbody>
</table>

Table 7. WIC receipt by 23- and 24-year-old women who aged out and their children

<table>
<thead>
<tr>
<th>WIC: 1 child</th>
<th>Female %</th>
<th>Number of Females</th>
<th>Number of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>WIC: 2 children</td>
<td>17.9%</td>
<td>2,496</td>
<td>2,496</td>
</tr>
<tr>
<td>WIC: 3+ children</td>
<td>12.3%</td>
<td>1,715</td>
<td>3,430</td>
</tr>
<tr>
<td>Total receiving WIC</td>
<td>5.4%</td>
<td>757</td>
<td>2,271*</td>
</tr>
<tr>
<td>Total receiving WIC</td>
<td>35.7%</td>
<td>4,968 women</td>
<td>8,197 children</td>
</tr>
</tbody>
</table>

TANF benefit rates depend upon the number of children in the household. According to TANF’s Eighth Annual Report to Congress, monthly cash payments to families averaged $314 for one child, $390 for two children, $465 for three children, and $558 for four or more children. It follows that at ages 23 and 24, foster care alumni receive TANF as shown in Table 6.

The average family on TANF received benefits in FY 2006 for 35.4 months. Assuming this benefit period, the anticipated cost of providing TANF benefits to parenting 23- and 24-year-olds who aged out of foster care nationwide is $15,994,286.40.
Providing WIC benefits to young mothers who aged out is similarly costly. In Table 7, we see the anticipated rate at which the approximate 13,920 females who aged out of foster care in 2007 will receive WIC at age 23 or 24.  

In FY2009, the average monthly WIC benefit per individual was $42.41. Women may receive WIC benefits during their pregnancy and for six months after delivery. Given that it takes time for a woman to learn of her pregnancy and register for WIC, this calculation assumes that women receive benefits for twelve months as opposed to the full fifteen months. Of the 13,920 young women who aged out of foster care in 2007, 4,968 are projected to receive WIC, at a cost of $2,528,314.56.

WIC-eligible children may receive benefits for their first year of life. Following this period, a child must be reassessed for eligibility every six months and may receive benefits until age five. Eligibility is defined as living at or under 185 percent of the poverty line. In 2009, the poverty line for a family of two was $14,570. The average income of 23- and 24-year-olds who aged out meets this criterion. Therefore, it is reasonable to assume a child’s eligibility will be extended until age five. The women who aged out of foster care in 2007 are anticipated to, at ages 23 or 24, parent 8,197 WIC-eligible children. If these children receive WIC until age five, this creates a nationwide cost of $20,858,086.20. The net cost of providing WIC to 23- and 24-year-old mothers who aged out and their children is $23,386,400.76.

**Mental Health Outcomes**

Foster care alumni report psychiatric hospitalization at a rate more than three times greater than the general population (see Table 1). Public insurance payments to psychiatric facilities average $8,016.03 per patient. Young adults who aged out use public insurance at a rate of 38.5 percent. Since 6.5 percent of foster care alumni are hospitalized for mental health concerns (see Table 1), of the 29,000 youth who aged out in 2007, 726 are expected to require psychiatric hospitalization by age 23 or 24 and be covered by public insurance at a cost of $5,819,637.78. If foster care alumni required psychiatric hospitalization at the same rate as the general population (1.95 percent) and were covered by public insurance at the same rate as the general population (5.9 percent), society could save 95 percent on psychiatric hospitalization of foster care alumni.

**Criminality**

Individuals who aged out are more than six times more likely than the general population to have been arrested by ages 23 or 24. Further, at age 23 or 24, former foster youth report having been convicted of a crime at a rate seven times greater than general population. Since their last

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49 Ibid.


52 Ibid.

53 Ibid.


56 Ibid.

57 Ibid.
interview approximately two years prior, 30.07 percent of 23- and 24-year-old former foster youth report spending time in a correctional facility.\(^\text{58}\)

The average cost per state inmate in 2001 (the most recent year for which the Bureau of Justice Statistics published state prison expenditures) was $62.05 per day.\(^\text{59}\) In 2009 dollars, that equals a daily cost of $75.17 per prisoner.\(^\text{60}\) In 2009, the average length of prison sentence was 46.8 months.\(^\text{61}\) (In 2001, the year for which the most recent data on the cost per prisoner is available, the average length of sentence was also 46.8 months.\(^\text{62}\)) Given that the average cost per prisoner is $75.17 per day and the average length of sentence is 46.8 months, the average cost per inmate in 2009 dollars is approximately $105,538.68. Since approximately 29,000 youth aged out of foster care in 2007,\(^\text{63}\) and 30.07 percent of 23- and 24-year-old former foster youth report spending time in a correctional facility,\(^\text{64}\) the cost of incarcerating former foster youth is $920,297,289.60.

**College Graduation**

Young adults who age out of foster care lag behind the general population in educational attainment. According to the “Midwest Study,” compared to the general population, foster care alumni are more than three times more likely to not have a high school diploma, and one-fifth as likely to have a college degree by age 23 or 24.\(^\text{65}\)

A college education requires an up-front investment but generates future returns both to the graduate—through higher earning potential—and to society because college graduates generate higher tax revenue and have lower rates of criminality than do individuals who do not complete college. The benefits of a college education more than offset the cost. In recognition of the return on investments in education, states such as Texas have passed legislation that exempts students in foster care from college tuition and fees at state colleges and universities.\(^\text{66}\) This legislation is intended to reduce the barriers that fostered individuals face as they pursue higher education.

Using Texas as an example, we can see how an investment in the education of former foster youth generates returns. The societal cost per foster youth who completes a two-year degree in Texas is $2,700.00.\(^\text{67}\) There is a return on this investment in the form of higher tax contributions by an individual with an associate’s degree compared to a high school graduate. According to the 2009 U.S. Population Survey and the 2009 tax rates, the average person with an associate’s degree contributes $1,868.00 more per year in tax revenue than he would have without the degree.\(^\text{68}\)\(^\text{69}\) The tax benefits of higher education repay the cost of providing a two-year education within 1.45 years. Every subsequent year, each foster care alumni who

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58 Ibid.
65 Ibid.
67 Ibid.
completes an associate’s degree generates an average annual societal benefit of $1,868.00 in tax contributions.

Benefits also clearly result from investing in four-year degrees for foster care alumni. The cost of a four-year degree in Texas is $27,464.00. According to the 2009 U.S. Population Survey and the 2009 tax rates, the average college graduate generates an additional $6,805.00 in tax revenue per year compared to high school graduates. The increased tax revenue from a college graduate compared to a high school graduate covers the cost of providing a free college education to former foster youth within four years. Every subsequent year, each foster care alumni with a bachelor’s degree creates a societal benefit of $6,805.00 in tax contributions.

Reducing the financial barrier to a college education for former foster youth is a first step in increasing their educational attainment. However, individuals who aged out of foster care report additional barriers beyond finances that inhibit their ability to pursue higher education. Though inability to pay was cited as the reason for not continuing their education by 39.9 percent of those who aged out and did not pursue higher education, other highly cited reasons for not continuing education include “the need to work full-time” (19.7 percent), “the need to care for child(ren)” (13.8 percent), a lack of transportation (3.2 percent), and “other” reasons (22.9 percent). This suggests that barriers larger than finances prevent foster care alumni from pursuing degrees. Therefore, policies intended to increase the educational opportunities for foster care alumni must also address these barriers.

Conclusion

Allowing youth to age out of foster care is detrimental to their wellbeing and costly to society. Those who age out are at higher risk of poor outcomes, including homelessness, low educational attainment, and involvement in criminal activity. From the preceding sections, it follows that the average annual cost associated with the 29,000 youth who aged out of foster care in 2007 is $1,048,416,281.80, or $36,152.29 per individual. However, it is likely that the societal cost is much higher because the limitations of this report do not include measures such as lost productivity.

This expense can be reduced by both promoting the adoption of children from foster care and incentivizing college completion by those who do age out. Finding permanent homes for more children in foster care, leading to lower rates of youth aging out, may improve the life outcomes of formerly fostered individuals and their children. Findings from the University of Minnesota reveal that “close, long-term relationships with persons who model pro-social behaviors and who affirm pro-sociality in the person who has experienced abuse and neglect” serve as protective factors to reduce the impact of early abuse and neglect. Adoptive parents of previously abused or neglected children can model pro-social behaviors and provide hope for their children’s future and resources for them to attain their life goals; all of these factors have been found to be protective, moderating factors for children who have experienced abuse or neglect.

74 This calculation includes cost of homelessness, Unemployment Insurance, Workers’ Compensation, SSI, Food Stamps, Public Housing/Rental Assistance, TANF, WIC, Mental Health Hospitalization and criminality. Because investment in college is a benefit rather than a cost, it is not included in this cost estimate.
Introduction

In Adoption Advocate No. 17, Finding Permanence for Kids: NCFA Recommendations for Immediate Improvement to the Foster Care System, NCFA presented several suggestions for immediate and long-term foster care reform.1 One of our areas of focus in those recommendations was foster parent recruitment. Now, in honor of National Foster Care Month, just celebrated in May,2 NCFA will highlight parent recruitment strategies from across the country that appear to be working. These stories were gathered primarily via word-of-mouth, and we know they are only the tip of the iceberg in terms of the amazing work that is being done nationwide to find better outcomes for children in foster care.

Intense Recruitment Services

Missouri Extreme Recruitment Grant

In three counties in Missouri, child welfare advocates are employing a parent recruitment strategy called Extreme Recruitment, consisting of 12-20 weeks of diligent recruitment services to improve permanency outcomes for hard-to-place youth in the city of St. Louis and three surrounding counties. The Extreme Recruitment project combines general, targeted, and child-specific recruitment efforts to achieve permanency for children aged 10-18 who have been in foster care for fifteen months or longer and do not have an identified permanent placement. When prospective resource families are identified, “Connector” services are provided to help the families navigate the licensing process and support the children and families before, during, and up to a year after placement.

During the first year of the project (October 2008—September 2009), The Foster and Adoptive Care Coalition (FACC) provided Extreme Recruitment services to 55 children and youth in the St. Louis area. As a result, 50 were connected with safe and appropriate relatives. Thirty-nine were matched permanently, either with a relative or in an adoptive family.

During the second year of the project, an experimental evaluation was established. In Years 2-5, 37 children and youth in the target population will be randomly assigned to the experimental group for Extreme Recruitment services, or to the control group for “business as usual.” As of May 2010, 20 children randomly selected are receiving Extreme Recruitment services. The group average is age 16, and most of the parents of the participating children and youth have not yet had their parental rights terminated. The Extreme Recruitment pilot program has generated local and national interest with its emphasis on family finding and the use of private investigators. On October 25, 2009, the St. Louis Post-Dispatch ran a feature about a teenaged girl

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2 President Barack Obama’s National Foster Care Month proclamation of April 28, 2010 can be viewed online at http://www.whitehouse.gov/the-press-office/presidential-proclamation-national-foster-care-month
receiving Extreme Recruitment services who “thought she had nobody left to love her.” The Extreme Recruitment Work Group believes publicity is important in educating the general public on the importance of kin connections for foster children, and to alter the belief that all relatives “fall from the same tree” as their abusive kin. The evaluation data at this point is very limited; however, by the end of the five-year grant, they expect to have more detailed information about the children and youth served through the Extreme Recruitment project.

For more information, contact:
Extreme Recruitment Project Manager
Sally Howard, sallylhoward@hotmail.com

Public/Private Partnerships

Focus on the Families’ “Wait No More” Project

The Wait No More Project is a collaborative effort between government officials, adoption agencies, church leaders, and ministry partners to raise awareness and recruit families for children waiting in foster care. Through half-day events and targeted media campaigns, Wait No More is highlighting the urgent need for foster and adoptive parents.

At Wait No More events, attendees have the opportunity to hear different perspectives on adoption and foster care from adoptive parents, adopted youth, adoptive siblings, and social workers. On-site adoption agency staff and local and country officials are available to answer questions and help families take the next step in getting involved in the lives of children in foster care. Most importantly, interested families have the opportunity to start the process of adoption from foster care before they leave the event.

So far, six Wait No More events have been held, attended by approximately 4,100 people. Of those in attendance, 945 families initiated the process of adoption from foster care at one of the events.

Networking with Churches and Synagogues

The Wisconsin Foster Care and Adoption Resource Center

In Wisconsin, the Foster Care and Adoption Resource Center (FCARC) “Wisconsin Success” has dedicated a portion of its website to highlighting efforts by individual local caseworkers in foster parent recruitment and retention. Here is one example of the ways in which involving churches and synagogues can prove beneficial at the local level:

Planting the Foster Care Seed in Washburn County

Lisa Cottrell, Foster Care Coordinator for Washburn County, found success in recruiting foster families in her rural northwestern Wisconsin county by writing letters to local churches. By providing several examples of short announcements about the need for foster families, the church staff chose the announcement for their bulletin and provided this message to congregations for about one month. Lisa had 7 families voice an interest in learning more about providing foster care! As a follow-up, Lisa scheduled an informational meeting for those families. As a result, she has met with two families who have followed through with the licensing process. Lisa is pleased with this result, knowing that the word has spread about the need for foster homes for children.

For more information, contact: Katie Porter, Katie.Porter@fotf.org

For more information, go to: http://www.wifostercareandadoption.org/site/indexer/465/content.htm
Support for Current Foster Families: Taking Care of the People who Are Taking Care of the Kids

Washington State’s Children’s Administration Foster Parent Support and Recruitment

As Bob Partlow, program manager for Foster Parent Support and Recruitment for Washington State’s Children’s Administration, explains it, imagine a foster mother waiting in line at the grocery store. She bumps into a friend who asks her how things are going as a foster parent. If that mom feels as though she is receiving the support and services she needs as a foster parent, and she shares that with her friend, she is a walking advertisement for foster parenting. Conversely, if she is having a terrible experience and feeling unsupported, then there is almost no chance that friend will pursue foster parenting. The state of Washington focuses its efforts on customer service, driven by the belief that the best foster parent recruiters are satisfied and supported foster parents. Keeping foster parents satisfied involves several strategies, including:

- Support groups—There are 50 to 60 support groups across the state. The groups typically include training opportunities for parents.
- Monthly newsletter—The newsletter covers a wide range of topics that are useful, helpful, and interesting to foster families. For example, the May 2010 newsletter included articles on mileage claims, a program offering free camp sites to foster families in Washington parks, information on crisis support for foster parents, and tips on stress relief.3
- Giving parents legislative and policy input—House Bill 1624, passed in 2007, mandated that DSHS consult with foster parents at least quarterly. Therefore, the “1624 Committee” meets quarterly with high-level children’s administrators to troubleshoot issues on a statewide and regional level. As Partlow explains, there is no “silver bullet,” but supporting foster parents is the key to recruitment and retention success.

For more information, contact: Bob Partlow, PBOB300@dshs.wa.gov

Support for Current Foster Families: Involving the Community

Metro Recruitment Team, MN Community Human Services, Child Foster Care Licensing

In Minnesota, six counties have teamed up to share the work and minimize the cost of their recruitment efforts. The “metro recruitment team” is made up of one representative each from Anoka, Carver, Dakota, Hennepin, Ramsey, and Scott Counties, as well as one representative from the Minnesota Department of Human Services.

The team is working on bringing in the larger community to recognize and support foster families. For example, during Foster Care Month, the metro counties collaborated for a fun-filled day at the National Sports Center. Activities included a soccer clinic sponsored by the Sanneh Foundation4 and face-painting by volunteers. The Sanneh Foundation solicited door prizes and purchased t-shirts for all participants, and, thanks to the NSC Minnesota Stars, everyone was treated to a free soccer game. At halftime there was a speech honoring foster families, with a representative from each county on the field to receive the honors.

As Terri Haselberger of Child Foster Care Licensing in Ramsey County explained, the day was a big hit with families, and demonstrated how truly valued they are in the community. Local press covered the event, commentators talked about it on the radio, and there was mention of it both on the Sanneh Foundation website and the Minnesota Stars website. Before the day was over, both the Stars and the Sanneh Foundation representatives were talking about new

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3 View the May 2010 newsletter online at http://www.dshs.wa.gov/pdf/ca/Caregiver_Connection_MAY10.pdf

4 The Sanneh Foundation is an organization committed to building positive networks within communities to support children. For more information, see: http://www.thesannehfoundation.org/
things to try next year. This demonstrates a new way to get the community and other organizations involved in supporting foster children and parents.

For more information, contact: Terri Haselberger, Terri.Haselberger@CO.RAMSEY.MN.US

**Social Networking: Facebook**

About a year ago, Hamilton County Job & Family Services in Ohio began using Facebook as a way to get the word out about foster care and foster parent recruitment. John Cummings, Community Adoption Recruitment Manager, believes it has been extremely successful so far in increasing awareness. The Hamilton County Job & Family Services Facebook page introduces visitors to specific children, shares general information about adoption, and provides answers to those interested in becoming foster or adoptive parents. For example, here is one status update:

*Butterflies & Blue Ribbons, 3-5 p.m., today, Krohn Conservatory. Honoring foster and adoptive parents. Sharing info with those interested in foster or adoptive parenting.*

Also, when featured children are posted on the website, staff find that there is a bump in the number of hits once it goes out on the Facebook page. Facebook has proven to be especially helpful for reaching a younger demographic.

For more information, contact: John Cummings, Community Adoption Recruitment Manager for Hamilton County Job & Family Services, cummij02@jfs.hamilton-co.org

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**Other Resources**

NCFA is proud to be part of a larger community devoted to working on adoption and foster care issues. For more information about NCFA's foster care initiatives, please visit www.adoptioncouncil.org or www.familiesforall.org

Our recommendations for other resources for best practices and promising new policies in foster parent recruitment include:

- From The Congressional Coalition on Adoption Institute
  *Best Practices in Foster Parent Adoptive Recruitment Roundtable* (held on May 13, 2010)

- From Denise Goodman, Ph.D., Consultant
  *Target Recruitment Strategies* (2008)

- From the United States Department of Health & Human Services, Administration for Children & Families, Children's Bureau

- From the United States Department of Health & Human Services, Administration for Children & Families, Children’s Bureau
  *Resources for Diligent and Targeted Recruitment* (2008)

- From AdoptUSKids
  *Selected Review of Foster Care & Adoption Recruitment Models and Strategies* (2006)

- From Casey Family Programs
  *Recruitment and Retention of Resource Families* (2005)
  [http://www.casey.org/Resources/Publications/BreakthroughSeries_RecruitmentRetention.htm](http://www.casey.org/Resources/Publications/BreakthroughSeries_RecruitmentRetention.htm)
Concurrent Planning: In Whose Interest?
Joan R. Rycraft and Guillermina Benavides

Introduction

The placement of children who have not been legally freed in pre-adoptive homes has been a common practice since 1970 (Edelstein, Burge, & Waterman, 2002; Mica & Vosler, 1990). Foster-adopt programs were the result of the identification of children with special needs who stayed too long in foster care and for whom finding an adoptive home was difficult (Mica & Vosler, 1990). Edelstein and colleagues (2002) define foster-adopt programs as “programs that place children with approved or prospective adoptive families, on a foster care basis, before children are free for adoption ... These same parents agree to adopt the child if and when parental rights are terminated” (p.103).

Gill (1975) used the term “foster care/adoption programs” to refer to this type of practice, and other terms such as “legal risk” or “at-risk adoption” are also found in the literature (Mica & Vosler, 1990). More recently, the term “concurrent planning” has emerged (Katz, 1999).

Historical Background

In the last two decades, foster parent adoption has become a common practice. In fact, estimates for 2009 indicate that 54 percent of adoptions were by foster parents (U.S. Department of Health and Human Services, 2010). In the past, adoption by foster parents was discouraged. Derdeyn (1990) states foster parents did not have a “legally recognizable interest in their foster child” (p. 338), and any attempt by foster parents to adopt a child in their care was considered a violation of the contract established between the foster parents and the agency, which stated that any plans for the child had to be made by the agency.

The purpose of the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) was to address the problems of multiple and long-term placements in foster care. The act “highlighted permanency and continuity of relationships for children” (Edelstein et al., 2002, p. 103). It clearly indicated that if reunification of a child with his or her family was not possible, an alternative plan should be pursued to provide the child a permanent home. The search for a permanent home for children opened the avenue for foster parents to provide for children on a permanent basis rather than the traditional temporary arrangement. The main reasons for this change in considering foster parents as potential adoptive parents were: 1) the foster parent role was given legal recognition; and 2) the traditional adoption model had not worked for children with special needs. Foster parents became an important resource for agencies in finding placement for these children (Mica & Vosler, 1990).

Although these changes increased the number of children adopted by foster parents, the problem of long-term foster care was not resolved. Children continued to remain in the foster care system for years with minimal hope of being reunited with their parents. In response, the Adoption and Safe Families Act (ASFA, P.L. 105-89), enacted in 1997, shortened the time frame for achieving permanent placements for
children and supported the use of concurrent planning to reduce the length of time children stayed in foster care (Edelstein et al., 2002). ASFA “reduces from 18 to 12 months the scheduling of a permanency hearing, defines parental conduct that obviates the need for reunification efforts, and cites concurrent planning as an appropriate practice” (Katz, 1999, p. 72).

Lutheran Social Services (LSS) in Washington State developed the first concurrent planning model in 1990. Concurrent planning began as an extension of the foster care adoption model and was developed “to work towards family reunification while, at the same time, developing an alternative permanent plan” (Katz, 1999, p. 72). This model was based on the same concerns as the foster-adopt programs: the existence of foster care drift, the extensive time needed to adopt a child in foster care, the decrease in the possibility to exit foster care, the slow process for case resolution, and the efficacy of court review (Katz, 1999).

The literature suggests that the difference between foster-adoptive programs and concurrent planning is the effort made to achieve reunification. In foster-adoptive programs, foster parents are committed to providing foster care until the child is free for adoption and assisting the child while he or she is placed in the foster care system (Edelstein et al., 2002). Concurrent planning is different, in that both objectives, reunification and adoption, are pursued simultaneously. Pre-adoptive parents are expected to work toward family reunification, facilitate visitation, and mentor birthparents (Edelstein et al., 2002). It is obvious that the foster parent role is much more demanding under the concurrent planning model.

The terms “legal risk adoption” and “legal risk foster home” refer to an inherent characteristic of both foster-adopt programs and concurrent planning. The goal of permanency for a child transfers the risk from the child to foster parents or pre-adoptive parents, given that they are the ones who assume the major risk of uncertainty, not knowing whether the child will stay with them or be reunified with his or her parents or other family members (Edelstein et al., 2002; Katz, 1999).

**Concurrent Planning Model**

The goal of concurrent planning is to begin a plan for an alternative permanency option as soon as children enter foster care (D’Andrade, Frame, & Berrick, 2006). ASFA requires agencies to make reasonable efforts to search for an alternative permanency option concurrently with reasonable efforts for reunification. The anticipated overall benefits of concurrent planning include:

- A decrease in the average number of placements per child
- A decrease in the average length of stay in out-of-home care
- An increase in voluntary relinquishments, specifically for foster parent adoption and open adoption
- Foster parents will keep in touch with a child returned to his or her biological parents, providing a continuity of relationships
- Biological parents who have previously relinquished a child will return with a later child, often seeking placement of the siblings (Katz, 1999, pp. 84-85)

Concurrent planning requires a series of steps for successful implementation. The model involves the placement of children, very early in the process, with a foster family who has agreed to adopt the child if reunification with birthparents fails. To do this, a comprehensive assessment should be completed within the first 90 days of a child’s placement to assess the likelihood of reunification with his or her family. Children of families with a poor prognosis for reunification are viewed as candidates for concurrent planning. Upon deciding the case is appropriate for concurrent planning, full disclosure of all aspects of concurrent planning with the birth family by the agency is required. The case must
follow the timelines established by law (ASFA) to achieve permanency, and birthparents must be informed of all dates of court hearings. Reunification efforts must be clearly articulated, including frequent parental visiting and a case plan developed with the birthparents that is used as documentation for the court. It is of utmost importance that birthparents understand that should reunification not be feasible, the child will be provided permanency through termination of parental rights and adoption by the foster parents or other potential adoptive parents. The decision to cease avenues of reunification is determined by the agency and the court based on the documented progress of the parents in meeting the requirements of the case plan.

The high complexity of the concurrent planning model requires intensive training and support for the agency’s staff to be able to manage the cases. The primary objective should be clear: achieve timely permanency either by reunification or adoption (Katz, 1999). Although this may be seen as a fairly clear and defined model, several complexities are identified.

**Availability of Resource Families**

Mica and Vosler (1990) reported that, for foster-adopt programs, the availability of families willing to take a child on a temporary basis is quite limited. Although the recruitment of these types of families may be difficult, it is not impossible. Foster-adopt programs typically include three types of families: 1) families whose only interest is adoption; 2) families whose only interest is providing foster care; and 3) families who are willing to foster and eventually adopt a child.

More recently, in a qualitative study by Frame, Berry, and Coakley (2006), it was reported that concurrent planning implementation in California suffered from a lack of foster parents willing to take a risk on this type of placement. The study also found that the majority of agencies responsible for the recruitment of resource families did not have a clear strategy for doing so. Finally, Edelstein and colleagues (2002) point out that sometimes, prospective adoptive parents “are willing to stretch their preferences and accept a child who is not yet legally free because this situation creates a higher probability of being matched with a child” (p. 105). This could prove more of a problem than an advantage because the pre-adoptive parents may be unprepared to manage the stress that occurs with the high levels of uncertainty of this model. The prospective adoptive parents’ desire to have a child can override the possibility of problems with the legal issues of a child not yet freed for adoption.

**Social Workers’ Training and Abilities**

Agency personnel are key actors in the successful implementation of concurrent planning. A lack of resources and adequate training could have a negative impact on implementing the model. The experience can be extremely stressful and painful for all the parties involved: the child, birthparents, pre-adoptive parents, and caseworkers. Frame et al. (2006) report that having the dual role of working with birthparents toward reunification while at the same time pursuing an alternative permanency option is exceptionally difficult. Some agencies assign two social workers to a concurrent planning case, one to work towards reunification and the other to pursue permanency through a potential adoption. Although the separation of tasks may be worthy of consideration and eliminate potential obstacles, the lack of resources and personnel, especially in public agencies, would make it difficult to implement this model.

**Role of Foster Parents**

Foster parents or pre-adoptive parents experience the highest risk, and their role is critical for the implementation of concurrent planning. Schmidt (2004) studied the motivations of pre-adoptive parents to become a resource family under concurrent planning. The results indicated that the main desire of pre-adoptive parents is adoption, with a majority of pre-adoptive parents becoming foster parents just to qualify for the program and have a higher chance of adopting. Two types of resource families were
identified: those who are driven by the sole interest of adoption, and those who are driven by the desire to adopt but also an altruistic sense of helping a child and providing the child with a safe environment.

Regardless of the motivations of pre-adoptive parents in accepting the placement of a child with concurrent planning, they need training and support to be able to cope with its implications. They need to understand that an adoption may or may not be the final result, and the agency should be committed to providing counseling and services to the foster parents even if adoption is not achieved.

**Identifying Children Subject to Concurrent Planning**

Concurrent planning is not a “one size fits all” practice. Some child and family situations are appropriate for concurrent planning while others are not. The correct identification of children is a challenge for program administrators. Usually, children with a poor prognosis of reunification are candidates for concurrent planning. The likelihood of achieving reunification decreases in the following circumstances:

- A death of a sibling as a result of abuse or neglect
- An abandonment that has not resulted in the location of parents in 45 days
- The child had returned home and is now returning to foster care as a result of abuse and neglect
- The child’s legal parents signed consent for adoption and cooperated in the planning for adoptive placement
- One of the parents signed consent, and the other parent is unknown, deceased, or cannot be located
- Both the child’s legal and/or biological parents are deceased
- One parent is deceased and the other parent is unknown or uninvolved in planning for the child
- The parents have failed to fulfill their service agreement for 60 days for children under three, and 180 days for children over three
- The sole parent is unable, due to mental illness, to make significant progress for the child to be returned home, but grounds for termination of parental rights (TPR) are not solid without his or her consent
- The sole parent is in jail for a felony conviction and is expected, based on his or her sentence, to spend at least three years in jail
- Parents cooperated in adoption planning for their child, but began to express ambivalence about the planning
- Parents are appealing TPR (Mica and Vosler, 1990, pg. 442)

Another difficulty in implementing concurrent planning is that it is best suited for young children. Edelstein et al. (2002) identified the risk of trapping older children in the middle while reunification services are being provided. This situation is exemplified during a visitation with birthparents if children are asked to misbehave or lie to their foster parents in the hope they will return home. This places the children in a situation of risk, in which the child could feel forced to keep secrets, feel anxious, feel the need to act out during visits, feel responsible for the adult’s emotional wellbeing, or have loyalty conflicts. All of these possible consequences have to be taken into account when implementing a concurrent planning model, since the primary objective is to protect the child.

**Empirical Evidence and Findings**

Although concurrent planning has been promoted by ASFA as a common practice, the lack of a standardized implementation and reporting system makes its evaluation difficult. It is reported that the only way to know the number of cases in which concurrent planning is used is to review the case files. Even then, the differences in the implementation of concurrent planning across the nation make it exceptionally difficult to assess its
impact. Two evaluation efforts, one in California and the other in Colorado, provide a beginning base for empirical evidence of the efficacy of concurrent planning.

**California**

Frame et al. (2006) examined the efforts in the implementation of concurrent planning in six California counties. The study used a qualitative methodology based on interviews and focus groups to identify the necessary elements for implementing successful concurrent planning. Seven components emerged from the data; however, not all are present in the six study agencies:

- A pro-concurrent planning philosophy permeates the child welfare agency
- Birthparents are provided with necessary services in a timely fashion
- An adequate number of concurrent planning families are available to provide concurrent placements
- Child welfare workers and supervisors actively embrace and apply concurrent planning principles in their work
- Child welfare and adoption units and agencies are well-integrated
- Formal systems or mechanisms are in place to actively encourage concurrent planning, insure that it occurs in a timely fashion, and distribute workload
- Concurrent planning is actively promoted by the Juvenile Court

The authors concluded that an efficient implementation of the concurrent planning model must be institutionalized in order to garner the necessary resources. The implementation of the model is not the job of a social worker alone; it requires a back-up system to provide orientation and assistance to foster families. The difficulties of using concurrent planning have been documented and need to be resolved. There is also the need for an active recruitment strategy for foster families willing to accept the risk of a concurrent planning placement.

D’Andrade and colleagues (2006) conducted a mixed method study of case reviews that analyzed the implementation of concurrent planning before and after ASFA. The results indicated a significant increase in the number of cases using concurrent planning after the passage of the law. However, the way in which counties implement concurrent planning differs. In many of the cases a simple notation was found that a concurrent plan should be pursued, but there was no evidence that it had been implemented. In other cases, “long term foster care” was the identified concurrent plan alternative, which clearly differs from the objectives of ASFA. Another important finding was that concurrent planning was done very late in the placement process, in direct opposition to what the prevailing literature recommends.

The qualitative findings showed that the implementation of concurrent planning varies in each county. In many counties, several components of the model are not applied. The impact of the model in achieving permanency for children was inconclusive due to the variability in its use.

**Colorado**

The Child Welfare Information Gateway (2005) reported on Colorado’s evaluation on the implementation of concurrent planning. The state uses this model under the name of “Expedited Permanency Planning” (EPP). The program requires the placement of a child within 12 months of entering foster care for children aged six and younger and their siblings. EPP uses concurrent planning and an accelerated judicial process for families with young children. The evaluation was conducted between 1995 and 1998 in two counties, using treatment and control groups. The results showed that 85 percent and 84 percent of children in the treatment groups of
the two counties achieved permanency within one year, while in the control groups this rate was 22 percent and 32 percent.

In 2001, Colorado expanded the use of the EPP program to all the counties. Data indicated that by December 2003, 82 percent (939 of 1,149 children) in the program achieved permanence within one year. Frame et al. (2006) stated that there are also differences in the implementation of the model among counties, especially in the timing of placement. While some counties placed children very early in the process, others were more traditional and waited until reunification seemed highly improbable.

**Conclusions**

Although the practice of placing children in pre-adoptive homes with a concurrent plan has been used for several decades, the failure to institutionalize and establish the model has made its assessment difficult. Literature on the subject is still limited, primarily due to the tremendous variation in implementation of the concurrent planning model. In spite of general acceptance of the model, there appears to be a lack of knowledge of its implications. The use of concurrent planning requires highly trained agency personnel to recruit resource families who fully understand what they are getting into. Failure to do so could cause more harm than benefit for all the parties involved.

**References**

“I went into foster care at age five. I can’t tell you how many different foster homes I have lived in, but I can tell you that it was a lot. I would have to move to a new home with no warning, and it just tore me to pieces. Adoption is the best thing that ever happened to me. I hope all kids in foster care get what I’ve been given ... a chance at life without uncertainty and chaos ... a life of love, happiness, and family that will always be there for me.”

—Clare, adopted at age 14 through Wendy’s Wonderful Kids

**Introduction**

Wendy’s Wonderful Kids is the direct-service signature program of the Dave Thomas Foundation for Adoption. In its design, it combines the following elements: aggressive management of the Foundation’s grants; fundraising by Wendy’s, its customers, and other partners; and the talent of experienced adoption recruiters throughout the U.S. and Canada.

The program helps to move children from foster care into permanent, loving adoptive homes.

The Wendy’s Wonderful Kids model is simple and effective: Wendy’s restaurants and their customers raise funds for the Foundation, which in turn issues grants to both public and private adoption organizations in the markets in which the funds are raised, for the purpose of hiring adoption recruiters. Wendy’s Wonderful Kids recruiters focus 100 percent of their time on finding permanent families for children in the local foster care system. As of March 1, 2010, the Foundation was funding 122 recruiters in all 50 states and the District of Columbia and seven recruiters in three provinces in Canada.

**How is Wendy’s Wonderful Kids different from programs that already exist?**

Unlike other efforts to recruit adoptive parents, Wendy’s Wonderful Kids is designed to identify parents that meet the specific needs of each child awaiting a permanent family. Because Wendy’s Wonderful Kids recruiters carry small caseloads and focus exclusively on adoption recruitment, they are able to provide a more intense and comprehensive recruitment effort.

Wendy’s Wonderful Kids is also unique in that it is the first nationwide program that partners a major corporation with a national foundation and local communities to place foster care children in permanent homes. Finally, the Foundation, through its management of the program, demands a level of accountability and measurable results on behalf of the children served that is unique in the United States foster care system.

**What exactly do Wendy’s Wonderful Kids recruiters do?**

Effective, aggressive, and accountable recruitment activities are critical to the success of Wendy’s Wonderful Kids. Currently, foster care social workers do not have adequate time and resources to ensure the safety of the children under their
care and actively recruit adoptive families for those waiting to be adopted. Rather than casting the broad net of general awareness and recruitment campaigns or defaulting to internet photo listings, media profiles of children, or public photography displays, Wendy’s Wonderful Kids recruiters are expected to be agents of change in the lives of the children for whom they are recruiting by managing an appropriate caseload (no more than 12-15 children) and employing an intensive and exhaustive child-focused recruitment strategy. This strategy includes:

- **Initial child referral:** Recruiters contact the child’s caseworker to introduce the role of Wendy’s Wonderful Kids, gather initial referral information, establish a date to begin case file review, and schedule an initial meeting with the child.

- **Relationship with child:** Recruiters meet with the child monthly, at a minimum, to develop trust and openness, preferably in person and one-on-one.

- **Case record review:** Recruiters conduct an in-depth review of the existing case file. An exhaustive case record review may take several days. The recruiter will develop a system to document:
  - Date and reason child entered the system
  - Child’s most recent profile/assessment
  - Chronological placement history
  - Significant services provided currently or in the past
  - Identification of needed services
  - All significant people in the child’s life past and present, including caseworker, foster parent, attorney, court appointed special advocate (CASA) volunteer, teacher, therapist, relative, mentor, faith-based representative, extracurricular activity leader, etc.
  - Next court date

- **Assessment:** Recruiters determine the child’s strengths, challenges, desires, preparedness for adoption, and whether the child has needs that should be addressed before moving forward with the adoption process. If so, the recruiter works with the child’s caseworker to assure these needs are met. A written assessment is developed initially and updated quarterly to enhance the child-focused recruitment plan.

- **Adoption preparation:** Recruiters ensure that the child is prepared for adoption. During the matching process, they also ensure that the family is adequately prepared to meet the needs of the child.

- **Network building:** Recruiters meet with significant adults and maintain regular and ongoing contact with them (caseworker, foster parent, attorney, CASA volunteer, teacher, therapist, relative, mentor, faith-based representative, extracurricular activity leader, etc.). Regular and ongoing contact with persons close to and knowledgeable about the child will facilitate recruitment activities. Monthly contact with the child’s caseworker is required.

- **Recruitment plan:** Based on the file review, interviews with significant adults, and the input of the child, recruiters develop a comprehensive recruitment plan or enhance the existing recruitment plan. The Wendy’s Wonderful Kids recruiter’s plan for each child is customized and defined by the child’s needs, and the plan is reviewed quarterly and updated as needed.

- **Diligent search:** Recruiters conduct a diligent search of potential adoptive families and identify connections to additional resources. They conduct aggressive follow-up sessions with the contacts identified, with the knowledge and approval of the child’s caseworker.

While a Wendy’s Wonderful Kids child may be included in the agency’s general recruitment efforts, frequently practiced as a matter of agency protocol in many adoption arenas (for example, internet photo listings, public photography
displays, PowerPoint presentations, and media profiles), or publicized within targeted audiences to reflect the specific needs of a child, these tactics, if utilized, are an adjunct to a child-focused recruitment strategy, and may not be the initial or predominant recruitment effort.

How are children selected for Wendy’s Wonderful Kids?

Wendy’s Wonderful Kids serves children with the goal of adoption, or who are free for adoption, and who do not have an identified adoptive resource. The program focuses on and typically serves children who are considered hard to place due to age, sibling status, or disability. Children served by Wendy’s Wonderful Kids may be in any type of foster care placement, including family foster care, group care, or residential settings. Interest or desire in being adopted is not a prerequisite for participation in Wendy’s Wonderful Kids.

Because of the intensity of the adoption recruitment activities they provide, the Wendy’s Wonderful Kids recruiters carry small caseloads. As a result, the recruiter can only serve a small proportion of the children who could benefit from the program. Grantees are permitted to prioritize amongst the eligible children as they see fit. For example, some grantees focus their Wendy’s Wonderful Kids programs on older teens, children who have been in care the longest, or those who have already had significant adoption recruitment.

The Wendy’s Wonderful Kids Caseload

Recruiters are directed to use the following guidelines in managing their caseload:

- **Caseload size:** The recommended number of children is 20, with a maximum of 25. The caseload may exceed 25 if children are moved to inactive status (see below).

- **Caseload composition:** Children may be at different levels of adoption preparedness, have had different levels of prior recruitment, and have been waiting for adoption for varying lengths of time.

- **Status of children**

  - **Active status:** At any given time, the recruiter should be intensely, actively recruiting for 12-15 children. The remaining children on the caseload may be in a less intensive phase of the recruitment process. For example, a child who is matched with a family and is in a pre-adoptive placement, or a child who requires greater adoption preparation (due to incarceration, hospitalization, having special needs which must first be addressed, adjustment to disrupted match or adoption, or opposition to adoption), may not be in the active recruitment phase, but still on the caseload.

  - **Inactive status:** A child may be considered part of the caseload but inactive if he or she is a runaway, continuously and adamantly opposed to adoption, or physically unavailable for adoption due to long-term incarceration or hospitalization. Recruiters are expected to have periodic contact with all children on the caseload regardless of status.

Grantee/Recruiter Requirements and Monitoring

Recruiters are required to implement the child-focused recruitment strategy outlined above, and grantee agencies are required to provide needed supervision, training, and support to the Wendy’s Wonderful Kids recruiter. Foundation staff members monitor the activities of grantees to ensure they are implementing the child-focused recruitment model, identify barriers facing grantees, and collaboratively identify solutions. In addition to regular phone and e-mail contact, Foundation staff visit grantees initially with newly implemented sites, then periodically with established sites. During these site visits, Foundation staff meet with the Wendy’s Wonderful Kids recruiter, supervisor, and agency director to discuss the implementation of the child-focused recruitment model. They
also review case records to ensure that recruiters are following the model and maintaining necessary documentation.

Grantees are required to submit monthly data, quarterly financial reports, and quarterly narratives addressing successes and challenges to date. Although grants are approved on an annual basis, the Foundation is committed to the grantees over the long-term, provided requirements and goals are met.

In addition, Wendy’s Wonderful Kids recruiters and supervisors are required to participate in an annual Wendy’s Wonderful Kids Summit in Columbus, Ohio. The Summit provides an opportunity for the Foundation to highlight innovative practices for implementing child-focused recruitment, address common barriers faced by grantees, facilitate peer-to-peer learning amongst the grantees, and build a cohesive Wendy’s Wonderful Kids brand through the growing community of agencies and participating personnel.

How is Wendy’s Wonderful Kids being evaluated?

The Dave Thomas Foundation for Adoption recognizes that an initiative the size and scope of Wendy’s Wonderful Kids has the potential to significantly alter perceptions about effective adoption recruitment strategies. As such, the Foundation is committed to ensuring that the lessons learned from Wendy’s Wonderful Kids are carefully documented and widely disseminated to the field.

The Foundation has contracted with Child Trends in Washington, DC to conduct a rigorous, longitudinal evaluation of Wendy’s Wonderful Kids. The primary question that the evaluation will seek to answer is whether the program improves the permanency outcomes of children waiting to be adopted, but we also plan to examine the impact on placement stability. The other research questions focus on understanding the factors that may influence the success of the program. The specific research questions guiding the evaluation include:

1. How does Wendy’s Wonderful Kids impact the permanency and stability of children?

   **Permanency**
   
   - Number of children who achieve permanency through adoption, guardianship, and/or reunification
   - Number of children who achieve permanency with relatives, foster parents, other kin, and non-kin/strangers
   - Frequency of adoption disruptions (pre-finalization)
   - Length of time children remain in foster care before achieving permanency
   - Identification of relatives and other people with whom children have a relationship
   - Likelihood of a child’s permanent placement with siblings
   - Frequency of out of state placements
   - Likelihood and timing of termination of parental rights
   - The post-permanency stability of placements

   **Placement Stability**
   
   - Number of placements children are in post-referral to Wendy’s Wonderful Kids
   - Number of placements in restrictive settings (congregate care) children experience post-referral to Wendy’s Wonderful Kids

2. What are the impacts attributable to?

   - How do Wendy’s Wonderful Kids recruiters function differently than other adoption workers (in the agency and/or compared to workers in other agencies)?
     - Caseload
     - Job responsibilities
     - Work schedule
     - Methods of recruitment
Methods and attention paid to preparing children for adoption
Attention to helping prospective parents through the adoption process
Role in matching process (e.g., extent to which they advocate for parents)
Preparing parents to access resources post-permanency

How are Wendy’s Wonderful Kids recruiters different from other workers assigned the task of finding adoptive parents for waiting children?
Demographics: Age, race/ethnicity, sex, languages spoken
Level/types of worker experience (public agency experience, adoption experience, experience with specific aspects of the adoption process, experience in foster care)
Community involvement
Worker satisfaction and retention?
Accountability

3. What factors influence the impact of Wendy’s Wonderful Kids?
Fidelity during implementation to the child-focused recruitment model
The type of agency receiving the Wendy’s Wonderful Kids grant (e.g., public/private, urban/rural, minority focus, faith-based, adoption exchange, full service)
Other agency factors such as size, operating budget, years of experience, etc.
The level of supervision, training provided to recruiters
Other adoption recruitment efforts underway in the agency and in the community (especially child specific and targeted recruitment efforts)
Public agency support of Wendy’s Wonderful Kids
The types and number of children available for adoption in the community

The types and number of children that the Wendy’s Wonderful Kids grantee is recruiting for
The types of recruitment undertaken beyond the child-focused techniques

4. To what extent does Wendy’s Wonderful Kids affect adoption practice more broadly?
Training of foster care and adoption workers
Recruitment activities of other staff/agencies, particularly the use of child-focused recruitment techniques
Referral of older youth to adoption recruitment (especially those previously considered “unadoptable”)
Implementation of child-focused model

5. How does Wendy’s Wonderful Kids affect the experiences of potential adoptive parents?
Number of people who express interest in adoption
Number of people who take steps to adopt
Parents’ satisfaction with the adoption process

To assess the impact of Wendy’s Wonderful Kids, the evaluation will compare the outcomes of children randomly assigned to treatment groups (children receiving Wendy’s Wonderful Kids services) and control groups (children not receiving Wendy’s Wonderful Kids services) in 25 of the grantee sites. When recruiters have an opening on their caseload, they identify two cases that are eligible for Wendy’s Wonderful Kids, one that will be randomly assigned to the treatment group and one that will be assigned to the control group. The evaluation will measure the difference between the outcomes achieved by Wendy’s Wonderful Kids and traditional adoption recruitment services.

The evaluation also utilizes a web-based database. Whenever a child is added to recruiters’ caseloads, they are required to enter background
information about the child, including the child’s demographics and child welfare history, and the extent to which the child has participated in past adoption recruitment effort. (This is required for all recruiters, whether or not the grantee is involved in the impact evaluation.) Each month recruiters are required to enter data on their Wendy’s Wonderful Kids activities. For each child on their caseload, recruiters must answer questions about:

- Frequency of contact with the child and the child’s caseworker
- Case record reviews completed
- Assessments completed
- Recruitment plans developed
- Efforts made to prepare a child for adoption
- Communication with other persons in the child’s network
- Efforts make to locate and contact persons known to the child who may be an adoptive resource
- Services for which the recruiter made or recommended a referral for
- Services received by the child
- Whether the child was matched with an adoptive resource
- Changes in the child’s placement status

Recruiters are also asked to identify activities they conducted for multiple children on their caseload. Finally, recruiters are required to enter information about all families recruited as possible adoptive resources for children on their caseload.

As this article goes to press, the results of the evaluation are pending. Initial statistics, though, are promising. More than 5,400 children have been served through Wendy’s Wonderful Kids, and recruiters have succeeded in finalizing adoptions for 1,438 of the longest-waiting children. Another 630 children are in their pre-adoptive placements, simply waiting for the final court hearing, and matches have been identified for 3,300 of the children served. Nearly 50 percent of the children successfully served are aged 12 or older, 55 percent have been in the system more than four years at the time of referral (10 percent have been in the system more than 10 years at the time of referral), and 20 percent have had a previous failed adoption.

**Conclusion**

The Foundation remains committed to aggressive goals for 2010-2012, including doubling the number of recruiters working nationwide, finalizing 8,000-10,000 adoptions of children in foster care, releasing the results of the national evaluation, and institutionalizing the program’s child-focused recruitment model within the child welfare system.

The board, staff, and funders of the Dave Thomas Foundation for Adoption fervently believe that every child deserves the stability, permanence, and support of a family, and that allowing a child to linger in foster care or turn 18 and “age out” of the system without a family is failure for those of us charged with their care. Dave Thomas always said, “These children are not someone else’s responsibility. They are our responsibility.” Wendy’s Wonderful Kids is working to help, one child at a time.
### Wendy's Wonderful Kids: United States and Canada

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<td>The Adoption Exchange – New Mexico: Statewide</td>
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Wendy’s Wonderful Kids Logic Model

**Resources/Inputs**
- **WWK Agencies**
  - Prior experience
  - Relationship to public agency
  - Complementary services
- **WWK Workers**
  - Characteristics of recruiter/supervisor
  - Recruiter/supervisor experience
- **WWK Children**
  - Child characteristics
  - Child’s child welfare history
  - Caseload characteristics
- **System/Community**
  - Community interest in/ views on adoption
  - Public agency focus on adoption
  - Judges’ views of adoption
  - Other recruitment activities
  - Post-adoption supports
  - Age of consent

**Implementation of Model**
- Review case record
- Complete diligent search
- Develop recruitment plan
- Engage child
- Assess child
- Engage child’s network

**Outputs**
- Connections to family and kin
- Adoptive resources identified
- Increased child participation in recruitment activities
- Reduced opposition to adoption
- Service referral
- Child’s service needs met
- Foster parent “conversions”
- WWK worker satisfaction
- Referring worker satisfaction

**Short-Term Outcomes**
- Increased pre-adoptive placements
- Increased adoption matches
- Foster parent “conversions”
- Child’s service needs met

**Intermediate Outcomes**
- Reduced time to permanency
- Increased permanency
- Increased adoption matches
- Greater use of less restrictive placements

**Long-Term Outcomes**
- Improved Child Well-Being
- Changes in Adoption Policies and Practices
  - Greater worker retention
  - More positive views of adoption

**Improved Child Well-Being**
- WWK Children
- WWK Workers
- WWK Agencies
- System/Community

**Dave Thomas Foundation for Adoption / Child Trends National Evaluation, Wendy’s Wonderful Kids**
The Racial Disproportionality Movement in Child Welfare: False Facts and Dangerous Directions

Elizabeth Bartholet

Abstract

A powerful coalition has made “Racial Disproportionality” the central issue in child welfare today. It notes that black children represent a larger percentage of the foster care population than they do of the general population. It claims this is caused by racial discrimination and calls for reducing the number of black children removed to foster care. But the central question is whether black children are disproportionately victimized by maltreatment. If so, black children should be removed at rates proportionate to their maltreatment rates, which will necessarily be disproportionate to their population percentage. Racial equity for black children means providing them with protection against maltreatment equivalent to what white children get. The evidence indicates that black children are in fact disproportionately victimized by maltreatment. This is to be expected because black families are disproportionately characterized by risk factors associated with maltreatment, including severe poverty, serious substance abuse, and single parenting. These are reasons for concern and reform. But the problems—and consequently the solutions—are entirely different from those identified by the Racial Disproportionality Movement. Society should act to prevent the disproportionate maltreatment of black children, and provide greater support to families at-risk of falling into the dysfunction that results in maltreatment. This should result in a reduction in the number of black children in foster care, without putting them at undue risk.

Introduction

“Racial Disproportionality” is the new war cry of a powerful group of players in the child welfare policy arena. Led by the Casey-CSSP Alliance for Racial Equity in Child Welfare, they characterize as overrepresentation the fact that black children are represented in the foster care system at a higher rate than white children as compared to their general population percentages. They claim that this overrepresentation is caused by systemic biases in child welfare system decision-making. They call for solutions which would reduce the rate at which black children are removed from their parents for maltreatment and increase the rate at which those removed to foster care are reunified with their parents. Their goal is to achieve what they term racial equity—the removal of black and white children to foster care at rates equal to their general population percentages.

The players include powerful foundations, non-profit organizations, and academics. Many of them have fought for years for policies that put a high priority on keeping children in their birth families and in their racial communities of origin. Accordingly, they have opposed federal laws passed in the 1990s designed to put new emphasis on moving children out of their birth families as necessary to keep them safe, and on removing racial barriers to adoptive placement, the Adoption and Safe Families Act (ASFA)1 and

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the Multiethnic Placement Act (MEPA). They have also promoted policies designed to keep black children in their birth families and their kinship and racial groups, such as Community Partnership or Alternative Track systems, Family Group Decision-Making, and subsidized kinship guardianship. In banding together now to fight what they call Racial Disproportionality, they have found not only a new cause but also a new vehicle with which to refight the ASF A and MEPA battles that they lost, and to promote the alternative policies they have for years been advocating.

The Racial Disproportionality “Movement” is having a dramatic impact on the child welfare field. Influential leaders recognize Racial Disproportionality as the hot issue of the day. Many states have been persuaded that they have a Racial Disproportionality problem and have begun to take actions designed to reduce the number of black children in foster care, and more are sure to follow given the pressure from the Movement’s campaign. The federal government has been urged to take an active role by requiring states to reduce Racial Disproportionality as a condition for receiving federal funds for their child welfare systems. The groundwork for such action has been laid with a 2007 General Accounting Office report and a 2008 Congressional hearing, both condemning disproportionality and calling for action.

The Movement’s reliance on statistics as evidence of discrimination calls upon a valuable tradition in our nation’s discrimination law. Disparate impact theory, which enables courts to find discrimination even in the absence of discriminatory intent, has been helpful in the employment area to strike down racially exclusionary practices that could not be justified as job-related.

But, in considering whether statistical impact warrants a conclusion of discrimination, it is important to determine whether nondiscriminatory factors explain and justify the impact. For example, disparate impact theory provides an employer charged with using a selection system that has an adverse impact on black job applicants an opportunity to show that its system selects employees based on essential job-related criteria that, if taken into account, explain away any apparent racial impact.

It is particularly important to be careful with the use of statistics in assessing whether the child welfare system is guilty of discrimination in removing children because of alleged harmful maltreatment by their parents. Black parents are disproportionately characterized by risk factors for maltreatment, such as extreme poverty, serious substance abuse, and single parenting; therefore, there is good reason to believe that black parents actually commit maltreatment at higher rates than white parents. If black children are in fact subject to serious maltreatment by their parents at higher rates than white children, it is in their interest to be removed at higher rates than white children. If the child welfare system is wrongfully found discriminatory, and, as a result, stops removing black children at serious risk for ongoing maltreatment, the children will suffer immediate and dangerous consequences.

This article should not be misunderstood as an attack on the black family as inherently problematic, although there is a real risk that it will be mischaracterized that way, or otherwise disparaged as racist. Racial Disproportionality Movement advocates regularly assert that...
everyone in the child welfare system needs anti-racism training so that they will recognize the truth that the system is functioning in a racially discriminatory way; if you do not agree with them, then you are by definition racist in your thinking and in need of anti-racism training. Those who have opposed Movement players’ positions on a range of related child welfare policies have often been accused of taking a racist position. In an earlier time, Daniel P. Moynihan was accused of attacking the black family when he noted problems in the black community “that amplified the effects of other social problems” and helped perpetuate “black poverty over time and across the generations.” Recent commentary has tended to vindicate Moynihan, pointing out that he clearly targeted historic and ongoing discrimination as responsible for the plight of the black family, and he argued for significant social reforms which, had they been implemented, would have done much to empower the black community.

Obviously, black parents are neither inherently more likely to abuse and neglect their children than whites, nor inherently more likely to be associated with poverty, single parenting, substance abuse, and other risk factors associated with child maltreatment. They are victims of historic and ongoing racial and economic injustice that has put them in a seriously disadvantaged position in our society.

The raw racial statistics that the Movement relies on in the child welfare area do represent a very real problem, both for black children and for the larger black community. Children removed from their parents for maltreatment, and placed in foster care for significant periods of time, generally do not fare well in later life. Appallingly high numbers end up in homeless shelters, unemployed, on drugs, and in prisons. They often end up continuing the cycle of child maltreatment into the next generation. This represents an ongoing problem for the black community, as does the fact that that community is disproportionately plagued by the risk factors that are so linked to child maltreatment.

But the question is what kind of problem these statistics represent, because that will determine what corrective action is appropriate. Black children are removed and placed in foster care because the social workers and judges involved in the child protective system conclude that the parents have been guilty of serious child maltreatment and are not capable of avoiding such maltreatment if the children remain in their care. There are many reasons to think that the social workers and judges are getting it right in terms of needed child protection by removing black children at higher rates than white children compared to their population percentages.

If actual child maltreatment rates for black children are in fact disproportionately high, then the racial problems we should focus on are the disproportionate maltreatment of black children, and the disproportionate victimization of the black community by severe poverty, unemployment, substance abuse, and other risk factors that are associated with maltreatment. Appropriate reform should be directed toward reducing black maltreatment rates by, for example, expanding programs to support fragile families at-risk of maltreatment, and programs to address the substance abuse so strongly associated with maltreatment. There is little mention, however, of such prevention programs in the Racial

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Disproportionality Movement literature. Instead, the focus is almost entirely on preventing the removal of black children from their parents, and on addressing the discrimination alleged to occur at various points in the child welfare decision-making process.

Appropriate reform should also include the fundamental social changes that would address the poverty, unemployment, and related social ills characterizing the lives of so many poor and black people in our society. Recognition of the racially disparate breakup of black families can usefully focus attention on finally taking more effective action to solve some of the results of our societal legacy of slavery and of racial and economic injustice.

Some Movement leaders may see what they are doing as part of a strategy to pursue these larger social reform goals. They may think it is useful to identify the disproportionate breakup of black families as a form of racism. They may think that by promoting the preservation of black families they will force a stingy society to commit more resources for supportive family services.

But if this is the strategy, it is wrong, both because it puts black children at unfair risk, and because it seems far too limited in its goals for the black community. Leaving black children with their parents to suffer ongoing maltreatment hurts those children, and sends them on to adult lives characterized by poverty, substance abuse, unemployment, and a high likelihood that they will in turn victimize the next generation through maltreatment of their children. The increased family support services that might result from an expansion of family preservation programs will be limited, and will do little to protect children from ongoing maltreatment, or to make any dent on the problems suffered by the black community. Focus on the claimed racism of child welfare workers puts attention on a non-problem, while ignoring the real problems of the black community—the societal legacy of racial injustice and the miserable socioeconomic conditions that characterize too many black lives.

Understanding the Racial Disproportionality Issue

The Statistics: Black Children Represent a Higher Percentage of the Foster Care Population than the General Population

Black children are reported for abuse and neglect, removed from their parents, and placed in foster care at higher rates than white children as compared to their respective percentages in the general population. Black children also spend longer in foster care than white children, are reunited with their parents at lower rates, and move on to adoption at slower rates. While they exit foster care by adoption at relatively high rates, the adoption exit takes longer than the reunification exit. As a result, black children appear in foster care at higher rates than white children as compared to their population percentages.10 So, for example, Wulczyn reports that, although black children make up only 15 percent of the children living in the United States, they make up roughly 37 percent of those in foster care.11

Recent years show some reduction in these racial differences. Black entries to foster care are going down, while white entries are going up.12 The racial disparity in length of time spent in foster care is also being reduced because black adoption

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rates are going up and the time to adoption is being reduced. This appears to be in part because of the influence of ASFA and MEPA.13

But despite these recent trends, the basic statistical picture remains the same: black children are represented in foster care at higher rates than white children compared to their population percentages. These raw statistics signal an important social problem that calls for action. But, the kind of action needed depends on the kind of problem lying behind the statistical picture.

Black children are being reported and removed at the rates that the child protective services systems we have in place to deal with child maltreatment have concluded are appropriate, given their findings as to the rates at which these children are being seriously victimized and the risks to these children posed by living at home. The fact that they spend longer in foster care than white children has largely to do with the fact that black children are placed disproportionately in kinship foster care, which generally lasts longer than non-kin foster care for reasons discussed below. The very groups pushing the Racial Disproportionality Movement have long promoted placing black children in kinship foster care as a way of keeping them in the family and also in the racial community. Accordingly, the key issue in assessing the Movement’s claims of discrimination is whether black children are being reported and removed appropriately, or unfairly.

If black children are being reported and removed at rates comparable to their actual maltreatment victimization rates, then the child welfare decision-making system is functioning appropriately. If, as urged by the Movement, we reduce black reporting and removal rates to achieve equal rates with whites, we would put black children at undue risk. This is true at least if the system generally intervenes in coercive ways, such as removal, only where serious abuse and neglect cases put children at high risk for ongoing maltreatment. In my view, this is clearly the case.

If black children are being reported and removed at high rates because of bias in the system for reporting, investigating, substantiating, and making removal and reunification decisions, then the Movement is right that efforts to correct that bias are appropriate. Even if that were true, it would still not be clear that the solution would be to reduce the number of black children reported and removed, as called for by the Movement. The problem might lie in disproportionate underintervention in white cases, and the solution in removing white children in greater numbers.

**Reasons for the Large Representation of Black Children in Foster Care**

**1. Actual Black Child Maltreatment Rates are Higher**

The obvious explanation for the large representation of black children in foster care is that black maltreatment rates are higher. Child Protective Services (CPS) agencies are designed to receive reports of maltreatment, investigate those reports, decide whether they are substantiated, and then decide on a course of action. In some cases, the decision is to remove children temporarily to foster care and then reunite them promptly with their parents. In the most serious cases, however, the decision is to keep them in foster care for prolonged periods or to place them for adoption. The people making the decisions at every stage of the system are in a position to have the fullest picture of the facts of each case. If they are doing their job, black children are showing up in the system at higher rates than white children because they are at higher risk of serious abuse and neglect in their families, and accordingly are most likely to need removal from home, and least likely to be safe if reunified with their parents.

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While the system is far from perfect, there are many reasons to think that it is correctly reflecting the reality in finding higher black child maltreatment rates. First and foremost is that blacks are disproportionately associated with a set of characteristics that have been repeatedly found to be accurate predictors for child maltreatment. These characteristics include poverty, unemployment, single-parent status, substance abuse, and living in a significantly disadvantaged neighborhood. There is no doubt that these characteristics are disproportionately associated with black families because of the generally disadvantaged socioeconomic status of blacks as compared to whites. For example, studies have long shown that black parents are disproportionately involved with serious substance abuse, that parental substance abuse is a factor in a very high percentage of all cases in which children are removed to foster care, and that children removed in these cases spend disproportionate amounts of time in foster care.

The Movement relies overwhelmingly on one source to support its central claim that actual black and white maltreatment rates are identical: the National Incidence Studies (NIS), and, in particular, NIS-3 (quoted below).

Interestingly, this study produced one of the most stunning demonstrations of the significance of socioeconomic status in predicting child maltreatment. The Foreword summarizes:

- Children of single parents had a 77-percent greater risk of being harmed by physical abuse, an 87-percent greater risk of being harmed by physical neglect, and an 80-percent greater risk of suffering serious injury or harm from abuse or neglect than children living with both parents.
- Children in the largest families were physically neglected at nearly three times the rate of those who came from single-child families.
- Children from families with annual incomes below $15,000 as compared to children from families with annual incomes above $30,000 per year were over 22 times more likely to experience some form of maltreatment that fit the Harm Standard [the NIS more serious maltreatment category] and over 25 times more likely to suffer some form of maltreatment as defined by the Endangerment Standard [the NIS less serious maltreatment category].
- Children from the lowest income families were 18 times more likely to be sexually abused, almost 56 times more likely to be educationally neglected, and over 22 times more likely to be seriously injured from maltreatment as defined under the Harm Standard than children from the higher income families (p. xviii).

NIS-3 further found that poverty predicted for the most serious forms of maltreatment. Children in families with incomes below $15,000 per year were sixty times more likely to die from maltreatment. NIS-3 noted that low income was associated with other factors likely to contribute to maltreatment, including substance abuse and emotional disorders.

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Other research has also attempted to assess actual maltreatment incidence rates among the poor as compared to those better off, free from any bias that might be reflected in official CPS rates. It has confirmed that actual maltreatment is much higher in poor families. Richard Gelles, a long-time student of family violence, assessed violence toward children based on parent self-reports to trained interviewers and found that the rates of violence were significantly higher among families with an annual income below the poverty line: the rate of “severe violence” is 62 percent higher and the rate of “very severe violence” 250 percent higher.\(^\text{18}\) He concluded:

> [A]busive violence is more likely to occur in poor homes. Specific social and demographic characteristics increase the likelihood that poverty will lead to abuse. Poor young parents who are raising young children have an elevated risk of using the most abusive forms of violence toward their children, as do poor single mothers (p. 271).

Given the powerful connection repeatedly demonstrated between poverty and related risk factors and maltreatment, and the fact that black families are disproportionately exposed to such risk factors, black parents would have to possess extraordinary compensatory features to enable them to overcome all these predictive factors to achieve child maltreatment rates comparable to those of white parents. The following chart taken from a study by Richard Barth and colleagues illustrates:

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Stated and unstated assumptions of disproportionality of population\(^\text{19}\)

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This chart shows two alternative ways of understanding the fact that black families have a high exposure to risk factors for maltreatment and that black children end up in foster care at high rates. The first, at the top, is that the risk factors lead to increased maltreatment rates and, accordingly, through appropriate CPS action, to high removal rates. The second, at the bottom, is that black families have “unspecified mediating factors” that counteract the risk factors, leading to maltreatment rates that are the same as white rates, and biased CPS agency decision-making then removes black children at higher than white rates even though they are not at higher risk for maltreatment.

The Movement has never explained the so-called “mediating factors” that could help black parents overcome the socioeconomic disadvantages that are understood to systematically predict, for other groups, the likelihood of child maltreatment.\(^\text{20}\)

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A recent study designed to assess whether race was a predictor for child maltreatment reporting when poverty was taken into account, found that it was not. The report sums up:

*It would be unwise to take the 2:1 relative disproportionality of reports of Blacks vs. Whites at face value and make changes in the reporting system to address this seeming disparity or bias. . . . [T]here is no evidence of a general racial bias in child maltreatment reports. Our findings in this area are not new, and are best seen as confirming prior work . . . (p. 314).*

There is, of course, always reason to suspect that conscious or unconscious bias might infect any decision-making system. There have been many studies in fields other than child welfare demonstrating the prevalence of such bias. The highly subjective decisions typical of child welfare decision-making provide a ready vehicle for the expression of both conscious and unconscious bias. However, there is reason to think that such bias may be less of a problem in the child welfare area than in areas where it has triggered significant attention like employment.

First, the child welfare workforce has a more substantial representation of black and other minority–race workers than many other workforces and one that is higher than their population percentages. The first national survey addressing this issue reports that child welfare workers are now 32 percent black, 11 percent Hispanic, and 46 percent white, with 12 percent identifying themselves as other, and that child welfare workers tend to be assigned to work with racially matched children.

Second, a few studies that have specifically tried to examine the issue of bias in social worker decision-making have resulted in findings that confound the assumption of bias. These studies have found that black social workers are sometimes more likely than white workers to find child maltreatment or to remove children. Black and white social workers are no more likely to conclude that maltreatment has occurred or to make removal decisions when they are working with other-race parents than when they are working with same-race parents. One important study of race and the child welfare system concludes: “Despite the degree of consensus regarding the importance of developing culturally competent child welfare services that make use of the expertise and experience of people of color, virtually no empirical evidence supports this consensus (p. 131).”

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An article based on this national survey, which was weighted to make the results of the NSCAW study representative of child welfare workers nationally, reports that social workers are 33 percent nonwhite (defined as African-American, Hispanic, Asian, or other) and 67 percent white (defined as white non-Hispanic) overall, and 39 percent of those hired recently are nonwhite as compared to 61 percent white. Barth, R.P., Lloyd, E.C., Christ, S.I., Chapman, M.V., & Dickinson, N.S. (2008). Child welfare worker characteristics and job satisfaction: A national study. *Social Work, 53,* 199-209.


Third, there are powerful pressures that may create bias in the opposite direction. Social workers have long been given anti-racism and cultural competency training, socializing them to worry about over-intervention in black families. For example, a Government Accountability Office (GAO) Report found that almost all states (45) systematically engaged in cultural competency training, a strong majority of states (36) had programs to recruit and retain culturally competent staff, and a number of states required that child welfare workers take an intensive program in “Undoing Racism.” Even Dorothy Roberts, a key Movement player, admits that “[a] common response to racial disparities in the child welfare system has been the implementation of ‘culturally competent’ social work practice.” Social workers are also educated and trained in a child welfare system that still tends to believe powerfully in race matching, despite passage of MEPA. They know that if they remove black children, it will be hard to find same-race foster and adoptive parents for them, and this produces pressure to keep black children with their birthparents.

Some have argued that black people, because they are disproportionately poor, are more likely to be reported because they have greater exposure to the social workers, police, and other officials who are “mandated reporters,” required by law to report suspected child maltreatment. This claim is often referred to as the visibility bias. However, studies examining this claim, including the NIS-3, have repeatedly failed to find any support for the visibility bias theory.

There is a good deal of evidence indicating that actual maltreatment rates for black children are in fact significantly higher than for white children, confirming the nondiscriminatory character of CPS decision-making. First, black children die from apparent child maltreatment at much higher rates than whites by comparison to their general population percentages. Again, it is always possible that some of these findings are biased, but most think that findings of maltreatment deaths are at less risk for reflecting bias than other maltreatment findings. This is so because most deaths will be carefully investigated, and the decision whether to classify the death as maltreatment is likely to involve less subjective judgment of the kind that can mask conscious or unconscious bias than in the case of less serious harm.

Official reports collected through the National Child Abuse and Neglect Data System (NCANDS) and published by the U.S. Department of Health and Human Services show that 29.4 percent of child fatality victims are black, significantly higher than their population percentage, while only 43 percent are white, significantly lower than their population percentage.

The CDC’s comprehensive study of fatal injuries among children, thought to reflect maltreatment rates, shows consistently and significantly higher rates for black, American Indian, and Alaskan Native children, with the death rate for blacks 2.5 times that for whites in infancy, and homicide rates highest for black children overall. Homicide rates for black infants are 3.6 times higher than for white infants.


An important recent study in California compares actual child death rates by race while simultaneously analyzing the degree to which the death rates track the official child maltreatment substantiation rates for each racial group. The study indicates that racial disparities observed in maltreatment rates are the manifestations of real differences in risk. It shows, like the other studies, that black death rates are significantly higher: black infants die of injuries at 2.5 times the rate of white infants. Even more significant, this study shows that injury death rates within each racial group closely track maltreatment substantiation rates.

In addition, black children are at greater risk of death and other severe violence when reunited with their birthparents than are white children. A careful research analysis of the degree to which foster care functions as a protection against harm children might suffer in their birth homes indicates that it does so function for black children significantly more than it does for whites, particularly with respect to “preventable (and especially violent) ends,” such as death.

Finally, studies relying on black and white parent self-reports indicate that black parents engage in severe violence toward their children and other problematic parental conduct at significantly higher rates than white parents. One study published recently by the Conduct Problems Prevention Research Group found, based on self-reports, disproportionately problematic parental behaviors among blacks in terms of warmth, appropriate discipline, and harsh interactions. The study concluded that the differences were explained by differences in neighborhoods and family structure, causing “stressful neighborhood and family conditions (p. 952).”

2. Black Children Placed in Foster Care are Placed Disproportionately in Kinship Care

Disproportionate placement of black children in kinship foster care rather than non-kin foster care provides the major additional explanation for why black children are represented in such large numbers in foster care. This is because foster children in kinship care generally stay longer than foster children in non-kin care. Many knowledgeable students of the foster care system have concluded that this provides a major part of the explanation for black children’s high representation in foster care and for their long stays in foster care. Black kinship care placement rates also explain why black children in foster care tend to receive fewer services than white children, another grievance cited by the Movement—kinship foster care families generally receive fewer services than non-kin foster care families.

The disproportionate placement of black children in kinship care could be thought of as discriminatory, but the Racial Disproportionality

Movement generally supports kinship placements as a way of keeping black children in the extended family network and in the black community.

In sum, there is good reason to conclude that Racial Disproportionality is mostly if not entirely explained by higher rates of actual black child maltreatment, and by broadly agreed-to preferences for black kinship placement.

The Bottom Line

There is No Persuasive Evidence that the Racial Picture Results from Discrimination by Child Welfare Decisionmakers

There is substantial evidence that black maltreatment rates are significantly higher than white maltreatment rates because black families are affected by poverty and other risk factors for maltreatment at significantly higher rates than whites. There is no persuasive evidence that child welfare decision-making is systematically biased in the sense that it is more likely to report, substantiate, and remove black children, as compared to similarly situated white children.

It is impossible to know exactly how closely official maltreatment records track actual maltreatment by race. Black children might be somewhat underrepresented or somewhat overrepresented in the child welfare system compared to their actual maltreatment rates, and there is no way to know which is more likely the case based on existing empirical studies.

Even if We Assume that CPS Intervenes Disproportionately in Cases of Black Child Maltreatment, this Would Constitute Discrimination Against White, Not Black, Children

Even if we were to assume that black children were somewhat overrepresented compared to actual maltreatment rates, this should be understood as discrimination against white children rather than discrimination against black children. This is because overall the child welfare system is guilty of under-intervention—of not doing enough to protect children against maltreatment. So if white children are not being removed to foster care at rates equivalent to black children given the incidence of actual maltreatment, it means that white children are being disproportionately denied protection.

I have written elsewhere extensively about why I believe the system is generally guilty of under-intervention. The NIS provides additional evidence of under-intervention. Its goal was to inquire into the differences between actual and officially reported child maltreatment, and it concluded that the CPS system fails to reach a large proportion of all cases of serious maltreatment.

Movement advocates often talk as if there was systematic over-intervention, and such claims are the basis for their promotion of Community Partnership or Alternative Track systems. Thus, they regularly argue that a majority of the cases that now trigger CPS intervention and removal to foster care can safely be handled without any coercive intervention. They cite as proof of the alleged over-intervention problem the fact that a majority of those in foster care have been removed based on neglect, and then characterize the entire neglect category as minor, “mere poverty” cases.

This is a fallacious argument. Abuse and neglect cases do not constitute a simple hierarchy, with abuse at the top in terms of the level of risk to children, and neglect at the bottom. Most neglect cases are cases in which parents are heavily involved in substance abuse, or suffer from serious mental illness, or for other reasons are unable to provide the basics of nurturing parenting. And of course many child maltreatment cases are categorized as neglect simply because it may be easier to prove than abuse. Social science


demonstrates that children identified as victims of neglect suffer at least as severe long-term consequences as children identified as victims of abuse.\textsuperscript{43} Out of all cases in which children die of maltreatment, more than 40 percent fall in the neglect category, far higher than the percentage in the physical abuse or any other category.\textsuperscript{44}

\textbf{The Racial Picture is Nonetheless Disturbing}

The fact remains that the statistical picture is troubling. Black parents are losing their children to foster care at high rates, compared to their population percentage, and this is a terrible loss for parents to suffer. Black children are victimized by maltreatment at high rates, and end up in foster care at high rates.

We know that abuse and neglect take a toll on children, leading to long-term problems. Removal from parents is often traumatic, even in cases where children have actually been subjected to maltreatment, and even if removal is generally preferable for the child over remaining at home. Lengthy stays in foster care are generally harmful. Children subjected to maltreatment, to the disruption related to trying to protect them from further maltreatment, and to lengthy foster care, are not likely, as a group, to do well in later life.

We should be concerned that black children are so disproportionately subject to the trauma and the risk of long-term damage that the raw statistics reveal. Our society suffers from a terrible divide between rich and poor, with blacks falling disproportionately in the poor group. The disproportionate representation of black children in foster care both reflects and exacerbates this situation.\textsuperscript{45} Moreover, the fact that black parents are disproportionately characterized by the risk factors associated with child maltreatment—factors that include extreme poverty, unemployment, substance abuse, and mental illness—represents a huge problem for the black community and the larger society. The raw statistics present a picture demanding some kind of action.

This does not, however, mean that the solution is the one proposed by the Racial Disproportionality Movement—cutting back on the reporting, substantiation, and removal of black children for maltreatment. Leaving children victimized by abuse and neglect at home to be further victimized is not only unfair to those children, but also unlikely to, in any way, address larger social justice concerns. Blacks abused and neglected as children will grow into adults at high risk for unemployment, homelessness, substance abuse, and incarceration, and at high risk for maltreatment of the next generation, not into leaders who will help empower the black community or promote productive social change. Moreover, by focusing on child welfare discrimination as the central problem, the Movement actually diverts attention from the real and burning problems facing the black community, and from the real solutions for those problems, which lie in the challenging but essential realm of addressing poverty, unemployment, and the other social ills that plague those at the socioeconomic bottom of our society.

\textsuperscript{43} Ibid.
\textsuperscript{45} Dorothy Roberts, a major Movement figure, makes a somewhat related point when she argues that even if Racial Disproportionality could be explained entirely by higher black poverty rates, there would still be a problem of racial injustice: “[D]isproportionate state intervention in Black families reinforces the continued political subordination of Blacks as a group.” Roberts, D.E. (2002). \textit{Shattered bonds: The color of child welfare}. New York: Basic Civitas Books.
The Policy Implications

Address Racial and Economic Injustice, and Expand Specific Programs Designed to Prevent Child Maltreatment

The real Racial Disproportionality problem is that black children are disproportionately victimized by abuse and neglect. We should focus Racial Disproportionality reform efforts on reducing this maltreatment.

The best way to reduce maltreatment is to fundamentally reform our society so that those at the socioeconomic bottom have the kind of educational, economic, and other opportunities that would enable them to escape the conditions that breed child maltreatment. This is, of course, also the best way to address the real injustice suffered by black parents and the larger black community—the fact that their lives are characterized by extreme poverty and all that goes with it.

What is more imaginable in the near future is to develop and expand programs that provide support for poor families and for fragile families at-risk of falling into the kind of dysfunction that produces child maltreatment, so as to reduce the incidence of maltreatment. We need family support systems that give poor, single parents a better chance to make it. We need more substance-abuse treatment services. We need to expand intensive early home visitation programs designed to reach new parents and link them with a range of supportive services, programs like David Olds’ Nurse Partnership model that have a proven record of success in reducing child maltreatment.46

These kinds of support and maltreatment prevention programs provide the best opportunity to protect black children against maltreatment as well as the child welfare system involvement that maltreatment triggers. They provide a route to reduce the number of black children in the child welfare system that will serve those children’s interests.

So, for example, we now have black infants entering foster care at especially high rates, apparently because many of them have been exposed during pregnancy to harmful drugs. Fred Wulczyn and his colleagues have noted this phenomenon and argued for home visitation and substance-abuse strategies to simultaneously address both the infant maltreatment and the racial disparity issues.47

The Racial Disproportionality Movement has been essentially silent on the importance of this kind of up-front support and prevention. This is not surprising given its claim that there is, in fact, no difference in maltreatment rates. But this does mean that it is missing the main point in terms of the civil rights of black children. Black children need to be protected against maltreatment. And appropriate efforts to prevent maltreatment would likely reduce Racial Disproportionality in ways that would genuinely protect, rather than endanger, black children.

The Movement does call for an expansion of family support services in the context of family preservation and family reunification programs, but these are programs designed to operate only after child maltreatment has been identified. They do not serve the same purposes as the early prevention programs recommended above. Once maltreatment occurs, it risks causing damage that may be irreparable. Also, once parents have fallen into the deeply dysfunctional patterns characterizing maltreatment, the evidence indicates that family support programs...

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do not work very well to prevent maltreatment from recurring. 48 Studies show that parents in these family preservation and reunification programs continue to maltreat their children at very high rates—official reports show recurrent maltreatment in more than one-third of all cases, and actual maltreatment has been found to significantly exceed this figure. 49 This is by way of significant contrast to the much-maligned foster care system, where the national annual average maltreatment rate is 0.5 percent. 50 Children die as a result of violence when reunified with their original families at a rate three times the rate of children in the general population, and one and one-half times the rate of children in foster care. 51

Reject Classic Racial Disproportionality Movement Recommendations

As discussed previously, the Movement’s policy recommendations all relate to the Movement’s goals of keeping black children in either their birth families or their racial community. We should reject these recommendations. Overall, the goal is to reduce the number of black children reported, substantiated, and removed, and to increase the number reunified. As discussed above, it is not in the interest of black children to do these things given that child welfare decision-making generally reflects the rates of actual child maltreatment. Changing child welfare decision-making without changing the reality of child maltreatment is likely to harm, not help, black children. Children now are generally removed only for extremely severe maltreatment. 52 They are generally kept in foster care rather than being reunified with their parents only because of serious risks that they will be maltreated if reunified. As noted above, even under current policies more than one-third of all children reunified will be victims of repeated maltreatment. 53 Children reunified quickly are more likely to reenter foster care than those reunified after a longer stay in foster care. 54 Black children are at particular risk of violent and dangerous maltreatment if kept in their homes after a maltreatment investigation and if reunified from foster care. 55

Address the Complex Dilemma Posed by Racially Disparate Stays in Foster Care

Black children’s stays in foster care last longer than white children’s primarily because of the high rates of black kinship foster care placement, and, additionally, because black children are reunified at somewhat lower rates than whites, and move on to adoption at somewhat slower rates. This is a potential problem for black children. Foster care is supposed to be temporary, with children moved in a timely way, either back to their original homes or on to adoption. Lengthy stays in foster care are generally thought to be negative for children, as compared to permanency.

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49 Patricia Kohl’s study for the Casey Alliance shows that out of those cases in which child welfare system (CWS) investigations found maltreatment and the child remained at home with a CWS plan, the plan failed approximately 33.5% of the time during the next thirty-six months by virtue of a new maltreatment report or placement into out-of-home care. The study found, in addition, based on self-reports, severe violence in many cases that never showed up in official reports, demonstrating that official rates underestimate the rates of recurrent maltreatment. Self-reports of severe violence occurred disproportionately in black families. Kohl, P.L. (2007). Unsuccessful in-home child welfare service plans following a maltreatment investigation: Racial and ethnic differences. Retrieved from http://www.casey.org/Resources/Publications/pdf/UnsuccessfulInHomePlans.pdf


52 See “The Bottom Line” section, above.


One obvious way to reduce racial disparity in this area is to reduce the rate of black kinship placement. But Movement advocates favor kinship placements and, so, do not advocate this solution.

However, some reduction in the rate of kinship placements may well be appropriate, not because it would reduce racial disparity, but because current preferences for placing with kin over non-kin are so powerful that they likely result in many placements which do not serve children’s interests in a range of ways, including their interests in achieving permanency. All things being equal, it makes sense to place children with kin rather than strangers. But things are rarely equal, and powerful preferences for kin placement have been put in place which often require social workers to ignore other factors generally thought relevant to the child’s best interest, including whether the kin at issue are likely to provide nurturing care on an ongoing basis. We should have policies that encourage social workers to make individualized, context-specific decisions as to when to place with kin, free from powerful kinship preferences that ignore the actual best interests of the child. Such policies would both serve children's best interests better than current policies and likely reduce racial disparity.

Movement recommendations also focus on increasing the permanency of kinship placements by creating subsidies for guardianship comparable to foster parent subsidies as a way of encouraging kinship foster parents to become guardians.

Expanding kinship guardianship through subsidies has both pros and cons. Guardianship means that officially the children are not in the state system’s care and, therefore, that social workers have no oversight role to ensure their safety. This might be fine in some cases, but might put the children at-risk in others, especially given the risks discussed above associated with today’s powerful kinship preferences. The kinship foster parents who become guardians may or may not be as good for the child as those that would be provided by a more open process, considering a broad pool of adoptive parents. Guardianship is a form of permanency, but generally it is not considered as good a form of permanency as the kind of full legal parenthood involved in adoption, in part because it does not have the same legal protections for permanency as adoption. The subsidies involved in guardianship may create perverse incentives, encouraging families to keep children in guardianship rather than moving them back to their parents or on to adoption, solely because of the financial rewards.

Subsidized guardianship should be developed as a policy option in a way that would encourage social workers to decide on an individual case basis whether it served the child’s best interests. For example, it might make sense in a case in which a child is happily bonded with loving, nurturing kinship foster parents, the foster parents pose no risk to the child, the foster parents do not want to adopt because they want to maintain the child’s legal relationship with its parents, and maintaining this relationship seems appropriate given past history and the child’s feelings about the parents. However, subsidized guardianship should not be embraced simply as a method of reducing the numbers of black children in foster care, because this creates too great a risk that such guardianships will be created in situations where they will not serve children’s best interests.

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There are some promising ways to reduce the number of black children in kinship foster care that are likely to serve their best interests. One is to do more to encourage kin foster parents to adopt. We should have policies which push social workers to inquire into the potential for kinship adoption, and make decisions based on children’s best interests. Another is to move more black children into non-kin adoptive homes. This means enforcing the current MEPA vigorously and working to broaden recruitment so that we enlarge the pool of adoptive parents. It also means vigorously enforcing ASFA and related state law reform moves. There are also many state system reform programs, which move in the same direction as ASFA. Concurrent planning is one, and it is given an approving nod by ASFA. It envisions placing children in foster care on a reunification track while simultaneously placing them on a pre-adoption track, so that if reunification turns out not to be appropriate the child can be immediately freed for adoption. Ideally the child would have been placed in the pre-adoptive or “foster-adopt” home when first removed, so that from the child’s point of view there is no disruption if the adoption decision is ultimately made. These and similar programs are the kinds of programs we should pursue to speed black and white children who cannot be safely reunified toward adoptive homes, and, thus, reduce their stays in foster care.61

Address Discrete Examples of Problematic Racial Disparities

One area for possible productive action reducing racial disparities in the child welfare system has to do with CPS intervention at birth for purposes of investigation and possible removal of children who have been affected by their mothers’ substance abuse during pregnancy. There does seem to be a significant racial disparity in the likelihood that infants will be tested, and evidence of substance abuse reported to CPS. Public hospitals are much more likely to test, and so black infants are more likely to be tested and identified as at-risk for maltreatment by substance-abusing parents, given that black parents are more likely, as a group, for economic reasons, to frequent public hospitals. Also infants are more likely to be tested for illegal drugs than for alcohol, and this likely has a disparate impact on blacks as compared to whites because of different drug and alcohol usage patterns in the different racial groups. However, alcohol use and abuse during pregnancy causes fetal damage that is probably at least as significant as illegal drug use during pregnancy, and parental alcohol abuse creates significant risks for child maltreatment.62

These policies and practices in combination mean that black children are much more likely to be identified as drug-affected at birth, their parents are more likely to be investigated for parental unfitness, and the children are more likely to be removed to foster care. White children whose parents are abusing illegal drugs or alcohol in ways that put them at high risk for maltreatment are not nearly as likely to be tested, have their cases investigated, or be removed. The racial victims, if they should be termed that, are the white children. And the appropriate action to correct this situation would be to increase testing for alcohol, and to mandate testing in all private, as well as all public, hospitals, so that all children receive greater protection against being sent home as fragile, needy, drug- or alcohol-affected infants to parents unfit to provide appropriate care, even to normal infants.63

Conclusion

We are now hurtling forward toward change in the direction set by the Racial Disproportionality Movement. To date there has not been much in the way of definitive action by states or the federal government that would systematically reduce the level of intervention by child protective services systems in black families to protect children against maltreatment. But there are many signals that if we do not change direction in short order, dramatic action will

61 Ibid.
62 Ibid.
63 Ibid.
be next. Racial Disproportionality is the hot issue of the day. Many states have called at the highest levels for the kinds of changes in child welfare practice demanded by the Movement. The federal GAO and a U.S. Congressional Committee have endorsed Movement claims and recommendations. Should the federal government take the step that Movement advocates urge, conditioning federal funds on state efforts to reduce racial disparities in child welfare, this will likely force radical changes. Federal funding is essential to the functioning of all state child welfare systems, so any such federal condition constitutes an irresistible demand.

Race does matter, as the Movement advocates like to say. But facts matter also. And the facts related to the racial picture in child welfare should direct those who care about black children to do something more to protect them against abuse and neglect. The facts should inspire more support for up-front maltreatment prevention programs. The facts should inspire more attention to fundamental socioeconomic reform. The facts should make state and federal policymakers wary of any move to reduce the number of black children in foster care by simply keeping more black children at home, without having first fundamentally changed the nature of what goes on at home. We have to hope that policymakers are interested in the facts, capable of resisting the Movement’s political pressure, and concerned enough about the genuine welfare of black children and the larger black community to pursue genuine reform.

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Editor’s Note: After this article was originally published in the *Arizona Law Review*, the NIS authors reversed their prior position, publishing NIS-4, in which they conclude that black maltreatment rates are significantly higher than white. For further information, see: http://www.acf.hhs.gov/programs/opre/abuse_neglect/natl_incid/index.html
Deconstructing Disproportionality: Views From Multiple Community Stakeholders

Alan J. Dettlaff and Joan R. Rycraft

Introduction

The existence of racial disproportionality has been well documented at every level of the child welfare system, including reporting (Ards, Myers, Malkis, Sugrue, & Zhou, 2003), substantiation (Rolock & Testa, 2005), placement into foster care (Goerge & Lee, 2005), and exits from foster care (Hill, 2005). This phenomenon is a concern, as numerous studies have indicated no significant differences in the actual incidence of maltreatment among children of different racial groups (Sedlak & Broadhurst, 1996; Sedlak & Schultz, 2005). Using data from the federally-funded National Incidence Studies (NIS) of Child Abuse and Neglect, these studies have consistently found no statistically significant differences in maltreatment rates between African-American and white children. In fact, after controlling for factors including income and family structure, the most recent NIS found significantly lower rates of maltreatment in African-American families as compared to white families (Sedlak & Schultz, 2005). While challenges have been made to the NIS methodology, these studies remain the most reliable estimates available concerning the incidence of maltreatment and are the only studies that provide national estimates of the occurrence of abuse and neglect (Barth, 2005).

Multiple studies have documented that children who are removed from their homes not only experience significant trauma, but also are at-risk for negative outcomes as adults including low educational attainment, homelessness, poverty, mental health disorders, and criminal justice system involvement (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Pecora et al., 2003). For African-American families, overrepresentation in the child welfare system not only separates parents from children, but also contributes to feelings of anger, hostility, and distrust of governmental systems. In addition to individual and family consequences, overrepresentation in the child welfare system and the resulting negative outcomes can serve to perpetuate many of the oppressive conditions and negative stereotypes that have historically affected African Americans (Roberts, 2002). Studies that have sought to identify the factors contributing to disproportionality have relied largely on quantitative analyses of state and national data sets and have often produced inconsistent findings. While these studies have contributed to the knowledge base, they may not include the robust data necessary to fully explain the complex array of factors related to this issue. Additionally, a critical shortcoming of this research is the lack of data from the voice of those in communities affected by disproportionality. This paper reports the results of a study designed to develop a deeper understanding of disproportionality from the views of multiple community stakeholders, including community members, legal professionals, and child welfare caseworkers.
Literature Review

Through analyses of state and national data sets, the following factors have been identified as potential causes of disproportionality: (1) individual and family risk factors, (2) community risk factors, and (3) agency and systemic factors. Studies identifying individual and family risk factors suggest that the disproportionate overrepresentation of African-American children in the child welfare system is the result of disproportionate need. These studies state that African Americans are more likely to experience many of the high risk factors associated with maltreatment, making them more vulnerable to contact with the child welfare system. Primary among these factors is the disproportionate number of African-American families living in poverty, as considerable evidence indicates that maltreatment disproportionately occurs among poor families (Drake & Pandey, 1996; Sedlak & Broadhurst, 1996). Additional data indicate that African-American children are overrepresented among children whose parents are unemployed, children with single parents, and children in families with four or more children, each of which is associated with higher risk of maltreatment (Sedlak & Schultz, 2005).

Studies identifying community factors suggest that disproportionality is related less to race than it is to the disadvantaged characteristics of neighborhoods in which individuals reside. Testa and Furstenberg (2002) found that African-American neighborhoods in Chicago with high rates of maltreatment are the same neighborhoods that experienced high maltreatment rates over 100 years ago when they were occupied by European immigrants. Poor families are more likely to live in neighborhoods experiencing concentrated poverty (where the poverty rate exceeds 40 percent), which is associated with higher rates of maltreatment (Coulton, Korbin, & Su, 1999). These neighborhoods are also more likely to experience higher rates of crime, violence, inferior schools, and unsafe housing further increasing risk to children. Thus, the increased likelihood for African-American families to experience poverty, combined with the neighborhood effects of concentrated poverty may contribute to disproportionality.

Other studies suggest that racial bias and inconsistencies in decision-making by professional reporters and child welfare staff are the causes of disproportionality. The term racial bias is most commonly used in child welfare literature to connote a phenomenon that, given equivalent levels of risk, African-American children are more likely than white children to enter the child welfare system at various decision-making points. This bias can affect outcomes when personal values, cultural differences, and professional judgments influence decision-making. While some studies have identified race as a significant factor at various decision-making points (Ards et al., 2003; Zuravin, Orme, & Hegar, 1995), other studies have produced inconsistent findings (Goerge & Lee, 2005; Sedlak & Schultz, 2005). However, once in the child welfare system, studies have consistently shown that African-American children spend more time in foster care and are less likely to be reunified than white children are (Hill, 2005).

Although studies have identified potential contributing factors at the individual, community, and agency levels, disproportionality likely results from a combination of these factors. The lack of consensus concerning the causes of disproportionality, however, suggests the need for additional research that examines this issue from different perspectives. The existing literature also demonstrates a critical gap in the research concerning the voice of those who reside and practice in communities affected by disproportionality. This study begins to address this gap by identifying the factors contributing to disproportionality from the views of multiple community stakeholders. This information can be used alongside existing studies toward developing an enhanced understanding of disproportionality in the child welfare system.
Methods

This study was conducted as part of a statewide effort to address disproportionality by the Texas Department of Family and Protective Services (DFPS). Efforts to address disproportionality began in 2004 through a collaboration with Casey Family Programs and were further supported in 2005 by the passage of Senate Bill 6 by the 79th Texas Legislature, which mandated comprehensive reform of DFPS, including a requirement to examine and address disproportionality. As an initial step in these efforts, focus groups were identified as a method of engaging the community as partners, as well as a means of gathering the data necessary to advance the understanding of disproportionality and inform efforts to address this issue.

Study Design and Sample

Focus groups were held in two of the communities most significantly affected by disproportionality in the state. Communities were defined by zip code boundaries and were selected based on the number of African-American children entering foster care from those zip codes. Community members were invited to participate in focus groups through a series of town hall meetings held in each community during the spring of 2006. Town hall meetings were announced through flyers posted in each community, public service announcements on local radio stations, and community news letters. During each meeting, information about disproportionality was provided, along with a discussion of the commitment of DFPS to address this issue. At the conclusion of each meeting, community members were invited to participate in focus groups through letters of invitation that were sent to all judges, district attorneys, and attorneys ad litem working in those communities. DFPS caseworkers were selected through a purposive sample of caseworkers from various stages of service delivery with more than one year of experience.

In total, eight focus groups were held with community members (n=57), three with legal professionals (n=19), and two with DFPS caseworkers (n=18). Community members identified themselves as concerned parents, grandparents raising grandchildren, and other kinship caregivers. Legal professionals included attorneys ad litem appointed by the court to represent children, civil attorneys representing parents, state district attorneys representing DFPS, and judges and associate judges who preside over DFPS cases. DFPS staff included investigators, family preservation caseworkers, and legal caseworkers.

Procedures

At the beginning of each focus group, the purpose was explained to participants by the researchers. Participants were informed that the focus group would be audio-recorded and transcribed and that only the researchers would have access to the full recordings and transcriptions. The focus group agenda was developed by the researchers in collaboration with DFPS administrators. Questions addressed participants’ views of the factors contributing to disproportionality in their communities at various stages of service delivery, including intake, investigation, removal, and reunification. Each focus group lasted approximately two hours.

Analysis of Data

Data analysis was conducted through a series of phases involving an inductive process using the constant comparative method to allow for a thorough understanding of participants’ views. The first phase of analysis began with a review of the transcripts of each focus group by the researchers. Transcripts were reviewed independently and emerging themes were discussed and agreed upon. Following this phase, axial coding was conducted by applying the identified themes to each transcribed statement. This round of coding was conducted independently by the researchers, after which
codes were compared and differences were discussed. Using constant comparative analysis, a final round of thematic coding was conducted to identify patterns within themes and ensure accuracy of categorization.

**Results**

The analysis resulted in the identification of three domains within which factors contributing to disproportionality are present. These domains were identified as the agency, the community, and the shared intersection of agency and community. The agency domain includes the policies, practices, and issues germane to only the child welfare agency that contribute to disproportionality, while the community domain includes those factors existing primarily in the community. The shared domain includes the factors that involve a shared intersection between the agency and the community. Factors in this domain contain both agency and community aspects contributing to disproportionality. Figure 1 demonstrates these three domains and the intersection of agency and community factors. Table 1 displays a summary of the factors contributing to disproportionality within each domain.

**Figure 1. Conceptual framework of domains and contributing factors**

![Conceptual framework of domains and contributing factors](image)

**Table 1. Summary of factors contributing to disproportionality**

<table>
<thead>
<tr>
<th>AGENCY FACTORS</th>
<th>COMMUNITY FACTORS</th>
<th>SHARED FACTORS</th>
</tr>
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<tbody>
<tr>
<td>Agency climate</td>
<td>Community breakdown</td>
<td>Lack of cultural sensitivity</td>
</tr>
<tr>
<td>■ fear of liability</td>
<td>■ lack of community cohesion</td>
<td>■ cultural misconceptions among child welfare staff</td>
</tr>
<tr>
<td>■ punitive nature of agency</td>
<td>■ lack of social supports</td>
<td>■ cultural misconceptions among community professionals</td>
</tr>
<tr>
<td>Disparate response</td>
<td>■ decline in intergenerational parenting</td>
<td>Barriers to kinship care</td>
</tr>
<tr>
<td>■ cultural bias</td>
<td>■ poverty</td>
<td>■ overly restrictive policies</td>
</tr>
<tr>
<td>■ lack of thorough investigations</td>
<td>■ crime and substance use</td>
<td>■ lack of resources for kin</td>
</tr>
<tr>
<td>■ inconsistent decision-making</td>
<td>■ young mothers and absent fathers</td>
<td>■ inadequate service provision</td>
</tr>
<tr>
<td>Ineffective interventions</td>
<td>■ Barriers to resources</td>
<td>Lack of engagement</td>
</tr>
<tr>
<td>■ lack of individualized services</td>
<td>■ limited resources</td>
<td>■ poor perception of child welfare agency</td>
</tr>
<tr>
<td>■ lack of family involvement</td>
<td>■ lack of knowledge of existing resources</td>
<td>■ lack of outreach and community collaboration</td>
</tr>
<tr>
<td>■ unrealistic expectations</td>
<td>■ lack of accessibility</td>
<td></td>
</tr>
<tr>
<td>Workforce issues</td>
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<td>■ lack of experience</td>
<td>■</td>
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<tr>
<td>■ inadequate training</td>
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<td>■ unmanageable caseloads</td>
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</table>
Agency Factors

Agency Climate
Agency climate refers to the environment in which caseworkers and administrators make decisions. Participants indicated that decision-making is often based on fear of liability rather than the best interests of children and stated that caseworkers often choose the “safe decision” of removal due to fear that a child will be harmed following a decision to allow a child to remain in the home.

*I think they have a lot of fear because they’ve had situations where they’ve made placements in families’ homes and they’ve allowed the perpetrator back and the child is injured or killed and then they’re attacked for that in the newspapers. I’ll tell you, it’s the fear, there’s a lot of fear in CPS.*

Related to this fear is the perception that agency administration would be unsupportive of caseworkers if children were harmed following a decision to allow a child to remain in the home, resulting in more frequent removals. Caseworkers often expressed that they would be in “more trouble” if a child died than they would be if they removed a child, and stated they have known other caseworkers who were fired or demoted following a child death. Community members were also aware of this, stating:

*When a child dies, usually someone gets fired. Why don’t we come together with the community and look at what happened in that child’s death? Why don’t we have a collaborative community review where we say, “Where did we fail as a community?” Not that the parent isn’t responsible, but it’s a very punitive system. So the CPS workers bleed.*

Disparate Response to African-American Families
Disparate response refers to the differential treatment of African-American families in the child welfare system. Participants indicated that many decisions involving African-American children reflect cultural bias, stating that caseworkers often judge families according to their own standards of appropriate parenting, rather than thoroughly assessing risk. Participants stated that when these biases exist, they affect caseworkers’ perceptions of risk and decision-making.

*I think racism plays a lot in the removal of a child, because the whole setting is something that the new caseworker is not accustomed to . . . the way they were raised, you’re not going to see that in [this community]. So they take the way they were raised into these communities and make value judgments on these families and say, “I was never raised like this, so therefore this must be abuse.”* Participants also stated that when caseworkers are fearful of the neighborhoods in which some African-American families live, it is likely to influence decision-making. One stated, “When you have workers that show up and it’s already dark, and they’re already afraid because they’re in [the neighborhood], I don’t know anything that parent could say that would convince them to leave that child in that home.” Several participants suggested that it is easier to remove a child than it is to complete a thorough investigation and stated that caseworkers often make quick decisions based on preconceived ideas or fears, rather than completing thorough investigations and risk assessments.

Participants also discussed inconsistencies in the decision-making process that impact African-American families more negatively and further reflect differential treatment. One caseworker discussed how differences in income levels can affect decision-making, stating, “You start getting some money involved, they have means of getting a lawyer, and we don’t like that because guess what? They can fight with us. You know, you can take advantage of the poor, and . . . that’s
not a rich neighborhood.” Legal professionals also indicated witnessing inconsistent decision-making standards:

I have seen caseworkers when you have an Anglo family, they do a lot of head turning. For instance, if they get ready to return a child home and they give the parent a UA and they’re positive for marijuana, I personally have heard them say, “Well, it was just a little marijuana” when it was an Anglo parent, but when it’s a black parent, they’re not going home.

Ineffective Interventions
Participants indicated that interventions are not effective in meeting the needs of African-American families once they are in the child welfare system. This is largely because service plans are not individualized to families’ unique needs and do not consider cultural factors. One caseworker stated, “We have staffings, but none of the parents are really involved in the process. We come up with our way of what we think should happen, what services they should participate in.” Another stated, “There are a lot of cookie-cutter services. Everyone is going to get parenting classes, and I don’t think they focus specifically on the parent to give them what they need.”

Participants stated that the agency often has unrealistic expectations of families and that many families in these communities are poor, have limited access to transportation, and are unable to take time off of work, yet these factors are not considered when planning services. One community member stated, “[Caseworkers] set up guidelines for these parents that they don’t know anything about, and they can’t meet that goal. [Caseworkers are] making guidelines, they set up these standards, and everybody is supposed to go by this standard. Middle class values, middle class economy, and you’re going to force a poverty person to meet it.”

Workforce Issues
While workforce issues do not directly impact disproportionality, when combined with other issues they serve as compounding factors. Participants primarily cited the lack of experience among caseworkers and supervisors as a contributing factor. When combined with cultural misunderstandings, inadequate training, and unmanageable caseloads, the results are incomplete investigations and poor decision-making. Participants also stated that due to the volume of cases being handled, it is difficult to complete thorough investigations that adequately assess risk. Without ample time to conduct thorough assessments, workers may allow their own perceptions and value judgments to influence their decisions.

Community Factors
Community Breakdown
The breakdown of the traditional community within the African-American culture was described as a major factor influencing disproportionality. Participants recalled a closer community in the past that supported families and worked together to ensure the safety of children in the neighborhood. Community members stated their communities now lack those bonds:
**People are afraid to go out and get a child who is in need of attention, so rather than deal with this child the way we used to, we call CPS because I’m afraid that if I go get your child, bring him in my house, clean him up and feed him, I’m gonna have his mama coming over, cuss me out. Nobody is concerned about anyone else, everybody’s looking at their own. So that’s part of the problem, we really don’t have a cohesive community.**

Participants also described the community as lacking in social supports for families. Of specific concern was the decrease in the role of the church and the number of support services that were once available that are no longer funded.

With the demise of the community structure, participants also identified a decline in intergenerational parenting. Viewed as a major cultural strength, participants recalled a time when child-rearing practices were handed down from generation to generation and stated that this is no longer present in many families:

> I think a lot of children are being referred because of the parents’ lack of information from their parents to raise their children. A lot of parents do what they were taught from their parents, and if they weren’t taught properly then they don’t know that what they’re doing is wrong.

**Environmental Issues**

Participants consistently cited poverty as a significant factor, as children raised in poverty-stricken neighborhoods face significant challenges that bring them to the attention of the child welfare system. One community member stated, “You’re looking at an area of low, low income, and low income people are not able to take care of children without the resources.” Participants also stated that these communities are often unsafe due to violence, crime, and drug use. Participants, particularly members of the communities, consistently cited parents who are addicted to substances as contributing to disproportionality.

**Drugs are so prevalent in our community. I’ve been on the same corner 29 years and I see a lot. The black females that I see on crack cocaine, all of them have children, and their children are somewhere. If I’m a parent and I’m a drug addict, I care more about the drugs than I do about my kids, and it’s an epidemic in our community.**

Participants also stated that the community consists of very young women with several children. Fathers of the children are not active in their lives, and these mothers do not have the parenting skills to provide a safe environment for their children. When combined with the environmental challenges and lack of resources, these children are at high risk for maltreatment.

**Barriers to Resources**

Participants stated that many needed resources are not available and those that are available are not well known. Similarly, when resources are available, they are uncoordinated and difficult to access. Participants stated that when needed resources are not available or accessible, everyday challenges become insurmountable and parents are unable to provide a safe home for their children.

**Shared Factors**

**Lack of Cultural Sensitivity**

Lack of cultural sensitivity occurs in the child welfare agency and in the community, with both contributing to disproportionality. Within the agency, lack of cultural sensitivity leads to cultural bias, which affects decision-making. Within the community, lack of cultural sensitivity by community professionals leads to higher rates of African-American children being reported. Participants particularly discussed the role of the educational system as a contributing factor.

> I’m not sure that a lot of the teachers in these schools actually live in the area; they come from their part of the city into an area that’s much different from theirs and things that are not normal for them are a concern. Sometimes
when you live in a certain environment you act a certain way . . . and it’s considered normal, but when you come from the outside, it’s like a red flag.

Participants also cited lack of cultural sensitivity among other community professionals including medical professionals, service providers, and judges.

Barriers to Kinship Care

Barriers to kinship care exist in the agency and the community. Within the agency, restrictive policies limit opportunities for willing kin to take children into their homes to avoid foster placement. Within the community, environmental factors such as poverty and crime contribute to the exclusion of willing caregivers. While participants acknowledged that caregivers often have issues in their past that raise concern, they agreed that many appropriate caregivers are being excluded due to overly restrictive policies that prevent kinship placements.

A lot of times the agency is almost forced to take the child to foster care because of disqualifying factors of the family, say for instance this person has an arrest record. But maybe things that have been in the past may not be present now. There’s people who have turned their life around; there are lots of people who have stumbled and have had contact with the law but that may be the only time.

Additionally, the lack of financial assistance that the agency is able to provide kin is a significant barrier to willing families. Many participants also expressed frustration over the lack of services provided to kin once placements are made. One current caregiver stated:

My concern is the welfare first of myself because I’m the caregiver, and then the welfare of the children that have been placed in my care. I have to be physically and mentally there for myself first, then for them. Some grandparents are older than I am, and they put the kids off on us and they don’t even come back and say, “So what do you need? Everything going okay?”

Lack of Engagement Between the Agency and Community

Further contributing to disproportionality is the lack of a relationship between the child welfare agency and the community, which contributes to fear, lack of trust, and negative perceptions. The community perception is that the agency only takes children away and does not provide any assistance or help to families in need. This perception exists largely because the agency is uninvolved with the community and makes little effort to change this perception. One community member stated, “To take people to the next level you must go to the people, live amongst them, learn from them . . . start with what they have and build on what they know, but they’re not willing to do that.” Another stated:

They need to be more present in the community. They don’t send anybody out unless it’s to do a removal or an investigation. That’s like the IRS, the only contact you have with them is bad. When you start having something other than the harsh contact, then you’re going to have a change in perception.

Discussion

While findings from these focus groups must be viewed with caution, as they are specific to these communities, many of the factors identified by participants are consistent with those found in existing literature. As such, these findings can provide a deeper level of understanding of these issues, as well as provide insight into other potential contributing factors. Similarly, implications resulting from these focus groups must be viewed with the understanding that differences may exist according to the community and agency dynamics present in each community.
However, these implications may provide valuable information to child welfare agencies in efforts to address disproportionality.

Within the child welfare agency, it appears that the current environment is one of fear, at both the administrative and the caseworker levels. Participants consistently stated that decision-making is often based on fear of potential agency liability or punitive consequences, rather than the best interests of children. To practice effectively, child welfare staff must be able to operate in an environment in which they feel supported by the agency. This message must be communicated by agency leadership, as well as demonstrated through action. To reduce disproportionality, child welfare agencies must demonstrate a commitment to maintaining children in their homes and resources must be allocated to provide appropriate service delivery to intact cases. Improvements must be made to the investigative and risk assessment processes to reduce the likelihood of ill-informed decisions, and staff must be able to trust that decisions to maintain children in their homes will be supported when evidence does not warrant removal.

The perceived cultural bias among child welfare staff presents a significant barrier to maintaining children in their homes. Participants indicated that caseworkers tend to judge African-American families according to their own values of parenting, child-rearing, and environmental standards, resulting in inadequate risk assessments based on stereotypes and bias. To prevent this, procedures must be developed that provide sufficient oversight and criteria for decision-making. Several authors have recommended the use of actuarial, or empirically based, risk assessment tools as a means of increasing equity in decision-making and potentially reducing disproportionality (Baird, 2005; Johnson, 2005). Although some authors have suggested that the use of these assessments may increase bias (Morton, 1999), most existing research indicates that actuarial models show no evidence of racial bias (Baird, 2005; Johnson, 2005). While debate exists concerning the use of actuarial models, findings from this study clearly indicate the need to examine current risk assessment protocols to ensure that decisions are based on actual risk of maltreatment or recurrence, rather than subjective views of parenting or environmental factors.

Once African-American children enter the system, the decision-making process regarding service delivery and reunification appears complex and fraught with inconsistency. Participants stated that parents are often held to unreasonable demands and expectations placed on parents are unrealistic. To address disproportionality, service plans must be individualized and address the unique needs of families. The development of service plans should closely involve family members and consider cultural factors. Services should be located in the community and provided by practitioners with experience providing services to African-American families. Family group decision-making (FGDM) may be an effective method of addressing some of these issues, as several authors have suggested the use of FGDM as a means of addressing disproportionality through increased family engagement in decision-making and service planning (Crampton & Jackson, 2007; Waites, Macgowan, Pennell, Carlton-LaNey, & Weil, 2004).

Barriers to facilitating and maintaining kinship placements also appear to be significant contributors to disproportionality. Participants indicated that restrictive agency policies often exclude willing caregivers, while the lack of resources and inadequate service delivery for kin further challenge caregivers who are struggling to meet the needs of children placed in their homes. To reduce disproportionality, child welfare agencies must make a genuine commitment to kinship care and ensure that an appropriate level of service delivery is provided to kin caregivers. Policies should be reviewed regarding the approval process for kin placements with guidelines established to address criminal histories and other issues in a consistent manner. Subsidized guardianships should be explored as a permanency
option for children in kin placements, as research indicates this can be an effective method of providing needed financial support, as well as reducing disproportionality (Testa, 2005).

Within communities affected by disproportionality, participants stated that the sense of community and shared responsibility that once existed is no longer present. When combined with environmental issues of poverty, drug abuse, crime, and unemployment, children are often at increased risk of maltreatment. While participants indicated that many of the referrals generated in these communities are necessary as a result of these environmental concerns, steps must be taken to ensure that environmental stressors are not used to stereotype individual community members or mistaken for deficits in parenting. Rather caseworkers must understand the impact of these environmental factors when conducting assessments, and barriers to accessing resources must be addressed when planning for services. To facilitate this understanding, efforts must be made to increase the cultural competency of child welfare staff. While staff are often provided training on cultural awareness, more emphasis needs to be placed on the application of this material. Several studies support the need for increased training on cultural competency to address disproportionality, emphasizing the importance of regular follow-up and application of training material (Lemon, D'Andrade, & Austin, 2005; U.S. Department of Health and Human Services, 2003).

Finally, findings from these focus groups clearly indicate the need for child welfare agencies to improve their relationship with the community. To reduce disproportionality, child welfare agencies must ally themselves with communities and draw upon the strengths of communities to address this problem. To facilitate meaningful engagement, efforts must be long-term and consistent. Meetings and open forums should be held with community groups, churches, schools, and other community stakeholders on a consistent basis. Agency administrators should establish connections with community agencies to develop collaborative partnerships that work toward the common goal of improving outcomes for children and families. Additional strategies include the establishment of satellite offices within communities and the development of community-based family service centers that emphasize community support and prevention.

Limitations

Due to the small sample size in this study and the use of non-probability sampling, findings from these focus groups are limited in generalizability. Similarly, findings from these focus groups and subsequent implications must be viewed with the understanding that state and jurisdictional differences may significantly impact the perceptions of factors contributing to disproportionality. Several factors that have been identified in the literature as contributors to disproportionality, including the role of law enforcement, court involvement in case planning, and federal policies, were not addressed by participants in these focus groups. This could be due to regional differences in these communities, practice or policy that is unique to the child welfare system in Texas, or lack of knowledge among participants. Additionally, while the focus group questions did not address any particular system, participants were aware that these groups were being conducted to help inform DFPS about the factors contributing to disproportionality in their communities. As a result, responses may have focused more on the role of this system, rather than the likely role of other systems, such as law enforcement and the courts, as contributors to disproportionality.

Conclusion

While many of the implications resulting from these findings involve efforts that must be made by child welfare agencies, it is important to note that efforts must also be made by communities affected by disproportionality. The safety and wellbeing of children is a community responsibility. This
includes the social service delivery system, law enforcement, the courts, and local government. Without concentrated efforts to address the issues facing these communities, children will continue to be removed from unsafe and poverty stricken neighborhoods with little chance of returning to their homes. Families living in these communities struggle to provide adequate care for their children and have few, if any, community resources available. A concentrated effort by child welfare agencies and other community stakeholders to address these issues may facilitate children being maintained in their homes and reducing disproportionality.

References


Section 4

*Intercountry Adoption*
In the face of the current crisis in international adoption, leading human and child rights experts have developed this policy statement supporting the principle that children’s most basic rights are to grow up in the true family that is often available only in international adoption. This policy statement was endorsed as of June 2009, by over 130 legal academics specializing in human and child rights, and by six child rights and adoption policy organizations (list follows). The Human Rights Center of the powerful American Bar Association (ABA) developed a related resolution supporting international adoption which was formally adopted by the ABA in August 2008. These developments demonstrate that the organizations which have opposed international adoption using child rights rhetoric have no lock on the child human rights position.

This policy statement is consistent with both the Convention on the Rights of the Child (CRC) and the Hague Convention, if those are interpreted to make central the child’s best interests and fundamental human rights. It is consistent with the Hague Convention’s preference for in-country over out-of-country adoption: the statement simply provides that any such preference be implemented through a strategy which does not result in delaying placement. And the Hague Convention specifically allows for private intermediaries, so long as they operate under the aegis of a Central Authority.

**Policy Statement**

- International adoption should be an integral part of a comprehensive strategy to address the problems of unparented children, together with the development of better temporary care for children pending permanent placement, the development of in-country adoption and other truly permanent nurturing placement options, and the provision of social services to parents so that they can keep and nurture their children.

- International adoption is consistent with other positive social responses to the problems of unparented children, bringing new resources into poor countries to support such efforts, and developing new awareness of and concern for the plight of poor children and poor communities worldwide.

- Adoption, whether domestic or international, generally serves children’s interests better than any form of state-sponsored care, whether that be foster care or institutionalization, although there will always be exceptions to this general rule; including, for example, situations in which placement of a child in a permanent, nurturing kinship foster care situation would be preferable to adoption for that specific child.

- Children whose original parents cannot provide permanent nurturing care should generally be placed as soon as possible in a permanent adoptive home, whether domestic or international.

- Efforts should be made to identify in a timely way all unparented children, and to promptly free for adoption all children who cannot or should not be reunited with their birthparents in the near future, and for whom there is no other preferable permanent parenting solution immediately available.

- Children free for adoption should be placed as soon as possible in appropriately screened adoptive homes, whether domestic or
international: no children should be held whether in foster care or institutions for any period of time for the purpose of placing them in-country; any in-country preference should be implemented through a concurrent planning strategy, planning simultaneously for both domestic and international adoption, and preferring domestic adoption only if it will involve no delay in placement for the child.

- International adoption should not be made more difficult for parents to accomplish than domestic adoption; given the inherent difficulties posed by adopting in a different country, efforts should be made to coordinate the adoption systems and related laws and policies of sending and receiving countries to reduce these inherent difficulties and make the international adoption process more comparable to the domestic process from the viewpoint of adoptive parents.

- Adoption abuses, such as kidnapping and baby-selling (defined as payments to birthparents designed to induce them to surrender their child and their parenting rights), should be dealt with by enforcing the laws prohibiting such practices, and where needed by developing new laws and policies to discourage such practices, without unduly restricting the placement of unparented children in domestic or international adoption, and without unduly limiting the private agencies and other adoption intermediaries that facilitate such adoptions.

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Report

**Background**

International adoption has increased dramatically since World War II and is recognized as an important method of serving the needs of unparented children worldwide. Adoption research has demonstrated that adoption, whether domestic or international, generally serves children’s interests far better than foster care or institutionalization. Indeed, when children are placed in adoptive homes at an early age they do roughly as well as children raised by untroubled birth families. While concerns have been raised about whether placement across racial and national lines poses risks for children, the research has failed to demonstrate evidence of such risks. At the same time, social science research demonstrates that severe harm is done to children by time spent in the kinds of institutions in which unparented children worldwide are generally held. And the developing science of early brain development has provided dramatic new evidence of the fact that infants’ and young children’s brains do not develop in the ways they need to in order to enable normal intellectual and emotional growth when the children are deprived of nurturing parenting relationships, as they are when they live in institutions. The Hague Convention on Intercountry Adoption provides new legal legitimization of international adoption, providing for the first time in any international law

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document a statement that such adoption should be preferred to any in-country placement except for in-country adoption.  

However, international adoption has been under attack in recent years, and is at a crisis moment now, with the numbers of such adoptions into the U.S. down these last three years in dramatic contrast to the steady growth over the previous six decades. Powerful political forces have aligned against international adoption, and have had an impact on the laws and policies of both sending and receiving countries. As new countries open up to international adoption and begin to release their unparented children to adoption abroad, they tend to close down again either partially or totally as the result of newly restrictive regulations. Romania was forced to close down international adoption as a condition for gaining entry to the European Union. Guatemala has just been closed down, pending development of a new regulatory regime which may transform the country which had been known for releasing unusually large numbers of children at early ages, in healthy shape, with good prospects for normal development, into a country which releases at best only a small handful of children, after having kept them for two to three years or more in damaging institutions. China has recently passed restrictions which limit significantly the parents considered eligible for adopting. Yet the needs of unparented children in these countries and worldwide for the nurturing homes that international adoption provides have not diminished. Indeed, it seems clear, given, among other developments, the terrifying numbers of newly orphaned children produced by the AIDS disaster, the needs have escalated.

This is a key moment in history for international adoption, with the potential for movement either in the direction of expanding the potential of international adoption to serve the needs of unparented children, or of closing it down. There are increasing numbers of prospective parents interested in such adoption, and the potential exists for expanding by a significant factor the number of homes for unparented children. There is an impressive body of evidence documenting the benefits for children of placing them in adoptive homes rather than leaving them in institutional care. There are many people, both in sending and receiving countries, who care about children and believe based on their own common sense and life experience that what children most need is the kind of early, nurturing parenting that adoption provides. But there are very few organizations with expertise in the world of law and policy committed to promoting international adoption as part of a general strategy to serve the needs of unparented children.

**Recommendations**

1. **Address the Needs of Unparented Children by Prioritizing Adoption, Whether Domestic or International, Over Placement Options Such As Foster Care and Institutionalization.**

Many millions of children are now growing up in institutions or on the streets in the sending countries of the world; a very small proportion of the children surrendered by or removed from birthparents in these countries are in foster care. The Hague Convention indicates that international adoption should be seen as preferable to all in-country alternatives except for adoption. However, some organizations, including UNICEF, argue for a preference for in-country foster care over international adoption. Some argue for mandated holding periods during which...
children must be kept in-country before they can be placed internationally, and several countries have established such holding periods.

This policy statement makes adoption the priority over other placement options except for safe and timely in-country adoption, and emphasizes the importance of prompt adoptive placement. It urges that procedures be created to identify and free up children in need of adoptive homes, and it rejects holding periods that would require delay in adoptive placement.³

The case for this policy statement rests on the biological science, social science, and child development expertise that demonstrates how harmful it is to children to grow up on the streets or in institutions,⁴ and how well children do when placed in international adoptive homes.⁵ Children placed early in life in international adoptive homes are likely to do essentially as well in their families and in life as do children raised by their biological parents in those receiving countries. Children subjected to terrible experiences prior to adoptive placement, as many internationally adopted children have been, often show remarkable success in overcoming some of the damage done by these early experiences. By contrast, research on orphanges shows how devastatingly harmful institutional life is for children. Interestingly, even the better institutions have proven incapable of providing the personal care that children need to thrive physically and emotionally. Research on children who started their early life in institutions vividly demonstrates the damage such institutions cause even when the children are lucky enough to escape the institutions at relatively early ages. Age at adoptive placement regularly shows up in adoption studies as the prime predictor of likelihood of successful life adjustment.⁶

Opponents of international adoption argue that children are best served by remaining in their communities of origin, where they can enjoy their racial, ethnic, and national heritage. But the opponents’ claims are based on extreme romanticism, without any grounding in the available evidence and without support in common sense. Children doomed to grow up

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³ Hague Convention Article 4(b) provides that international adoption can take place only after “due consideration” to the possibility of domestic placement. U.S. post-Hague regulations require “reasonable efforts” to find placements for U.S. children within the U.S. before placing them abroad, and a two-month holding period subject to certain exceptions. See Bartholet, E. (2008). International adoption: The child’s story. Georgia State University Law Review, 24, 333. This Policy Statement says that any preference for in-country adoption should be implemented through a concurrent planning strategy, preferring domestic adoption only if it will involve no delay in placement.


⁶ Early results of the Bucharest Early Intervention Project, (see footnote 4), show that placement of the institutionalized Romanian children in specially designed, model foster care had ameliorating effects on their intellectual, emotional, psychiatric and brain development, with the length of time previously in the institution and the age at which removed to foster care factors in their functioning. University of MD Press Release. (2006). Institutionalized children benefit from early intervention. Retrieved from http://www.newdesk.umd.edu/socsci/release. cfm?ArticleID=1225
in orphanages or on the streets cannot expect to enjoy their cultural heritage in any meaningful way. The real choice today for most existing homeless children in most of the countries of the world that are or might become sending countries, is between life—and often death—in orphanages or on the streets in their home country, or, for a lucky few, life in an adoptive home abroad. Possibilities for adoption at home in the birth country are drastically limited by the poverty of the population and by attitudes toward adoption in most Asian and many other countries that are more blood-biased and otherwise discriminatory toward adoption than is the U.S.

Opponents argue that children might be placed in in-country foster care, and in that way benefit from remaining in their country and culture, as well as possibly still being linked in some way with their birth family. But foster care does not exist to a significant degree in the sending countries and the poor countries of the world—overwhelmingly, the homeless children of the world are living and dying in orphanages and on the streets. The U.S. is the country which has had the greatest experience with foster care; for many decades now, the vast majority of the children committed to state care here have been living in foster care because it has been seen as superior to institutional care. Even with the resources that the U.S. has to support foster care, it does not work especially well for children. Social science clearly demonstrates that while foster care works better for children than living in birth families characterized by child abuse and neglect, it does not work nearly as well as adoption.7 It is extraordinarily unlikely that foster care will work better in countries that are desperately poor than it has in the U.S. Moreover, the bottom line for children who might find adoptive homes abroad now is that foster care, whether good or bad, rarely exists as an option.

This Policy Statement is consistent with action taken in recent decades by the Congress in

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enacting the Multiethnic Placement Act (MEPA) as amended in 1996, and in enacting the Adoption and Safe Families Act of 1997 (ASFA). MEPA constitutes a powerful rejection of the philosophy at the heart of efforts to restrict international adoption—the idea that children must at all costs be kept within their communities of origin, and the related idea that racial and ethnic communities necessarily benefit by keeping “their” children within the group. ASFA similarly rejects ideas at the core of opposition to international adoption about the absolute priority of birth heritage as compared to other interests, and related ideas about the last resort status of adoption. ASFA also rejects the idea of holding in limbo children who have only technical ties to their birthparents, rather than moving promptly to terminate such ties so the children can be placed in adoptive homes.


International adoption now serves some 40,000 children per year, out of the many millions worldwide in need of homes. We need to develop better in-country foster care and institutional solutions for children, to serve the needs of the many millions who would never be adopted even if the numbers of adoptions were significantly increased. We also need to do more to improve social welfare services designed to enable birthparents to raise their children themselves.

This Policy Statement argues that international adoption should be an integral part of a comprehensive strategy to address the problems of unparented children, and to increase social welfare support for birthparents. It further argues that there is no inconsistency between international adoption and other initiatives designed to help unparented children and their birthparents.
International adoption brings significant new funds into poor sending countries, funds that can be used for and often are specifically directed to the improvement of institutional conditions and the creation of foster care alternatives. It also relieves sending countries of the cost of supporting the children who are adopted. It helps develop new consciousness about adoption as a positive parenting option in sending countries, which may make it easier to encourage adults in those countries to consider adoption. It helps develop new consciousness among those in privileged nations about the needs of poor children in sending countries, and seems likely to foster attitudes supportive of a wide range of governmental and private initiatives to do more to address those needs.

3. Address Adoption Abuses By Enforcing Existing Laws and Policies Prohibiting Such Abuses as Baby-Selling and Kidnapping and Penalizing Those Committing Abuses, Rather than By Restricting Legitimate International Adoption and Penalizing Unparented Children by Denying Them Adoptive Homes.

Layers of overlapping laws and regulations forbid adoption abuses involving any kind of exploitation of birthparents or children that could take place in connection with the transfer of children to adoptive parents in another country. Nonetheless, we know that some number of abuses take place. Payments are sometimes made to birthparents in connection with their decision to surrender children in violation of the laws prohibiting baby-selling. Occasionally there is evidence that birthparents have been induced to surrender by some form of fraudulent misrepresentation, and even that children have been kidnapped to be placed in adoption.

A common response to allegations of adoption abuses is to first “temporarily” shut down international adoption in the country at issue, and then to call for regulation of an additionally restrictive kind, with the new restrictions often eliminating the private agencies and intermediaries that tend to function as the lifeblood of international adoption. Half of the top sending countries in the last couple of decades have officially or effectively shut down international adoption as the result of claimed adoption abuses. Many countries in South America have eliminated private intermediaries in recent years in response to claims regarding adoption abuses, and the numbers of children placed in adoption have plummeted as a result. Guatemala has recently been shut down at least temporarily in response to claims regarding baby-selling, and many powerful forces have called for eliminating private intermediaries in any future international adoption system that Guatemala might institute.

This Policy Statement asserts that the appropriate response to adoption abuses is to enforce the laws prohibiting such practices, and, where needed, to develop new laws and policies to discourage such practices without unduly restricting the placement of unparented children in international adoption, and without unduly limiting the private agencies and other adoption intermediaries that facilitate such adoption.

All laws are at risk of being violated on occasion, and typically we respond to violation problems by gearing up enforcement efforts. We should do the same in this area. Temporary or permanent shutdowns of international adoption simply penalize the children waiting for adoptive homes by locking them into damaging institutions, when we should be penalizing those breaking the laws. Calling for new restrictions that would eliminate private intermediaries sounds reasonable to many. However, the fact is that in many parts of the world a government monopoly over all aspects of international adoption means that such adoption will either be closed down altogether or so stringently limited that only relatively few children will ever be placed. Those few will likely be placed only after spending unnecessary years in damaging institutions. It is for these reasons that the U.S. Department of State fought to ensure that the Hague Convention would permit the continuation of private adoption, as it does.
Conclusion

International adoption has been shown to work well for children, providing the nurturing homes they need to thrive in their present and future lives. The children who might be placed in international adoptive homes generally have no other good options. Typically they will live or die on the streets or in institutions, and an institution is no place for children to grow up. Dr. Dana Johnson, a widely respected specialist in international adoption pediatrics, has appropriately condemned the practice of relegating children to institutions:

> Putting a child in a long-term institution is an act of abuse... Children in institutional care have deteriorations in many things that we want to see children improve in during the earliest years of their life... Their cognitive abilities are lower, their growth is terrible and their brain development is abnormal as well... A few days in an institution should be as long as children are asked to endure (p. 20-21). \(^8\)

The world is now insisting that many, many children spend many months and years of their lives in institutions, despite the fact that millions of prospective parents are ready and eager to step forward to adopt them. Powerful forces are aligned to make the laws and policies governing international adoption ever more restrictive, eliminating international adoption altogether or limiting it to very last resort status. Relying on the best that science and social science has to offer, we hope to mobilize the many unorganized people who believe, along with the experts, that what children most need is a nurturing home as early in life as possible, and to take action to promote laws and policies which will better serve children’s interests.

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Individual Endorsements

Law School Faculty Members and Legal Professionals with Expertise in Human Rights, Child Rights, Family Law and related areas (As of June 12, 2009):
Fletcher N. Baldwin, Jr.
Chesterfield Smith Professor of Law
Director
Centre for Int’l Financial Crimes Studies
College of Law, Univ. of Florida
Carlos Ball
Professor of Law
Rutgers University School of Law Newark
Ralph Richard Banks
Jackson Eli Reynolds Professor of Law
Stanford Law School
Corinna Barrett Lain
Professor of Law
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Our World is Getting Smaller

Mark Melson

Today it is impossible to turn on the television without hearing a story of a child in a foreign country who is facing insurmountable odds or a celebrity who is either adopting a child or starting a program to help these children in need. Gone are the days when we could hide behind our walls and pretend that the challenges facing the rest of the world do not have an impact on us. As awareness grows about the plight of the estimated millions of orphaned children around the world, donors are being called on to take action. The challenge now is not just the need, but rather how a donor can make a safe investment that will make the greatest impact.

When international adoptions began, most agencies were entering countries focusing primarily on the number of children that could be adopted by American families—and rightfully so. There are children who need a family, and there are loving families who would like to bring a child into their home.

Over the past 25 years, international agencies have seen firsthand the challenges that most of these children face, as have adoptive parents. In the early years of international adoption, humanitarian aid gifts were primarily “donor driven.” A family would travel to a country to pick up their child and witness a need that was not being met—no playground at the orphanage, worn-out shoes on the children, a lack of books, food, or water, etc. They would return home and rally their family and friends to raise money to support the cause. This was a wonderful gesture, as it fulfilled an obvious need for the orphanage. The adoptive family themselves also benefited, in that they received joy by giving back to the place that gave them their child. It also helped solidify a connection to their child’s heritage.

Due to increased awareness and the ability to understand the needs of children, the scales are beginning to shift, from a singular priority of advancing international adoption to now also supporting the children left behind; children who may never know the love of a mother and father, who will face a challenging life on their own once they leave the security of an orphanage. Because of this shift, agencies are becoming more strategic in their humanitarian aid efforts. Working in conjunction with local governments, orphanages, foster homes, and other child service organizations, adoption agencies are now better able to guide their families to support efforts that will strategically make an impact on the lives of the children. Adoptive parents and donors now see the agency as a safe place to invest their philanthropic dollars.

Agencies have the ability to directly apply gifts to specific projects firsthand. Donors are finding comfort in:

- **Lack of red tape**: Because of the relationships adoption agencies have in-country, it is easier and quicker for gifts to be administered.

- **Immediate impact**: Contributions are generally handed directly from the agency to the partner delivering the aid.
Direct and lasting impact on children:
Because of the strategic nature of directing gifts, donors are able to guide their giving to a specific area where it will have the most impact—such as a clean water system at an orphanage, computers to help teach children English, job skills training, or scholarships.

Stewardship: Systems are in place now to allow donors to see their gifts in action—e.g., an online video that shows a well being dug, or video messages delivered by the children expressing how a gift has been used. This type of interaction is very gratifying for the donor and also helps to increase the awareness of the challenges many of these children face.

Around the world, many adoption agencies are engaging in significant projects to truly change lives. These are strategic projects that work in conjunction with in-country agencies to further expand their impact. Below are a few examples:

Africa: Cattle fattening farms are being developed to employ young men as they age out of orphanages. This provides these young men with shelter as well as ownership in the farm. They learn the intricacies of farming, and, once the cattle are sold, a portion of the proceeds goes to them, while another portion goes towards purchasing more cattle. The intention is to someday give the former orphans the ability to provide a sustainable revenue stream and ultimately a better life for themselves.

Eastern Europe: Local “grandmas” are hired to go into orphanages to rock and play with children daily. The grandmas are able to earn a fair wage, and, since they devote their time to the same children each day, the orphaned children are able to experience one-on-one attachment and desperately needed attention that they might not normally receive.

Asia: Programs are being developed to take children out of orphanages and place them in individual foster homes. Even though these children may not stay in the foster home permanently, it gives them a bonding opportunity with a family they would otherwise never have.

All over the world, adoption agencies are asked to provide financial and volunteer support following a natural disaster. Agencies are seen by their families as a safe resource to support a region of the world that has given them so much.

While the above examples (and so many more) are helping to permanently change the lives of children, there are potential pitfalls when supporting humanitarian aid projects. We live in a world of immediate gratification. Whether buying something online, downloading a movie, or waiting in line at Starbucks, we often become frustrated if there isn’t an instant response. Supporting projects in developing countries will often require tremendous patience on the part of the donor. The pace at which projects are developed and implemented are, in most cases, much slower than we are used to in the United States. As long as the donors are made aware of potential delays, they are usually accepting of the longer timeframes required for success.

A second pitfall is political unrest. We live in a volatile world with ever-changing political systems. Sometimes humanitarian aid projects are begun with the best of intentions (and often at the direction of local governments), only to be shut down as a new administration takes over. Or, in the case of projects begun by adoption agencies, they might be delayed or shut down as adoption laws change. Unfortunately, sometimes the initial investment in these humanitarian projects is lost before the project can be completed, and obviously this is disturbing both to the agency leading the initiative and to the donor families supporting it.

These obstacles can be avoided if the necessary due diligence is taken at the onset of the project. Contingency plans can be put in place, in cooperation with local governments, that will allow for certain projects to be implemented regardless of the changes within the laws.
Because of the relationships built by adoption agencies and the understanding of local governments that we are not just here to “take children” but rather to help all children, humanitarian aid gifts now cross many boundaries—cultural, religious, and regional. Donors and families can now feel safe in their investments in international gifts by utilizing their adoption agencies as a resource for continued support in many countries.
United States Implementation of the Hague Adoption Convention

U.S. Department of State, Bureau of Consular Affairs, Office of Children’s Issues

Introduction

The U.S. Department of State (hereafter also referred to as the Department) ratified the Hague Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption (hereafter, the Convention) at The Hague in November 2007, and the Convention entered into force for the United States on April 1, 2008.

The Convention provides a framework for Convention countries to work together to ensure that adoptions take place in the best interests of children and to prevent the abduction, sale, or trafficking of children in connection with intercountry adoption.

The text of the Convention, along with a current list of the approximately 75 Convention parties with which the Convention is in force with the United States, can be accessed through the Department’s website, [www.adoption.state.gov]. Also available on the Department’s website are:

- A detailed description of the Convention adoption process
- A list of agencies and persons accredited or approved to provide adoption services in adoption cases covered by the Convention
- Technical guidance on a wide range of issues, including but not limited to: accreditation and approval standards, U.S. citizens residing abroad, and homestudy requirements
- Links to laws and regulations cited in this article

This article gives an overview of the United States’ implementation of the Convention to date, including a discussion of U.S. implementing law and regulations, the accreditation and approval of adoption service providers, Hague Adoption Convention case processes, and annual reports on implementation.

U.S. Laws and Regulations Implementing the Hague Adoption Convention

In 2000, Congress passed the Intercountry Adoption Act (IAA), legislation that implements the Convention in the United States; the Convention entered into force for the United States in April 2008. The IAA designates the Department as the Central Authority for the United States for the purposes of the Convention.2 The Office of Children’s Issues in the Department’s Bureau of Consular Affairs is the office responsible for the day-to-day implementation of the Convention. The Department of Homeland Security’s

1 Disclaimer: The following is intended as a general overview of Hague Adoption Convention implementation in the United States, as of this writing. It is not a substitute for the actual Convention, the Intercountry Adoption Act of 2000 (IAA), 42 U.S.C. §§ 14901 et seq. (2010), or regulations, nor is it a comprehensive summary of them for the individual provisions discussed. In the case of any inconsistencies between this article and the Convention, the IAA, or regulations, the Convention, the IAA, or the regulations govern, as appropriate. The reproduction or inclusion of this article in any collection does not reflect the U.S. Department of State’s position on any opinion expressed by the other authors in the collection.

U.S. Citizenship and Immigration Services (USCIS) also performs certain key Central Authority functions as delegated by the IAA. The Department and USCIS coordinate extensively on Convention matters.

Pursuant to the IAA, the Department and USCIS issued several new regulations, each of which serves an important role in the United States’ implementation of the Convention:

- Adoption under the Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption and the Intercountry Adoption Act of 2000 (consular officer procedures in Convention cases) (22 CFR 42.24)

Implementation of the Convention: Convention Adoption Cases

Identifying a Convention Adoption Case

At the outset, parties to an adoption must determine whether the Convention applies to their case. The Convention governs cases where a child habitually resident in one Convention country (the country of origin) has been, is being, or is to be moved to another Convention country (the receiving country) for the purpose of adoption by prospective adoptive parent(s) habitually resident in the receiving country.

Under U.S. law, in an incoming Convention case, a U.S. citizen prospective adoptive parent(s) adopts a child from another Convention country who will immigrate to the United States. In an outgoing Convention case, a child resident in the United States emigrates from the United States to another Convention country for the purpose of adoption by a prospective adoptive parent(s) habitually resident in that Convention country.

In terms of the timing of the case, the Convention does not apply to cases that were in process prior to April 1, 2008, the date the Convention entered into force for the United States. These are “transition cases” that are processed under U.S. immigration regulations for orphan adoptions in effect at the time the case was filed.

Accreditation and Approval Requirements

Agencies and persons that provide any one of six “adoption services” identified by the IAA in a Convention adoption case generally must be accredited or approved, or working as a supervised or exempted provider.

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3 IAA § 103, 42 U.S.C. § 14914. These responsibilities of the Attorney General were transferred to USCIS when the Department of Homeland Security was created.

4 See U.S. Dept. of State, FY 2009 Annual report on intercountry adoptions (2010), available at adoption.state.gov for an in-depth description of coordinated activities.

5 Convention Article 2. Each Convention country’s laws may interpret “habitual residence” differently. A prospective adoptive parent with any question about his/her habitual residence and/or that of the child should contact the Central Authorities of all countries involved prior to initiating the adoption process in order to avoid any potential immigration issues. Contact information for each Central Authority under the Hague Adoption Convention is available at www.adoption.state.gov under “Country Information.”

6 U.S. Citizens residing abroad can find information on determinations of their habitual residence at http://adoption.state.gov/about/who/livingabroad.html

7 IAA §505.

8 See also http://adoption.state.gov/pdf/FAQs_Transition_Cases.pdf

9 22 CFR 96.12. Public domestic authorities like state human services agencies may also provide adoption services. 22 CFR 96.16. Temporary accreditation was initially available as an alternative for eligible agencies pursuant to 22 CFR Part 96, subpart N; however, all temporary accreditation terms expired by March 31, 2010.
Agencies and persons must demonstrate substantial compliance with all applicable accreditation and approval standards in 22 CFR Part 96 to become accredited, or approved. These standards cover a wide range of topics and were designed to ensure that an agency or person performs its duties in accordance with the Convention and the IAA. A current listing of all accredited agencies and approved persons as well as those denied accreditation and approval is available at [www.adoption.state.gov].

Significantly, in every incoming and outgoing Convention case, one accredited, or approved agency or person must be identified as the primary provider responsible for ensuring that all six adoption services are completed and for supervising other providers engaged in the case.

**Convention Case Processing**

**Incoming Cases**

In Fiscal Year 2009, American families adopted more than 700 children abroad who subsequently immigrated to the United States in accordance with the Convention adoption process. In many respects, the Convention adoption process for incoming cases mirrors the process for adopting orphans from non-Convention countries; however, increased scrutiny and safeguards in the Hague adoption process ensure that children who are eligible for adoption, their birth families, and those seeking to adopt them uniformly receive greater protections than those involved in non-Convention adoptions. The incoming Hague Adoption process is briefly summarized below.

1. **Selection of an accredited or approved adoption service provider**

   As discussed above, a prospective adoptive parent must choose an accredited agency or approved person to serve as the primary provider in a Convention adoption case. Other private providers may work in a Convention case if they are: 1) supervised by an accredited or approved adoption service provider, or 2) exempted providers.

2. **Eligibility to adopt**

   In an incoming Convention case, a prospective adoptive parent applies to be found eligible to adopt under U.S. law by the U.S. Citizenship and Immigration Services (USCIS) by filing form I-800A, Application for Determination of Suitability to Adopt a Child from a Convention Country, along with a homestudy that meets federal and state requirements for preparation and content, as well as any particular requirements of the child’s country of origin.

3. **Referral to a child**

   If USCIS finds that a prospective adoptive parent is eligible to adopt and approves the form I-800A, the primary provider sends the approval notice and homestudy to the Central Authority for the Convention country where the child is considered habitually resident. The foreign Central Authority then determines whether the prospective adoptive parent is also eligible to adopt under its country’s law. If so, the foreign Central Authority sends an official report on a specific

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10 In 2006, the Department designated two accrediting entities to perform accrediting functions—the Council on Accreditation (COA) and the Colorado Department of Human Services (CDHS) and published its Memorandum of Agreement with each Accrediting Entity in the Federal Register. The Department monitors each Accrediting Entity to ensure that it performs its functions in compliance with the Convention, the IAA and implementing regulations, other applicable law, and the respective Memorandum of Agreement.

11 Subpart F of the accreditation regulations (22 CFR 96.30-96.55) contains the standards that Accrediting Entities used in evaluating applicants for accreditation and approval.

12 See 22 CFR 96.12, 96.14, 96.44-46. The primary provider is identified as such on the Form I-800A Application for Determination of Suitability to Adopt a Child from a Convention Country.


14 For a detailed description of the Hague adoption process and additional guidance, please see: http://adoption.state.gov/about/how/hague.html See also www.uscis.gov (search “Hague Process”).

15 8 CFR 204.311. All forms are available on the USCIS website, www.uscis.gov For additional information on homestudy requirements in Convention cases, see http://adoption.state.gov/about/who/homestudy.html, www.uscis.gov (search “Hague Home Study Guidelines”).

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child, including information on his/her psychological, social, and medical history pursuant to Article 16 of the Convention. The parent has at least two weeks to review the report and decide whether to accept the referral.17

4. **Eligibility of the child to immigrate to the United States**

After the prospective adoptive parent accepts a proposed referral, he or she submits a form I-800, Petition to Classify Convention Adoptee as an Immediate Relative, to USCIS for provisional approval to adopt that particular child. If, based on available information, USCIS provisionally approves the form I-800, the prospective adoptive parent or his/her adoption service provider submits a visa application to a Consular Officer at the appropriate U.S. embassy or consulate. If, after a preliminary review, the Consular Officer also determines that the child appears to be eligible to immigrate to the United States, he/she will issue a letter to the Central Authority of the child’s country of origin pursuant to Articles 5 and 17, stating that, based on available information, the parents are eligible and suitable to adopt, the parents have received counseling, and the child will be authorized to enter and reside permanently in the United States. This letter also indicates the U.S. Central Authority’s agreement, under Article 17 of the Convention, for the adoption to proceed.20

A prospective adoptive parent(s) may not proceed with finalizing the adoption or obtaining custody for the purpose of adoption until the Department issues the Hague Adoption Convention Article 5/17 letter.

5. **Adoption/grant of custody for purpose of adoption**

When all of the previous steps have been completed, the prospective adoptive parent(s) must follow the legal process of the foreign Convention country to obtain an order of adoption or custody for the purpose of adoption.

6. **Obtaining documentation for the immigration of the child**

The prospective adoptive parent must obtain various documents, including a new birth certificate (if applicable) and the child’s passport from his/her country of citizenship to travel to the United States. Once the country of origin sends notification that the adoption or grant of custody was completed in accordance with the Convention and USCIS approves the I-800, the Department can issue a U.S. immigrant visa.

**Outgoing Cases**

The IAA and its implementing regulations mark the first U.S. federal regulation of cases involving children emigrating from the United States. Key steps in an outgoing Convention case are briefly summarized below:21

1. **U.S.-authorized entity performs child background study**

A public domestic authority or an accredited, supervised, or exempted provider performs a child background study for a child resident in the United States who is in need of a placement. The U.S.-authorized entity also obtains necessary consents.

2. **Reasonable efforts to find a timely domestic placement**

The public domestic authority, or the accredited agency or approved person makes reasonable efforts to find a timely adoptive placement for the child in the United States.

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16 For additional detail on the Article 16 Report, please see [http://adoption.state.gov/about/how/ hague.html](http://adoption.state.gov/about/how/hague.html)
17 22 CFR 96.49(k).
18 In the Hague Adoption Process, the form I-800 must be filed after the referral has been accepted.
19 See [http://adoption.state.gov/visas/hague.html](http://adoption.state.gov/visas/hague.html)
20 See 9 FAM 42.21 N14.8, 9 FAM 42.21 Exhibit VIII.
21 Please see [http://adoption.state.gov/hague/outgoing.html](http://adoption.state.gov/hague/outgoing.html) for a detailed description of the outgoing case process and additional guidance.
22 IAA § 303(a)(1)(A); 22 CFR 96.12, 96.13, 96.53.
in accordance with IAA § 303(a)(1)(B) and 22 CFR 96.54.

3. **Eligibility to adopt**
   A prospective adoptive parent(s) who is resident in another Convention country decides to provide a home for a child in need of placement who is resident in the United States. The prospective adoptive parent(s) has a homestudy prepared that meets the requirements of 1) the receiving country in which he/she is resident, 2) the U.S. State with jurisdiction over the adoption, and 3) 22 CFR part 97. The prospective adoptive parent(s) files any required application to adopt with a foreign authorized entity. The prospective adoptive parent(s) provides the homestudy, including a criminal background check, and any approved application to adopt to the U.S.-authorized entity.

4. **Referral to a child/proposed placement for the child**
   The U.S.-authorized entity transmits to a foreign authorized entity for approval the child background study, proof that necessary consents have been obtained, and a proposed placement, along with the reason for its determination that the proposed placement is in the child’s best interests, based on the homestudy and child background study and giving due consideration to the child’s upbringing and his or her ethnic, religious, and cultural background in accordance with Article 16 of the Convention.

5. **Eligibility of the child to immigrate to the receiving country**
   After the prospective adoptive parent(s) accepts a proposed referral, the U.S.-authorized entity must seek and obtain the authorization from the foreign authorized entity that the child will be able to enter and reside permanently in the receiving country.

6. **Adoption/grant of custody for purpose of adoption: U.S. state adoption court proceedings**
   U.S. State adoption laws and court procedures vary widely. In every case, the prospective adoptive parent(s) must petition a U.S. State adoption court with jurisdiction over the case to adopt the child, and must present all supporting evidence required by State law. U.S. State adoption court judges hearing outgoing Convention cases must verify information related to Convention requirements prior to issuing a final adoption order in an outgoing case.

7. **Hague Adoption Certificate or Hague Custody Declaration**
   It is recommended that any party involved in an outgoing adoption apply to the Department of State for a Hague Adoption Certificate or Hague Custody Declaration, certifying that a child has been adopted or custody of a child for purposes of adoption has been granted in the United States in accordance with the Convention. The Department of State will review the application, and either issue the Hague Adoption Certificate or Hague Custody Declaration, decline to issue it, or request additional information. If the Department does not receive required additional information within 120 days of the request, the application may be considered abandoned.

8. **Emigration of child to receiving country**
   The child and parent(s) obtain all documents required for the child to enter and reside permanently in the receiving country. Post-placement monitoring is performed, if required.

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23 IAA §303(a)(2)(B).
24 22 CFR 96.53(e).
25 IAA §303(a)(2)(C).
26 IAA §303(b), 42 USC § 14932.
27 22 CFR 97.2(a).
28 See 22 CFR 97.2(b).
29 22 CFR 97.2(c).
Annual Reports

Pursuant to IAA § 104, the Department submits an annual report to Congress covering a wide range of Convention implementation activities and information. The reports include:

- Accrediting entity monitoring and oversight activities
- Accreditation and approval fees
- Adoption statistics
- Visa processing for Convention adoptions
- Length of Hague Adoption Convention process
- Fees for Hague Adoption Convention adoptions
- Disrupted Hague Adoption Convention adoptions

Reports are available at http://adoption.state.gov/faqs.html30

Conclusion

In the two years since the Convention entered into force for the United States, the United States has issued over 2,300 Hague visas for children immigrating to the United States in Convention cases.31 The children and families involved in intercountry adoption deserve all available protections, and the Department is committed to its obligations as a member of the Hague Adoption Convention to support and sustain an intercountry adoption system with integrity, transparency, and the best interests of the child at its very center.

30 See the following links for Fiscal Year 2008 and 2009 Reports, respectively: http://adoption.state.gov/pdf/fy2009_annual_report.pdf; http://adoption.state.gov/pdf/Adoption_Report_v9_SM.pdf

31 This figure reflects the total number of IH-3 and IH-4 visas issued since April 1, 2008, at the time this article is written.
A Case for Ethical Intercountry Adoption

Marc Zappala and Chuck Johnson

Introduction

Throughout its history, intercountry adoption has had its detractors in the form of nationalists in other countries objecting to foreigners, usually Americans and other Westerners, providing loving homes and families to their country’s orphans. Recently, however, voices have been raised in the United States questioning the appropriateness of Americans adopting babies from foreign countries, typically those in the developing world. These advocates contend that the so-called demand for children to adopt far outstrips the number of available orphans, and that women are frequently coerced or tricked into making adoption placements for their children as a result.

The worldwide orphan population has been exaggerated by some, but there is little evidence to support the claim that the demand for children to adopt among Westerners exceeds the number of adoptable children worldwide. And while deplorable abuses of the intercountry adoption process do occur, these can and should be prevented through systemic reforms, enforcement of existing laws, and self-policing on the part of international adoption agencies. To shut down intercountry adoption, as some of its more radical critics suggest, would harm far more children than it would help and is therefore not an appropriate response to the problems facing the institution.

The History of Intercountry Adoption to U.S. Parents

Agency-sponsored intercountry adoption began in the United States in the mid-1940s, when American parents opened their hearts and homes to European children orphaned by World War II and the Greek civil war. Several thousand Asian-born children, a majority of them Japanese, were also adopted by American parents in the late 1940s and early 1950s. In the mid 1950s the number of intercountry adoptions to American parents increased dramatically as American couples began adopting children orphaned during the Korean War. Between 1953 and 1962, approximately 15,000 foreign-born children were adopted by American parents, and by 1976, the total number of foreign-born children adopted by Americans exceeded 30,000.1

As the number of children born abroad and adopted by U.S. parents has increased, the children’s countries of origin have diversified. For example, in every year from 1972 to 1987 save one, the majority of foreign-born children adopted by American parents were from the Republic of Korea. But in 2008, no single sending country was responsible for the majority of foreign-born adopted children. Children from Guatemala and China each comprised about 23 percent of the total number of children adopted internationally by U.S. parents. An additional 10 percent were

born in Russia, while the remaining 45 percent were born in countries as diverse as Ethiopia, Vietnam, Kazakhstan, India and Haiti.²

There are two reasons behind this diversification. First is the decision of more countries to open up to the practice of intercountry adoption as one way to provide for their orphan populations. Second is the Republic of Korea’s successful initiatives to promote domestic adoption, which have decreased the number of orphans available for adoption from that country. These initiatives were spurred largely by nationalist embarrassment over the number of Korean orphans being taken in by Americans.³ Thus, intercountry adoption has benefited not only those Korean orphans adopted by American parents, but also many Korean orphans adopted domestically.

**Criticisms Regarding the Size of the International Adoptable Child Population and Western Demand**

Domestic opponents of intercountry adoption increasingly argue that the demand among Western couples for healthy infants is far greater than the number of healthy infants available for adoption abroad. As a result of this disparity, such critics allege, women are tricked, coerced or bribed into making international adoption placements for their children, and children themselves are outright kidnapped by adoption service providers. As E.J. Graff argued in a recent opinion piece on intercountry adoption appearing in *Foreign Policy*:

> Yes, hundreds of thousands of children around the world do need loving homes. But more often than not, the neediest children are sick, disabled, traumatized, or older than 5. They are not the healthy babies that, quite understandably, most Westerners hope to adopt. There are simply not enough healthy, adoptable infants to meet Western demand.⁴

The majority of children Americans adopt from foreign countries have traditionally been very young. As recently as 2001, 89 percent of children adopted internationally were under the age of five.⁵ However, the percentage of children adopted internationally who were over the age of five—11 percent—is not insignificant. It is not true that Americans are unwilling to adopt children who are sick, disabled, or traumatized. On the contrary, the history of international adoption is one of Americans adopting children precisely from those areas of the world where children are least likely to be emotionally and physically healthy. For example, the mid 1970s saw a peak in the number of Vietnamese children adopted by Americans, who rushed to care for orphans created by that country’s conflict. And in 1991, following the fall of Communism and the United States media’s reporting of thousands of abandoned Romanian children living in terrible institutions, Americans adopted over 2,500 children from Romania alone.⁶

Also, while countries of origin often have systems favoring the adoption of younger, healthier children, Americans respond in significant numbers when foreign countries create systems for special needs adoptions. One example of this is China’s Waiting Child Program, through which thousands of Americans have adopted Chinese children with mild to severe special needs. Another example is Russia, which only allows Russian children with special needs to be available for international adoption, and from which thousands of children are adopted by Americans each year.

Having said that, it’s true that many Westerners would prefer to adopt healthy infants, for understandable reasons. Included among

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⁶ Ibid.
these reasons are the severe, negative effects of institutionalization on children’s cognitive and emotional development—effects which can be circumvented by the timely placement of orphans with loving families. Unfortunately, there is not enough data to know whether the global population of healthy, adoptable infants falls short of what would be necessary to meet Western demand. Opponents of intercountry adoption are often quick to point out that UNICEF’s estimate for the global orphan population is grossly inflated, which is true. UNICEF defines the term “orphan” to mean a child who has lost one or both parents to death or desertion. The overwhelming majority of the 133 million orphans that UNICEF estimates are living worldwide have only lost one parent to death or desertion, and would not be considered orphans as the term is commonly used and understood. However, this still leaves a global population of over 16 million “double orphans,” or children who have lost both parents to death or desertion. Many of these children are being cared for by aunts, uncles, cousins, grandparents, and other members of their extended families, but many are not. Many others may find their adoptive families in their own countries. But again, many may not.

Furthermore, it’s erroneous to assume that only those children in the developing world who have lost both their biological parents are adoptable. In 2002, the most recent year for which statistics are available, 22,291 women living in the United States made adoption placements for their child. In 1970, prior to Roe vs. Wade and changing cultural mores leading to greater acceptance of single motherhood, 175,000 American women made adoption placements for their children. Women in the developing world should have the same freedom from coercion, exploitation and solicitation in the course of making or considering adoption placements. (Sadly, poverty and a lack of education make women and their children especially vulnerable to human rights violations in this as in other areas.) Women in the developing world should also have access to the same type of family preservation services as do women in the West. Finally, an ethical intercountry adoption system would be one that sought to place a child internationally only after genuine and timely efforts to both preserve adoption placements are as unique as the women themselves and the circumstances surrounding their pregnancies. However, most American women who make an adoption placement do so in the hope that their children might have a better life. Like their American counterparts, women living in the developing world should have the opportunity to make adoption placements for their children without condemnation, either explicit or implicit, when they feel that doing so is in their children’s best interests. This opportunity may be all the more important to women in countries where poverty rates are high and access to family planning is minimal.

How the Hague Convention on Intercountry Adoption Helps Ensure Ethical Adoption Practices

Rather than argue over the size of the international adoptable child population and whether it is large enough to satisfy Western demand, we would like to propose methods to ensure that all intercountry adoptions are done in an ethical manner, with the best interests of the children involved paramount. Once such an ethical intercountry adoption system is in place and the laws governing it are strictly enforced, the question of whether there are enough adoptable children worldwide to meet Western demand will answer itself. We’ve already asserted that women in the developing world should have the same right as their Western counterparts to make adoption placements in the best interest of their children. We should add to this that women in the developing world should also enjoy the same freedom from coercion, exploitation and solicitation in the course of making or considering adoption placements. (Sadly, poverty and a lack of education make women and their children especially vulnerable to human rights violations in this as in other areas.) Women in the developing world should also have access to the same type of family preservation services as do women in the West. Finally, an ethical intercountry adoption system would be one that sought to place a child internationally only after genuine and timely efforts to both preserve...

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the child’s biological family (assuming the child is not an orphan) and to place the child in an adoptive family in his or her country of origin had been made without success.

To date, The Hague Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption, which over 75 nations including the United States have signed, represents the best international effort at ensuring an ethical intercountry adoption system. The Hague Convention requires each signatory nation to take appropriate measures to allow the child to remain in the care of his or her biological family and to prevent “the abduction, the sale of, or traffic in children.”10 The Convention also stipulates that the child’s parents or guardians must provide written consent to any adoption placement and that such consent may not be “induced by payment or compensation of any kind.”11 This stipulation is particularly important considering that poor parents in some developing countries will customarily leave their children in institutions where they may receive education, housing, or regular meals with the intention of retrieving them once the family’s financial situation improves. Finally, the Convention gives preference to domestic adoptions over intercountry adoptions, and requires that each signatory country’s central authority take “all appropriate measures to prevent improper financial or other gain in connection with an adoption and to deter all practices contrary to the objects of the Convention.”12

One frequent criticism of The Hague Convention is that it doesn’t cap the adoption fees paid to adoption agencies, but instead stipulates that such fees be “reasonable.” Reasonable fees are to be arrived at after taking into account both “the country in which the adoption services are provided and norms for compensation within the Intercountry adoption community in that country.”13 Some have alleged that allowing “norms for compensation within the Intercountry adoption community” to bear on what fees are considered reasonable allows international adoption agencies and their partners to charge however much they like, simply because other adoption agencies or service providers operating in the country are charging the same. This is worrisome. For while the majority of adoption service providers do good work and are motivated by humanitarianism, experience has shown that when the prospect of making large amounts of money by placing children for adoption in the United States or other Western nations becomes feasible, foreign adoption service providers who are motivated by greed also enter the system. Fortunately, if properly enforced, the stipulation to also consider “the country in which the adoption services are provided” should be sufficient to deter exorbitant fees and adoption abuses in Hague compliant countries.

**How Self-Policing on the Part of International Adoption Agencies Can Ensure Ethical Adoption Practices**

Recent adoption scandals in Cambodia, India and Guatemala involving international adoption agencies in the United States or Europe show that even experienced agencies may inadvertently partner with alleged child launderers and traffickers. International adoption agencies can protect themselves from unknowingly participating in such abhorrent practices in several ways. The first step agencies should take is to set and abide by guidelines for reasonable adoption services fees in each country of origin based on the costs of living and of comparable social services in that country. Agencies may wish to publish their reasonable fees guidelines on their websites in order to motivate other agencies to take similar measures to ensure the integrity of intercountry adoption. Furthermore, agencies should provide prospective adoptive parents with country-
specific guidelines and counseling on the dangers of acceding to additional fees, with the possible exception of elective donations to reputable orphanages to be paid after the child arrives in the United States. Finally, agencies should take it upon themselves to investigate allegations against staff members of any adoption services providers with which they partner as though these allegations had been made against members of their own staff.

In addition to setting and abiding by country specific guidelines for adoption services fees, international adoption agencies should also exercise extreme caution and restraint when operating or partnering with adoption services providers in non-Hague compliant countries. There has been a pattern whereby international adoption agencies descend on a recently opened, developing nation that lacks the means necessary to adequately oversee the adoption process, leading to allegations of widespread abuses and, ultimately, the complete closure of international adoptions from the recently opened nation. International adoption agencies simply cannot operate on the assumption that a developing, non-Hague compliant country is capable of providing proper oversight for each intercountry adoption. Furthermore, agencies must realize that there are those who would take advantage of their exuberance for placing orphans with loving families to make a profit without any regard for the wellbeing of the children involved.

An ideal way to ensure best practices is for an international adoption agency to oversee its own orphanage and child welfare systems in the foreign countries in which it operates. These orphanages, complete with their own staff members familiar with the country’s laws, language or languages and customs, would partner with state and private child welfare organizations in the country to ensure that intercountry adoption is the last option for children in need of permanency. By removing the need to partner with other adoption services providers, an international adoption agency may ensure that every intercountry adoption placement it facilitates is done ethically and is in the child’s best interests. It must be stressed that such orphanages cannot operate or provide services independently of the broader child welfare system. For example, any birthing center associated with such an orphanage must be made available to women in need of a safe place to give birth regardless of whether they plan to make an adoption placement for their child. Otherwise, the international adoption agency may unintentionally create an incentive (i.e. access to a safe birthing center) for women to make adoption placements for their children.

Having suggested this option, however, we should note that it is not a practical one in the majority of cases. Many countries prohibit non-state run orphanages, and many agencies simply don’t have the means necessary to run orphanages even in those countries where they would be allowed to do so. A more practical measure would be for agencies to ensure that the adoption services providers with which they partner are integrated as much as possible in that nation’s broader child welfare system. This will help ensure that an intercountry adoption placement is made for a child only after attempts at family preservation and domestic adoption have failed.

Conclusion: The Benefits of Intercountry Adoption to Adoptable Children Worldwide Make Ethical Intercountry Adoptions Indispensable

Since its beginnings in the 1940s, intercountry adoption has given hundreds of thousands of children who otherwise might have grown up in institutions or on the street the loving families that are so crucial to their development. Today, it offers the possibility of helping hundreds of thousands more. The immeasurable benefits of intercountry adoption to a child who would otherwise never enjoy the safety and security of a family make it all the more imperative that we prevent adoption abuses from being carried out in its name. Implementation of the Hague Convention on Intercountry Adoption...
among all sending countries is the first step toward ensuring ethical intercountry adoptions. However, self-policing on the part of international adoption agencies is vital to ensuring only ethical adoptions occur in both Hague compliant and non-Hague compliant countries alike. Perhaps most importantly, international adoption agencies should set and abide by their own fee guidelines for significant countries of origin which take into account the costs of living and comparable social services in those countries. Agencies that can afford to do so may want to run their own orphanages in those countries where non-state run orphanages are permitted. When this is not an option, agencies should work with credible child welfare organizations in sending countries to ensure that intercountry adoption is only an option after attempts at family preservation or domestic adoption have been tried and failed. Finally, agencies must exercise restraint and avoid overwhelming developing countries that open up to intercountry adoption as a way to provide for their orphans. The implementation of the Hague Convention by more countries and increased self-policing on the part of international adoption agencies will go a long way toward ensuring that intercountry adoption achieves its goal of helping adoptable children throughout the world find the loving families they need.
State of Adoption from China

Elisa Rosman

Introduction

In September 2009, the National Council For Adoption (NCFA) hosted a 13-member delegation from the China Center for Adoption Affairs (CCAA). Over the course of twelve days, NCFA helped to educate the Chinese officials on adoption practice in the United States and the experiences of children adopted from China.

This issue of the Adoption Advocate presents statistics on adoption from China and its recent decline, shares information from the CCAA delegation members, reviews current research on children adopted from China and their families, and concludes with a list of additional resources and suggested contacts for those interested in learning more about Chinese intercountry adoption.

The Decline in Adoptions from China

Since 2005, the year in which adoptions from China to the United States peaked at 7,906 children,1 there has been a steady decline in the number of adoptions from China, with just 3,852 in 2008. In 2008, the breakdown was as follows:

- 3,030 girls
- 822 boys
- 925 infants under 1 year
- 2,533 children aged 1 to 4 years
- 394 children aged 5 years and older2

Chinese adoption officials have attributed the recent decline in international adoption to several factors, including the decreased number of children entering orphanages, the growing number of domestic adoptions, and an increased interest among citizens of other countries in adopting Chinese-born children.

As the number of children available for adoption decreased, the Chinese government also established stricter standards for prospective adoptive parents. These new adoption policies established in May 2007 required all adoptive parents to be married and meet age, income, and education requirements. Prospective adoptive parents also cannot have a recent history of taking antidepressants, and cannot be obese.

Although recent statistics indicate there are still more girls than boys being placed for adoption in China, it is possible that the attitude towards infant girls in China is changing. A recent Time article quoted Joshua Zhong, the director of Chinese Children Adoption International in

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Colorado, who has observed a change in the way individuals in China view having a daughter: “I have friends [in China] who have girls, and they are just so excited.”

While China was once considered one of the most stable programs for parents adopting internationally, the wait time has recently become a much bigger factor—and an unpredictable one—for many families. American families who received referrals in August 2009 had waited over three years from the time their dossiers were logged in China, and many are concerned that the wait time will continue to increase. As a result of the longer wait times, many Americans are turning to China’s Waiting Child program, which is focused on finding families for older children and those with special needs. The visiting CCAA delegation confirmed to NCFA that approximately 50 percent of all intercountry adoptions now taking place are for children with special needs. During their visit, the CCAA delegation learned how adoption agencies are counseling and supporting those families planning to adopt children with special needs, and also took the opportunity to check on the progress of several of the children who have been placed through the Waiting Child program.

**The CCAA Delegation’s 2009 Visit**

In September of 2009, with NCFA as their national host, the CCAA delegation spent nearly two weeks in the U.S., traveling across the country to meet with adoption advocates, adoption agencies, government officials, and adoptive families.

At the conclusion of the visit, Mr. Lu Ying, head of the delegation and then-director-general of the CCAA, reaffirmed China’s commitment to intercountry adoption as a means of finding permanent families for many of China’s orphans. Director Lu also indicated that the CCAA intends to expand adoption opportunities for orphans in provinces with lower than average rates of adoption, particularly for children with special needs.

“I have a strong belief that cooperation with the United States will continue and go forward smoothly,” said Mr. Lu. “It is my sincere hope that we can work closely with the U.S. government, NCFA, and adoption agencies to the greatest extent possible to help the children living in orphanages in China flourish in loving, permanent homes.”

**Research**

This section provides a review of current research on children adopted from China. Overall, the message is quite clear: Most children adopted from China, though they often experience some delays when they first arrive home, tend to catch up within a relatively short period of time and are, in general, thriving with their families.

Research results are presented in the following areas:
- Growth and Development
- Behavior Issues
- Language Development
- Boys from China
- Adoption/Cultural Issues
- Family Dynamics

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**FREQUENTLY USED TERMS**

- Internal behavior problems: withdrawn, anxious, or depressed behavior
- External behavior problems: acting out, aggressive behavior
- Assessment: the process of documenting an individual’s knowledge, skills, etc.
- Expressive language skills: the ability to communicate one’s thoughts, ideas, needs, and wants through language
- Receptive language skills: the ability to understand communication from others

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Growth and Development


This study examined the growth and development of children adopted from China during their first two years with their adoptive families. The authors recruited the families of 70 girls who were adopted from China to Canada between the ages of 8 and 21 months (average age: 13 months). The girls were assessed within six weeks of arriving in Canada, and again six months, one year, and two years after their adoptions. The study investigators kept track of the children’s physical development (height, weight, and head circumference), cognitive functioning, motor functioning, and language development. At each age check, they compared the girls to a control group of 43 nonadopted Canadian girls.

Physical development: At the initial assessment, the children from China measured significantly lower than their nonadopted counterparts in both height and weight. However, over the next two years, their rate of growth was faster, narrowing the gap between the two groups. Furthermore, even though they were smaller than the children in the comparison group, the adopted children were all within the 50th percentile (of widely used North American norms) for height, weight, and head circumference by the one-year follow-up.

Cognitive development: The authors found that, while the adopted girls had, on average, lower cognitive scores at the time of their adoptions, they had caught up by the two-year check.

Motor development: The adopted children had significantly lower scores at the first time point, but were no different from their nonadopted peers by age three.

Language development: At six months post-adoption, the receptive language skills of the children from China were similar to those of their nonadopted peers. However, at the two-year follow-up, the adopted girls’ expressive language skills remained lower than their peers.

The authors concluded: “At two years post-adoption [the children adopted from China] resemble Canadian children from a similar family background in most areas of development” (p. 466).


These authors surveyed 240 families that adopted children from China between 1992 and 2001. Of these children, 69 percent were adopted in their first year, 80 percent were eighteen months or younger when adopted, and 98 percent were girls. The authors’ findings included the following:

- Sixty-two percent of families reported that their child had a developmental delay upon arrival in the United States, with motor delays being the most common.
- Fifty-two percent of families reported some kind of sleep problem, with the majority of these problems being categorized as minor.
- Nineteen percent of families reported problems with diet or eating; again, the majority of these issues were described as minor.
- Sixteen percent of families reported that their children had problems with social interaction.
- Thirteen percent reported problems with bonding.
- Seven percent reported that their children had been identified as gifted.
- Four percent had been referred for special education services due to special needs (note: for the final two percentages, it is important to remember that very few of the children were school-aged).
The authors concluded their study with the following recommendations for social workers, parents, and educational professionals:

- Children adopted from China should receive complete medical and developmental evaluations as soon as possible after their arrival in the U.S.
- Attention should be paid to the emotional health of the children.
- Families should be assisted in identifying local, state, and national resources for adoptive families, including support groups and parent “mentors” who have also adopted from China.
- Families should be encouraged to learn as much as possible about their child’s culture of origin so that they will be prepared to answer questions honestly and effectively.


This study investigated the physical, cognitive, motor, and psychosocial development of children in Quebec who were adopted before the age of 18 months. In order to determine the impact of differing pre-adoption experiences, this study included children adopted from China, East Asia, and Russia. The authors obtained data from the children at the time of their arrival in Quebec, then again three and six months later. The study included 58 children from China, 39 from East Asia, and 26 from Russia.

At the first assessment, the children from China and Russia were smaller than the children from East Asia, but the size of the Chinese- and Russian-born children increased more over the course of the next six months.

The study authors wanted to determine which factors might have played a role in the children’s different outcomes. They found that the children whose height, weight, and head circumference indicated better nutritional status upon arrival had somewhat higher cognitive and motor scores six months later. They also found that the children with low or high muscle tone, retarded growth, microcephaly, or other signs of neurological problems upon arrival tended to have lower cognitive scores later in the study.

Comparing the ages of the children at arrival, the study authors found that younger children, in general, showed more positive outcomes at the follow-up times of three and six months. They determined that the best predictors of mental and physical outcomes were the child’s age at arrival, height to age ratio, and neurological indicators. “Thus, it appears possible to change a deficient developmental trajectory associated with negative early experiences when medical signs are not extreme and when the depriving conditions are not sustained for a very long period,” the study concluded. “The qualities of the adoptive environment, including good parental schooling level, high family financial resources, and adequate parental practices, should also be considered as determinant factors when assessing the global improvement of the adopted children” (p. 455).

**Behavior Issues**

Dr. Tan conducts a longitudinal study to assess the development and adjustment over time of girls adopted from China by American families. Phase 1 of the study began in 2005 with a survey of 853 families (with a total of 1,123 children adopted from China). Phase 2 followed in 2007, when 674 of the families (representing a total of 842 girls) completed follow-up surveys.

The first article mentioned above addresses three primary questions:
1) How does the behavior adjustment of girls adopted from China change over time?
2) How does their suboptimal behavior change over time?
3) What role does the age of the girls at the time of their adoptions play in their behavior adjustment?

Dr. Tan divided the adopted girls into three groups: a preschool cohort (girls in preschool for both phases of the study); a transition cohort (girls who moved from preschool to primary school between Phases 1 and 2); and a school-age cohort (girls who were primary school age in both phases). Parents completed the Child Behavior Checklist (CBCL) in both phases, which provided scales for rating Internalizing Problems (e.g., anxiety), Externalizing Problems (e.g., aggression), and Total Problems.

There were changes in the girls’ CBCL scores over time. For the preschool cohort, their internalizing behavior scores increased between 2005 and 2007. For the transition cohort, there was an increase in all three areas. For the school-age cohort, there was no change in any of the three areas over time.

Dr. Tan also compared the girls’ scores to those of a “normative” sample in the United States. The preschool cohort of girls adopted from China scored significantly lower than children in the control sample; the transition group scored lower in Phase 1, but not in Phase 2; and the school-age cohort was similar to the comparison group in both in phases. Dr. Tan found a strong continuity in behavioral problems; girls who demonstrated these problems in Phase 1 were likely to continue them over time. Also, girls who were adopted over the age of 12 months showed higher rates of suboptimal behavior.

Dr. Tan’s study concluded with the following information for practitioners:
- Adopted Chinese girls’ early behavioral adjustment is predictive of their later adjustment.
- In some cases, primary school entry presented more challenges for the adopted Chinese girls than it did for their nonadopted peers.
- Girls adopted from China do not seem to have a higher risk for suboptimal behavior than nonadopted children.

Dr. Tan’s second article mentioned above explored the impact of pre-adoption adversity on outcomes for adopted children. This study focused on two primary questions:
1) How did preschool-aged girls adopted from China initially adjust to their adoptions, and how was their behavioral adjustment over time?
2) How is the initial adjustment and behavioral adjustment over time affected by age at the time of adoption, and by experiences of pre-adoption adversity?

This study surveyed 452 girls who were in preschool for both Phase 1 and Phase 2. Dr. Tan noted pre-adoption adversity by asking parents about a range of observable signs and symptoms, including lice/fleas, scars, rashes, etc. He also asked whether there were any developmental delays at the time of adoption.

Dr. Tan determined a child’s initial adjustment to adoption by asking her parents about their child’s behavior the first two weeks after adoption. For example, parents were asked if their child avoided
eye contacted during that period. As with the first study by Dr. Tan, the CBCL was used to describe behavior problems.

The data indicate that initial difficulties adjusting to the adoption, as well as developmental delays at the time of adoption, did in fact predict behavior problems at both Phase 1 and Phase 2. If a child was older at the time of her adoption or had experienced more pre-adoption adversity, she was more likely to have a difficult initial adjustment, but neither age nor pre-adoption adversity were necessarily predictors of future behavior problems.


The authors studied 44 families with adopted children from China. A total of 45 children were studied (one family had adopted two children from China), 39 girls and six boys. Because of the small number of males, the authors did not include the boys’ scores in their data analysis (this is common in studies of children from China due to the lower number of boys placed for adoption).

The authors used the Parent Rating Scale (PRS) of the Behavior Assessment System for Children (BASC) in order to learn parents' perceptions of their children’s behavior. The BASC gathers information in nine different categories of behavior problems: hyperactivity, aggression, conduct problems, anxiety, depression, somatization (overly sensitive to minor physical problems), atypicality (immature behavior that is considered unusual), withdrawal, and attention problems. Overall, behavior scores within these categories fell within the normal expected range.

The authors wanted to determine whether three different factors influenced the behavior scores: the child’s age at adoption, the child’s current age, and the length of time the child had been with his/her adoptive family. They found that, for age at adoption, there was no significant difference in behavior scores for children adopted before 18 months of age as compared to children adopted after 18 months of age. Concerning the child’s current age, all of the children’s average scores were within normal range; however, children over the age of three were described as having more hyperactive and aggressive behavior than children under three, while children in the younger age group were found to demonstrate more withdrawn behavior. Finally, comparing children who had been with their adoptive families for less than two years with those who had been with their families for more than two years, the authors found that the latter were more likely to score higher on the hyperactivity scale, the aggression scale, and the somatization scale.

In their conclusion, the study authors pointed out that some researchers suggest the behavior problems among children adopted internationally become much more apparent in adolescent years, so perhaps the children in this study were simply too young to experience those issues. This, they said, illustrates the need for long-term, longitudinal research of children adopted internationally.

The authors concluded: “While discrepancies exist, evidence from this study suggests that Chinese adoptees exhibit generally normal behavior patterns similar to international adoptees from other countries examined in prior studies. Although older children had higher hyperactive and aggressive behavior patterns than their younger peers, these behaviors were still well within normal behavioral expectation for preschoolers. The results are positive in that, at least at this relatively early stage of life, adoptees did not experience significant behavioral problems as a result of their experience” (p. 94).


This study examined the behavior problems in children who had been adopted after being
institutionalized by comparing children who were adopted post-institutionalization to adopted children who had never been institutionalized. The authors also examined the relationship between the child’s age at adoption and later behavior problems, and compared the rates of behavior problems based on the area of the world from which the children had been adopted.

This study included 1,948 adopted children in Minnesota between the ages of four and 18 at the time of the study, all of whom had been adopted between 1990 and 1998. Of these children, 899 made up the post-institutionalized group; these children had spent 75 percent of their lives prior to adoption in an institution. The comparison group consisted of 1,038 children who had spent less than four months in an institution. Three hundred seventeen of the children were from Russia/Eastern Europe, 1,062 were from Asia, 557 were from Latin America/the Caribbean, and 12 children were from other areas.

In order to determine behavior problems, parents completed the Child Behavior Checklist (CBCL). Most children did not exhibit any type of behavior problem. Of those who did, attention problems were the most common; however, even for post-institutionalized children who were 24 months or older at adoption, the number exhibiting behavior problems was still less than half the total sample.

Fifty-one percent of the post-institutionalized children were completely problem-free, while 11 percent demonstrated pervasive problems. In the comparison group, 65 percent demonstrated no problems, and five percent had pervasive problems. While long-term institutionalization did not predict either internalizing or externalizing behavior problems, adoption at the age of 24 months or older was a predictor of both.

Institutionalization did predict attention problems and social problems. The study authors found that length of time in the adoptive home was also a factor in both internalizing and externalizing problems; i.e., as a child’s time in the adoptive home increased, so did her scores on both of these behavior scales. It may be that problem behaviors become more apparent to parents as the children age.

The authors found that children adopted from Russia/Eastern Europe were more likely to exhibit behavior problems than children from other areas. They also noted that racial identity and being a member of a racial or ethnic minority could become more of an issue as the children age.

**Language Development**

- Speech-Language Development in Children Adopted from The China Project at the University of Alberta (multiple publications), http://www.rehabmed.ualberta.ca/spa/phonology/Ongoing.html

This project builds on previous results indicating that, for most preschool-aged children who are two or more years post-adoption, speech and language outcomes are very good. The authors hope to provide speech–language pathologists with a description of “normative” development for children adopted from China. The ultimate goal of the study is to create developmental charts for children adopted from China for use by parents and professionals.

In 2001, the study team began a longitudinal study of language development with over 150 children from the United States and Canada, with parents completing a questionnaire every three months until their child is approximately three years old. While this study is still in progress, preliminary findings can be shared. For children adopted before the age of one year, their vocabulary and sentence length at the end of the study is similar to those of a comparison group of monolingual, U.S.-born English speakers. Children adopted between 13 and 18 months communicate almost as well as those in the comparison group by six months post-adoption.

Team members also examined language skills and academic performance in school-aged children. Two separate studies used the Children’s
Communication Checklist, 2nd edition (CCC-2) and the Academic Competition Evaluation Scales (ACES) for children in elementary school. They found that the children adopted from China scored in the same range on the CCC-2 as their nonadopted, U.S.-born peers. On the ACES, the children from China scored as well or better than their nonadopted, U.S.-born peers.

Boys from China


Due to the relatively small number of Chinese boys placed for adoption, the bulk of research on intercountry adoption from China focuses on girls. This study was designed to provide a snapshot of boys adopted from China and their families.

For this study, 61 parents completed surveys. Forty-three of the boys in the study were adopted through the Waiting Child program (China’s adoption program for children with special needs, mentioned previously in this issue of the Adoption Advocate), with cleft lip and cleft palate the most common problems. Interesting findings include:

- Parents were generally not shocked to receive a boy, as 51 percent had requested a boy (in many cases, it was a specific boy identified via the Waiting Child program).

- Overall, families in this study received positive responses to their adoptions from friends and family, with 80 percent mentioning some form of positive response or a response no different from when they adopted a girl.

- Over half of the parents had no concerns specific to adopting a boy.

- The majority of parents voiced positive comments about their son’s adjustment, saying it was “easy,” “easier than expected,” or “the same as older kids,” etc.

- The children in this study appeared to have fewer sleep problems than has been reported in other studies of children from China. Fifty-four percent reported either no major sleep problems or described their children as sleeping particularly well (e.g., “our son is a great sleeper”).

- When parents were asked about the challenges unique to adopting a boy from China, they most often mentioned lack of support and/or a natural peer group for their son due to the predominance of adopted Chinese girls, as well as the difficulty in explaining to their son the reason for his abandonment.

Overall, the families in this study felt extremely positive about the process of adopting a boy from China, and were eager to share their experiences. The majority reported that their sons were adjusting well, sleeping well, and not presenting unique or overwhelming challenges.

When parents did voice a concern, it was typically in an area where progress can and should be made. First, families adopting sons from China need more resources, as the majority of families with children from China have adopted girls. Second, families adopting boys from China need help in framing their sons’ stories. The knowledge that boys are also adopted from China and a greater awareness of their experiences might also help change the way adoption stories are told in the Chinese adoption community at large. As one mother stated, “I wish that there was more knowledge about boys from China, that they do indeed exist. That it would be seen as normal and not an aberration.”

Adoption/Cultural Issues


This study examined the extent to which adoptive parents acknowledge and support their child’s cultural heritage. Parents were recruited via the
Internet, and 79 adoptive parents of Chinese-born children completed the survey. The 79 children represented were between the ages of 10 months and 11.3 years, and the average age at time of placement was 11.9 months. For this study, Dr. Rojewski used a cultural attitudes survey that he created.

He found that while parents only occasionally discussed adoption with their children who were under two years of age, the frequency of these conversations increased as the children grew older. In contrast, discussions focused on the children’s culture of origin did not change with age.

Parents were uniformly positive in their responses to questions about the benefits and importance of exposure to Chinese cultural heritage, the ability of their children to identity with both Chinese and American culture, the relevance of Chinese culture to personal adjustment, and the role of a child’s Chinese heritage in his or her personal identity. Among the children studied, their awareness of their Chinese birth culture increased from the youngest age group to the oldest age group. When asked about how Chinese culture and history were represented in home life, the largest portion of respondents said that they occasionally celebrated Chinese holidays or festivals, and parents reported that books were the most frequently used tool for learning about Chinese heritage (with videos, music, and art used less often).

The author concludes: “Very few parents either ignored or rejected the presence of Chinese cultural heritage in their families. Frequency of activity designed to recognize and integrate Chinese cultural heritage was consistent and fairly frequent across all three age groups, undoubtedly reflecting the strong beliefs parents had about the importance and benefits attributed to acknowledging cultural heritage. This strong commitment to acknowledging their child’s birth cultural heritage has been recognized (e.g., Tessler et al., 1999) as a defining characteristic of most parents with children adopted from China. Despite the strong commitment to acknowledge Chinese culture and heritage, parents did not report a growth in their knowledge about China and Chinese culture comparable with their child’s age” (p. 159–160).

**Family Dynamics**


This study explored the parent/adopted child relationship in middle childhood, comparing outcomes for children adopted from Romania with outcomes for children adopted from China. The study was based on questionnaires answered by parents, all with children between eight and 12 years of age. There were 80 mothers with adopted daughters from China and 54 mothers with adopted daughters from Romania. The researchers used the Child Behavior Checklist (CBCL) to determine children’s behavior problems, and studied mother–daughter relationships based on a survey they created.

Overall, the scores measuring the quality of the mother/daughter relationships were very high; e.g., 84 percent of all the mothers surveyed reported getting along very well with their daughters. However, the study authors did find that, compared with the sample of mothers who had adopted from Romania, mothers of daughters from China experienced more closeness, respect, trust, and better communication, and generally got along better with their daughters.

The authors suggested that one possible explanation might be the child’s age at adoption, with a younger age at the time of adoption associated with a more positive mother/daughter relationship. The level of behavior problems among children were significantly related to the mother–daughter relationship, with the children adopted from Romania demonstrating more problems overall. The authors noted that the children adopted from Romania were, on average, adopted at older ages, and therefore they were
exposed to longer periods of institutionalization than their Chinese counterparts: “The results of the current study extend those of previous research on international adoption by showing how attachment difficulties nested in different child welfare systems may affect the mother-daughter relationship by influencing its early trajectory” (p. 40).

Additional Resources and Contacts

University of Minnesota, International Adoption Project
http://www.cehd.umn.edu/icd/iap/About/default.html

University of Minnesota, International Adoption Medicine Program and Clinic
http://www.med.umn.edu/peds/iac/

TCU Institute of Child Development
http://www.child.tcu.edu/index.htm

China Adoption Research Program at the University of South Florida
Contact: Dr. Tony Tan,
adoptionstudyusf@yahoo.com

Dr. Nancy Cohen’s Longitudinal Study at the Hincks-Dellcrest Centre, Ontario, Canada
Contact: Dr. Nancy Cohen,
nancy.cohen@utoronto.ca

Dr. Karen Pollock’s Study of Language Development at the University of Alberta, Canada
Contact: Dr. Karen Pollock,
karen.pollock@ualberta.ca
Introduction

Ever wonder, given the media blitz over every failed adoption, how often it really happens? The media seems to focus on only negative stories, leaving the media consumer with a distorted sense of the danger and its frequency. Take, for instance, the lamentable case of Artyom Saveliev, the seven-year-old boy who was returned to Russia by his adoptive American mother in April 2010. Google reported over 2,500 media stories about this incident alone. Truth be told, failed adoptions such as little Artyom’s are actually quite rare.

After what undoubtedly took many months, much paperwork, and much money, Torry Ann Hansen traveled to Far East Russia three times to visit little Artyom in the Partizansk orphanage before adopting him. On the second trip, Ms. Hansen stood in front of a Russian judge and stated she wanted to adopt this child. A final adoption decree was issued based on her representations to that judge and the accompanying paperwork. Little Artyom was then given a Russian passport in his American name, Justin Artyom Hansen. Soon thereafter, the American embassy placed an IR-3 visa in his Russian passport, entitling Justin Artyom Hansen with American citizenship once he landed on American soil. He then lived with his adoptive mother in Shelbyville, Tennessee for over six months before she sent him alone on a one-way flight to Moscow to be greeted in the airport by a stranger she hired over the Internet.1

Once a contemplated adoption is finalized by court order or decree, as Artyom’s adoption was, it is legally binding. Throughout America, a parent cannot simply abandon her adopted son, any more than she can abandon her biological son. By placing her legally adopted son on an airplane with a one-way ticket to Moscow, Ms. Hansen arguably ran afoul of one or more state criminal statutes designed to protect children from endangerment or abandonment.2 To dissolve an adoption, the adoptive parent(s) must return to court to set aside the final adoption order or decree. Although there exists no single or central source for tracking adoption dissolutions in America, the data that are available suggest that dissolutions of final adoptions rarely occur.

Dissolution Rates

Few studies purport to measure dissolution rates. For those few, none appear to be comprehensive. Accurate data is hard to find in part because adoption records are often sealed. In 2003, the U.S. Government Accountability Office (GAO) reported that one percent of public agency adoptions that were finalized between 1999-2000 were later dissolved. The GAO further cautioned that the percentage rate of dissolution could rise


2 Although the laws vary from state to state, every state has at least one provision in its penal code to prevent the abandonment or endangerment of children. In fact, media reports indicated that prosecutors in both Shelbyville, Tennessee and Loudoun County, Virginia (where Artyom’s grandmother actually placed him on the plane bound for Moscow) investigated, at least preliminarily, the conduct of Ms. Hansen. See, e.g., Richmond Times Dispatch, No Loudoun Charges Planned In Russian Adoption Case, April 14, 2010. It appears that the prosecutor in Virginia did not pursue the case because Ms. Hansen lived in Tennessee. See ibid.
over time. Researchers Barth and Berry observed that dissolutions for infant adoptions is less than one percent, while the dissolution rate for older children is as high as ten percent. Other limited studies put the dissolution rates between three and six percent. Dissolution rates are predictably much lower than disruption rates, though the two are often erroneously cited as if they were synonymous.

Data from Adoption Agencies

In the absence of a reliable central source for the number of failed adoptions, the data maintained by the adoption agencies themselves appear to be at least facially valid. Many adoption agencies offer post-adoption services, and many adoptive parents utilize these services. As a result, when a problem first arises, adoptive parents typically turn to the agencies and the resources they provide. In addition, certain state and foreign laws require post-adoption home visits and the submission of post-adoption reports. During these legally required post-adoption visits, adoptive parents may on rare occasions ask the adoption agencies for help with a difficult placement or, on even rarer occasions, to find another family for the adopted child. Further, the contracts between the adoption agencies and the adoptive parents typically contain language calling for the adoptive parents to permit the agency to find another family for the adopted child in the event the adoptive parents are dissatisfied with the placement. Accordingly, dissolution data reported by adoption agencies appear to be reliable.

A quick survey of some of the adoption agencies in America reveals, perhaps unsurprisingly, consistent results. The adoption agency that placed Justin Artyom Hansen, World Association for Children and Parents (WACAP), reports a one percent dissolution rate after 34 years and over 10,000 placements (see www.wacap.org). KidsFirst Adoptions Services, an adoption agency in Indiana specializing in overseas adoptions, similarly reports only four dissolutions after 11 years and over 700 placements, or approximately one-half of one percent. Bethany Christian Services, one of the largest adoption agencies in the country reports that dissolution rates for 2009 were 0.3 percent for intercountry adoptions and 1.2 percent for infant adoptions.

These reports are consistent with the 2003 GAO report cited above. Although the media spotlight tends to find them, parents who return their legally adopted children are anything but representative of the tens of thousands who adopt every year in the United States. Well in excess of 99 percent understand that the adoption is final and thereafter they remain parents for life, as they would if they had been the birthparents.

Data Regarding Successful Adoptions

The data regarding successful adoptions in the United States, though rarely reported, are somewhat staggering. In 2009, Americans adopted an estimated 140,000 children in toto (Chuck Johnson, personal communication, May 6, 2010). Over the last ten years, Americans adopted between 12,700 and 23,000 foreign-born orphans.
each year. Since 1990, when Russia opened its doors to intercountry adoption, Americans have adopted over 60,000 orphans from Russia alone. An estimated 2.5 million children under the age of 18 in the United States are adopted and remain with their adopted parents, according to the latest governmental survey, the National Survey of Adoptive Parents. That survey also indicates that less than three percent of all adoptive parents say they “probably would not” or “definitely would not” adopt if they were given the choice to adopt their child again, while 87 percent stated that they “would definitely adopt” their child if they had the choice to do it again. These figures suggest that adoption in the United States is a whopping success, notwithstanding media stories to the contrary.

Conclusion

Why do misleading media stories matter? They matter to those who are contemplating adoption and those waiting to be adopted. They should matter to any society that wishes to invest in its future. In Russia alone, there are an estimated 700,000-800,000 children in orphanages. Only 15,000 or so (or roughly two percent) are adopted each year. The United Nations reports that there are an estimated 30-40 million children in the world who desperately need a home, with another 100 million at-risk for becoming orphans. A growing body of medical research further indicates that life in an orphanage is very detrimental to a child’s cognitive development. For the orphan who is never adopted, life beyond the orphanage is anything but promising. Indeed, one could argue that the existence of orphanages in any society is a ticking time bomb, given the high correlations between orphanage “graduates” and social pathologies. Any media attention, therefore, that fails to acknowledge that a failed adoption is in fact a rarity jeopardizes all contemplated adoptions, dashes hope for orphans, and imperils the future of the society that must embrace them as adults.

To put these numbers in perspective, the United Kingdom, a country of roughly 30 million adopts approximately 5,000 children each year, with some or so coming from outside its borders. See, e.g., www.baaf.org.uk The United States, a country that is roughly five times the size of the United Kingdom, adopts over 30 times more children in total, and 40-70 times more children via intercountry adoption each year.


Examining Intercountry Adoption
After the Earthquake in Haiti

Megan Lindsey

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Introduction

In January 2010, the earthquake in Haiti and its aftermath brought the longstanding debate over intercountry adoption and its place in the wake of an emergency to the public attention. This article summarizes and evaluates the United States’ response in Haiti relating to intercountry adoption, highlighting mistakes and successes in order to better prepare us for future events. It examines first two significant events relating to intercountry adoption following the earthquake, then reviews the Humanitarian Parole program offered by the U.S. government, and finally provides some recommendations for continued U.S. support in meeting the needs of children adopted through the Humanitarian Parole program.

Background

On January 12, 2010, a 7.0 magnitude earthquake shook Haiti. This disaster caused over 222,000 deaths and over 300,000 injuries. The effects were devastating in this already impoverished nation. It is estimated that there were already 380,000 orphans (children with one or two deceased biological parents) in Haiti in 2007. Additionally, many children with living parents live outside parental care due to poverty. Placing children in institutions or as restaveks is common practice in Haiti. The numbers of children in these forms of alternative care is unknown, but estimates are over 300,000. It is likely that these numbers have increased drastically in the face of this tragedy, but as efforts for family reunification are ongoing, the exact statistics remain unknown.

Timeline

The timeline of the major events pertaining to U.S. intercountry adoption after the earthquake in Haiti is as follows:

- January 12th—Earthquake hits Haiti
- January 18th—Special Humanitarian Parole Program announced
- January 19th—53 children arrive in Pittsburgh on a flight with Pennsylvania Governor, Ed Rendell
- January 29th—10 missionaries from the U.S. attempt to escort 33 Haitian children across the border to the Dominican Republic
- April 14th—U.S. closes Humanitarian Parole Program at request of Haitian Government
- April 29th—Haiti’s adoption authority, the Institut du Bien Etre Social et de Recherches (IBESR), alerts the U.S. government that

3 Restavek is a Creole phrase which means “stay with.” Restavek children are placed in the care of a family other than their own and work as domestic servants in exchange for room, board, and an education. Restavek Freedom Foundation. (nd). What is a Restavek. Retrieved from http://www.restavekfreedom.org/index.cfm?fuseaction=cms.page&id=1020
they are accepting new adoption applications for Haitian children who were documented as orphans before January 12, 2010 or who have been relinquished by birthparents since January 12th.

Reactions to the Earthquake and Lessons Learned

Major U.S. media outlets gave much attention to two events involving efforts to remove children from Haiti: a flight bringing 53 Haitian children to Pittsburgh, Pennsylvania on January 19th and the arrest of a group of U.S. missionaries on January 29th that had attempted to remove 33 Haitian children to the Dominican Republic. While both events point to valuable lessons, it is important to remember that these were isolated. The media attention they received was due in part to the uniqueness of the situations, and not because they represent the overall culture of child welfare or, more specifically, intercountry adoption in the U.S.

The Pittsburgh Flight

On Tuesday, January 19th, 53 Haitian-born children and supervising adults were flown to Pittsburgh. Pennsylvania Governor Ed Rendell, travelled with the group and helped to arrange for the children to leave Haiti. Rendell was contacted by University of Pittsburgh Medical Center regarding the children who had resided in Bresma Orphanage, a Haitian home for children operated by sisters and Pennsylvania natives, Ali and Jamie McMutrie. Rendell reported that adoptions were under way for 47 of the children: 40 in the U.S., four in Spain, and three in Canada. However, Ali and Jamie McMutrie refused to leave without all of the children and planned to find adoptive families for the remainder upon arrival. Only after special efforts by Governor Rendell and intervention by several social service agencies and the White House, was the full group given permission to travel by the U.S. embassy.4

By this time, the plane that had initially been arranged had returned to Miami. The group traveled on a military plane to Miami, where they met their original plane and continued the journey to Pittsburgh. In Pittsburgh, the children were bused to Children’s Hospital of Pittsburgh for medical evaluation before being united with either their adoptive parents or temporary foster homes.5

U.S. Missionaries

On January 29th, ten U.S. missionaries attempted to cross the border into the Dominican Republic with 33 Haitian children. The group was travelling on behalf of New Life Children’s Refuge, a non-profit started by two of the travelers. New Life Children’s Refuge states its purpose as a ministry created to support orphaned, abandoned, and impoverished Haitian and Dominican children by equipping “each child with a solid education and vocational skills as well as opportunities for adoption into a loving Christian family.”6 The group of missionaries was arrested by Haitian authorities while attempting to cross the border without appropriate documentation allowing them to exit Haiti with the 33 children. The children were then placed in the care of SOS Children’s Villages International. According to SOS, all 33 of the children had parents that they have since been reunited with.7 All kidnapping charges were dropped and nine members of the group were subsequently released (eight in February, and the ninth in March). Laura Silsby, the trip organizer, was charged and found guilty of trying


to arrange irregular travel for children. She was sentenced to time already served and released on May 17th.8

Lessons from These Two Incidents

Although both groups responsible for the above events can be presumed to be acting with the best of intentions, these incidents highlight areas of concern and opportunities for improvement in the transfer of children following major crises. Caring individuals should not be discouraged to respond. They should be encouraged to remember the value of responding with respect for the laws and long term consequences of actions instead of reacting emotionally.

Rules are not made to be broken—especially in an emergency

It is human nature to react emotionally in an emergency. One example of this is the McMutrie sisters demanding that all of the children come or none of them, despite several of the children in the group being ineligible to travel based on both preexisting laws and the Humanitarian Parole guidelines. The missionary group’s attempt to cross a border without any documentation for the 33 children is another example. The positive intentions of these groups are not in question; however, the stir these situations caused is of concern. It is especially important to enforce laws that were prepared by experts during times when crisis did not affect judgment.

Exceptions should be limited and based on the best interest of the children

The U.S. Humanitarian Parole Program is an example of a reasonable exception (as detailed later in this article). The number of those included was limited, and individuals were included based primarily on the extreme likelihood that the children meeting the requirements would have been permitted to enter at a later point in time. Other temporary travel arrangements for emergency medical care were also reasonable because of the limited capacity of medical care available in Haiti following the earthquake. Governor Rendell’s efforts are to be commended to the extent that the children in the group travelling with him met these requirements. However, there were several children travelling without any connection to anyone in the United States. A plan for their future was unsure, and it was not necessarily the most beneficial to them to remove them from Haiti only to place them in a new, unfamiliar place without a permanency plan. The exception made for these children was based on the political connections of Governor Rendell and the emotional response of the McMutrie sisters, when it should have been based on a plan that ensured permanent care for the children.

Small numbers does not equal small impact

Although these events directly affected only a very small number of children, these “small” incidents can have a large impact. It is important to remember that any time individuals act outside of their nation they act as representatives of it—particularly in the case of public officials such as Governor Rendell. Actions such as these have the potential to impact U.S. diplomacy with Haiti. Over time, a series of these events have the potential to build distrust, and can ultimately lead to limitations on intercountry adoption. This, in turn, could effectively cut off one potential permanency option for many children.

U.S. Humanitarian Parole Program

The U.S. Department of Homeland Security established a special parole policy as part of the U.S. government’s response to the earthquake. The program specifically addressed two groups of Haitian children:

- “those who had full and final adoptions completed by United States citizen parents before the earthquake” or,
- “[those] who were far enough along in the adoption process that both the governments of Haiti and the United States could verify the identity and eligibility of the children for adoption, and the United States government

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could confirm the suitability of the adoptive parents.”

Between January 18th and April 14th, 2010 parole was authorized for more than 1,000 orphans and as of April 5th, approximately 340 cases were still being considered. At the request of the Haitian government, the U.S. ended the Humanitarian Parole Program on April 14th and regular intercountry adoption processes were resumed between Haiti and the U.S. on April 29th.

The Humanitarian Parole Program is noteworthy because, as Joanne Ruppel, a senior Homeland Security official explained, “It’s not in the playbook.” Nothing like it has been done before. Unlike some previous responses, the program was carefully targeted to apply only to children confirmed to be available for adoption and only to adoptive parents who met U.S. requirements to adopt.

Arguments have been made that international regulations were not met, particularly in the case of Category 2 parolees. However, if expediting should make a process “as fast and efficient as possible, with no undue delay, while respecting the rules and process that the proper accomplishment of the task or procedure imply,” then it seems that this program made clear efforts to act quickly and ensure proper respect for Haiti by ensuring Haitian approval of every child who travelled. The U.S. program expedited the process only for children who were deemed appropriate for adoption and matched with a family before the earthquake, when normal procedures for matching and adoption completion were still in place. Further, it was required that both countries could confirm that children to be transferred were eligible for adoption by both Haiti and the U.S. In turn, Haiti responded to this program with due care, considering the many concerns facing the nation. By January 22nd, Prime Minister Jean-Max Bellerive had taken personal responsibility for signing off on all children leaving Haiti.

The benefits of adoption expedition through this program were many. First and most obvious, 1,000 children were removed from the immediate danger of emergent situations in Haiti including unsafe buildings, an increased risk of child trafficking, and limited access to food and medical care. Additionally, family placement offered not only permanence to children, but individualized care and attention that could help them cope with trauma suffered due to the earthquake.

Finally, many children who travelled through this program were removed from institutional care. It is well established that even in the best of institutions at the best of times institutional care cannot compare to that provided in the structure of a family. The Bucharest Early Intervention Project is a long-term study measuring the impact of institutionalization vs. family foster care. Their work has shown that once previously institutionalized children are placed in family environments they typically make rapid increases in affect and social interactions, as well as demonstrating other positive signs of growth.

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10 Ibid.
13 Ibid.
15 Ibid.
16 Ibid.
The structure of family care is always superior to institutional care. This is especially true in the wake of an emergency when resources at institutions are more limited than usual and caregivers are stretched by caring for many more children due to separation from or loss of parents.

Arguably, the benefits of the program reach beyond the children who found permanence with their new adoptive families. Their efficient exit offered caregivers the opportunity to give attention to other children who may have been separated from their families or orphaned during the earthquake. Important identification, family tracing, and future planning for these children became immediately necessary when the earthquake occurred. (Estimates vary, but sources say the earthquake may have tripled the number of children living without one or both parents in Haiti.)

How Legislation Can Help

The Humanitarian Parole Program was only the beginning of helping children adopted after the earthquake in Haiti. In order to be expedient, it could not account for every variable in state laws or the individual needs of every child. Following are some recommendations for continued legislative support to eliminate legal barriers to permanence and provide access to best practice support services that will help children and families to successfully transition past trauma, gain necessary support for any special needs they may have, and thrive as families.

Work is still in process to ensure that adoptions are finalized for every child that travelled under the guidelines of the Special Humanitarian Parole Program. One such effort to ensure this occurs is the Help Haiti Act of 2010. This act allows all children under age 18 who entered as humanitarian parolees to be granted legal permanent resident status and for adoption processes to be completed as necessary. Versions of the Help Haiti Act of 2010 passed the U.S. House of Representatives on July 20, 2010 and the U.S. Senate on August 4, 2010. Currently the bill is in a bicameral conference committee to reconcile differences in the versions passed by each chamber. Upon completion of this process, it will be sent to President Obama, who may sign it into law. This act will help alleviate any concerns adoptive families have about legal technicalities that may arise due to differences in state laws and the varying amounts of documentation available for children who entered the U.S. as humanitarian parolees.

Another piece of legislation that would benefit adoptive families, including those who have or will complete adoptions through the Humanitarian Parole Program, is the Supporting Adoptive Families Act. Introduced in the Senate on August 5th, 2010 by Senators Klobuchar, Landrieu, Brownback, and Johnson, this bill would help improve pre-and post-adoptive support services for American families in many ways including highlighting and providing funding for best practices developed in the private sector and establishing a grant program for states to develop relevant mental health programs for adoptive children and families. These services, valuable to any adoptive family, may prove especially important to families whose children have lived through a major trauma such as the earthquake in Haiti and its aftermath.

Conclusion

Continued support for both adoptive families and the children remaining in Haiti is crucial. The outpouring of care in the immediate aftermath—through financial contributions, service work, and best practice advice—should not fade away. Efforts must be made to not only meet previous standards, but to exceed them. As Kathleen Strottman, Executive Director of the Congressional


Coalition on Adoption Institute said, “We can go about making plans to provide protection to orphan children in temporary shelters until they can be returned to their orphanages, or worse, the streets, or we can take the recent outpouring of international support and use it to begin anew. Working together, we can help the people of Haiti to develop a child welfare system in which Haitian children are being raised in safe, loving and permanent families, not by institutions. Such a system could be built upon international best practices in preserving families, providing foster care, as well as promoting domestic and international adoption.”

In the wake of such tragedy, Haiti deserves a fresh start and the children of Haiti deserve the opportunity to grow up in a child welfare system that other nations will aspire to.

The Effect of the 2007 Tuberculosis Technical Instructions on the International Adoption Community

Cathy Crenshaw Doheny

History of the 2007 Technical Instructions for Tuberculosis Screening and Treatment for Panel Physicians

In order for internationally adopted children to be permitted to enter the United States for the first time with their new American parents, they are required to be screened for tuberculosis (TB), an infectious disease primarily affecting the lungs. In the United States, this screening is overseen by the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia, and has been created to help protect the public from an illness with a significant history of morbidity and mortality complicated by its contagious nature. These TB screenings affect not only children who have just been adopted from other countries; they also apply to all immigrants entering the United States. Since our current legislature does not recognize internationally adopted children as U.S. citizens upon adoption in their country of birth, but instead only allows citizenship to be made official for these children when they first enter the U.S., they are considered “immigrants” in their travels to America and are subject to the same regulations as all other immigrants.

In 1991, the CDC created a set of guidelines, known as the 1991 Technical Instructions for Panel Physicians, to be used to evaluate immigrants for a variety of conditions, including tuberculosis. At that time, the only requirements for TB screening included a chest X-ray and three lab-analyzed samples of sputum, a small amount of mucus from deep in the lungs. As the CDC began to discover deficiencies in this screening protocol (i.e., people were screened, but still imported the disease), it was determined that a more precise method needed to be developed. In order to accomplish this, the CDC collaborated with the National Tuberculosis Controllers’ Association, the Advisory Council for the Elimination of Tuberculosis, and the National Council for the Elimination of Tuberculosis (now known as STOP TB USA) to develop updated technical instructions. These new screening guidelines became known as the 2007 Technical Instructions for Tuberculosis Screening and Treatment for Panel Physicians and were differentiated from the 1991 Technical Instructions (TI) primarily by requiring immigrants suspected of having TB to undergo sputum culture testing, a test in which the sputum sample is placed in a petri dish to see if TB bacteria grows over a period of time. In addition, the 2007 TB TI require directly observed therapy (DOT). This means that, if an immigrant tests positive for TB, his treatment must start before arrival in the United States, and medical staff must observe him in person as he swallows each dose of TB drug.1

The CDC began implementing the 2007 TI on a country-by-county basis beginning on April 9, 2007 in Thailand.2 They have added a few countries each year, in hopes of eventually

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implementing them in all countries. The order of implementation is based on a country’s number of immigrants coming to the United States, the number of refugees resettling in the United States, the health care resources in the country, the rates of TB in the country, and the rate of TB among immigrant groups in the United States. Countries already affected by the 2007 TI that also offer international adoption programs currently open to American citizens include:  

- Thailand (beginning April 9, 2007)  
- Mexico (October 1, 2007)  
- Philippines (October 1, 2007)  
- Nepal (December 13, 2007)  
- Hong Kong (November 3, 2008)  
- Dominican Republic (February 2, 2009)  
- Uganda (March 2, 2009)  
- Ethiopia (April 1, 2009)  
- Taiwan (April 1, 2009)  
- Japan (June 1, 2009)  
- China (July 1, 2009)  
- Haiti (October 1, 2009)

Case Studies

Case summaries of three families who experienced delays and hardships because of the 2007 TB Technical Instructions follow.  

**Family Adopting from the Philippines Experiences Nine-Month Delay Due to 2007 TB Technical Instructions**

On August 26, 2008, after a 13-month wait, Michelle and Philip Crombie of Florida received a referral for their future daughter, Jaylee, who they were adopting from the Philippines. With her new family expecting to travel to bring her home in January of 2009, Jaylee’s I-600 and visa paperwork were finalized by November 13, 2008. However, Jaylee was not allowed to travel at that time because she had tested positive for TB in June of 2008. Even though she had immediately been started on anti-TB treatment and had completed that regimen in December of that year, the CDC did not recognize it as sufficient, stating that she had not received DOT.

In March of 2009, Jaylee’s application for a visa was once again denied after a diagnosis of TB could not be ruled out. A gastric lavage, a procedure to collect morning sputum samples via a tube into her stomach, was scheduled for July 1-3, 2009. The Crombies were requested to not only consent to the procedure, but to pay for it at a cost of $578.

“We are told that the TB culture will be read on August 28,” said Michelle Crombie. “We are at the mercy of a group of panel physicians holding the life of our child in their hands. The CDC and group of panel physicians in all countries need to be educated as to the adoption process, the health conditions of these children, and their medical, physical and psychological needs. There is so much more to adoption than deeming these children fit for travel. The bottom line is that these orphaned children need homes, not more obstacles to overcome.”

Jaylee’s culture was negative on August 28, 2009, and she received her follow-up visa medical exam on August 31. The Crombies received their travel approval that day, left for the Philippines on September 13, and were united with their new daughter five days later.

**Family Must Temporarily Leave Newly Adopted Daughter in China Due to 2007 TB Technical Instructions**

Candace Litchford and Jay Scruggs of Virginia were in China in July of 2009 when they were informed that their newly adopted four-year-old had tested positive for TB. Candace and Jay were in the process of completing the adoption paperwork. In August, they were told by the U.S. embassy in Beijing that Jay’s I-600 and visa paperwork were finalized, but that she could not travel because she had tested positive for TB. Candace and Jay’s hearts sank. They had been in China for a month, had spent $15,000 to adopt Jay, and were told that Jay had to be treated for TB.

Candace and Jay reluctantly left without their daughter. “We had to leave her here,” said Candace. “We were willing to do anything to bring her home.”

Jay’s culture was negative on August 28, 2009, and she received her follow-up visa medical exam on August 31. The Crombies received their travel approval that day, left for the Philippines on September 13, and were united with their new daughter five days later.

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5 All information contained in the case studies below was obtained through interviews with the subject families.
old daughter Harper Yue Ye Scruggs had been diagnosed with TB two months prior to her adoption and would not be allowed to travel home with them as they had planned. They had been told prior to traveling that the child did not have TB and had, in fact, tested negative on three occasions using purified protein derivative (PPD) skin tests. Already having been administered a triad of anti-TB drugs for over a month, Harper had three sputum smear results that were negative for TB, as well as one sputum culture that was negative. Her chest X-ray also indicated that her lungs were clearing and that the medications were working. However, the CDC would not accept the sputum culture processed in the hospital in China because it was not done by a CDC approved lab, was not the right type of test, and was only one of three positive test results that would be required.

As the new sputum culture results would take at least 42 days to process, Candace Litchford and Jay Scruggs felt they had no choice but to temporarily return home to the U.S. without their daughter in order to attend to their jobs and six-year-old son. Unable to imagine the prospect of handing Harper back over to the state, the couple reached out to the adoption community that had rallied around them in their crisis.

“People, many of whom we had never even met from all over the country, contacted us through our blog6 and offered their ideas and contacts,” said Litchford. “In fact, that is how we were able to find the American foster family who is caring for Harper in China until we are allowed to bring her home.”

Back in Virginia without Harper, Litchford and Scruggs made repeated attempts to petition the CDC to sign a waiver that would allow an exception to their policy to be made. Finally, on August 24, 2009, administrators at the CDC signed the waiver, allowing Harper Yue Ye to come home to her parents and her new country.

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Italy Welcomes American Family with Adopted Ethiopian Child when 2007 TB Technical Instructions Banned Them from U.S.

Marily Nixon and Luca Rigotti of North Carolina traveled to Ethiopia on July 25, 2009 to pick up their four-year-old adopted daughter, Tsehaynesh. They expected to only spend two weeks away from home, but quickly realized that was not going to be the case when their new daughter had a positive PPD skin test, followed by a “suspicious” chest X-ray. The couple was then told that sputum cultures, which could take eight to ten weeks, would need to be completed before Tsehaynesh would be allowed to travel. Unable to imagine leaving their daughter in Ethiopia or staying there themselves for an extended amount of time, they traveled to Rigotti’s native homeland of Italy, where he still held citizenship. The Italian government welcomed the family, provided medical care for Tsehaynesh, and was sympathetic to their plight.

“The Italian media has been very interested in our case. The major Italian newspaper, Corriera della Sera, ran a front-page article about our plight,” said Nixon. “The stories convey the Italians’ disbelief at the unnecessarily harsh policy of the U.S. government, which forced us to take months out of our lives and move temporarily to another country to provide our child adequate medical care.”

Despite the fact that Tsehaynesh received a clean bill of health from the finest doctors in Italy, she still was not allowed to come home until the CDC personally provided medical clearance two and a half months after Nixon and Rigotti first arrived in Ethiopia. The 2007 TB Technical Instructions were revised the very next day to take into account the special circumstances of pre-adolescent immigrants being screened for TB.

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6 You can visit Jay Scruggs’ blog at http://jayscruggs.livejournal.com/
National Council For Adoption (NCFA) and Joint Council on International Children’s Services (JCICS) Rally the Adoption Community to Take Action

As word of the difficulties these families experienced spread across the Internet and many from the adoption community expressed a desire to help, NCFA, JCICS, and many other organizations quickly organized initiatives to help bring about change. JCICS created the Build Families, Not Barriers petition, which states: “We, the undersigned, call on the CDC to eliminate the new TB protocols for children adopted abroad by U.S. citizens on the grounds that they are unnecessary for this population. Implementations of the protocols for children adopted abroad by U.S. citizens are not in the best interest of this vulnerable population and create unnecessary delays. Additionally, the protocols deny adopted children of U.S. citizens the right to U.S. medical care, while children of U.S. citizens who are born abroad are exempt. We request this change in order to ensure more children live in permanent, safe, and loving families. We ask the U.S. government to help build families, not barriers.” They also encouraged concerned individuals to contact members of Congress to take action to exempt this population of adoptees from the CDC’s policy.

There were three main points of concern from the advocacy organizations with the 2007 TB Technical Instructions as they applied to children being adopted internationally. The first of these was the policy’s reliance on sputum cultures, which are not effective screening tools for pediatric tuberculosis. According to Dr. Jeffrey Starke, a professor at Baylor College of Medicine, Chief of Pediatrics at Ben Taub General Hospital, Infection Control Officer at Texas Children’s Hospital, and pediatric tuberculosis expert, most children have a dry cough and do not produce sputum. “In the rare instance that the child does produce sputum, only 20-30 percent of the samples can actually be cultured to check for the germ,” said Starke.

The second point of concern was that pre-adolescent children are not contagious, unless they have the adult form, which carries only an infinitesimal risk. Starke states that children under the age of 12 are only able to transmit the disease in less than a fraction of one percent of cases. “In children less than 10 years old, the adult form of TB is extremely rare. In these cases, it is very apparent that these children have the adult form, as they have all of the symptoms that adults have, including a cough that produces sputum,” Starke adds.

The last main point of concern with the 2007 TB Technical Instructions was the fact that adoptions from China and Ethiopia are finalized prior to the initiation of this testing. This meant that the children were legally the sons and daughters of U.S. citizens and were being denied access to U.S. medical care. “Though we applaud the CDC for the work that they do, they have unfortunately developed an overreaching policy that’s not appropriate for this particular population and cannot exist in a vacuum to achieve its purpose. They need to take into consideration the legal citizenship issues and diplomatic ramifications. Chapter 1, Article 1 of the Hague Convention states that the main objective is ‘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.’ The CDC’s policy is clearly not in the best interest of these children,” said Thomas DiFilipo, president and CEO of JCICS.

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CDC Revises 2007 TB Technical Instructions for Applicants Ten Years of Age or Younger

All of the advocacy efforts paid off. In an act that would typically take years to come about, the CDC provided an addendum to the policy just five months after beginning talks with key organizational leaders. This addendum allows children aged 10 and younger requiring sputum cultures to travel immediately to the U.S. while the results of the cultures are still pending, if NONE of the following conditions exist.  

- Sputum smears are positive for acid-fast bacilli (AFB)
- Chest X-rays include one or more cavities
- Chest X-rays show extensive disease (particularly involving both upper lobes)
- Respiratory symptoms include forceful and productive cough
- Known contact with a person with multi-drug resistant TB (MDR TB) who was infectious at the time of contact

This revision represents the profound effect that the adoption community can achieve when it bands together for the greater good of orphans worldwide and the families who strive to provide to them stable and loving homes.

9 For further information see: http://www.cdc.gov/immigrantrefugeehealth/exams/ti/panel/tuberculosis-panel-technical-instructions.html
Parents’ Reports of Their International Adoption Experience

Karyn B. Purvis, Shanna K. Mittie, David R. Cross and Kelly L. Reed

Introduction

Families experience unique and often unanticipated challenges throughout the adoption process. However, comprehensive data pertaining to families’ experiences and the impact of those experiences is lacking. Challenges include meeting the ever-changing physical, emotional, and cognitive needs of an adopted child, as well as changes in family and marital dynamics, social support and financial considerations.

Families who adopt internationally often face more difficulties.

International Adoption and Institutional Care

More than 17,000 immigrant orphan children were adopted by U.S. citizens in 2008, with the highest numbers originating from Guatemala and China. Unfortunately, most of these children are cared for in institutional settings before adoption, which puts them at risk for potential developmental disorders, especially regarding attachment, self-regulation, aggression, and peer relationships.

Characteristics associated with institutionalization include: inadequate medical care; malnutrition; poor sanitation; contact with environmental toxins; exposure to infectious diseases; few stimulation opportunities for language and communication; inconsistent and inexperienced caregivers; and possible abuse.

Researchers have revealed that post-institutionalized adopted children exhibit some degree of behavioral, medical, emotional, and language difficulties at the time of adoption\textsuperscript{17, 18} and often persisting long-term.\textsuperscript{19} The longer a child is reared in an institution, the more likely he or she is to suffer developmental, emotional, and behavioral problems, which can be especially challenging for new families.\textsuperscript{20}

**The Texas Christian University (TCU) Survey**

The TCU Survey was developed to gain a better understanding of parents’ international adoption experience and its impact on their family system. It consists of more than 100 questions regarding: (1) parents’ knowledge of their adopted child’s orphanage experience; (2) behavioral characteristics of their adopted child; (3) use and effectiveness of intervention strategies; (4) familial stress; (5) sources of support; and (6) how well prepared they were for international adoption.

**Survey Responders**

Fifty-two surveys were completed by families who had adopted a child from outside the United States. Surveys were completed by mothers (61 percent), fathers (21 percent), both (seven percent), and unknown (11 percent). Most responders were married, middle-class professionals with higher education. Prior to adoption, more than half had no biological children residing in their home (55 percent zero; 45 percent one or more).

Their adopted children ranged in age from two to 17 years at the time the surveys were completed ($M = 8.45$, $SD = 3.95$). Fifty-five percent of adopted children were males, and 45 percent were females. Most were adopted from Russia and Eastern Europe (71 percent Russia, 16 percent Romania, four percent China, three percent South Korea, two percent Thailand, two percent Ukraine, and two percent Vietnam). Their ages at adoption ranged from 2.5 months to 15 years ($M = 5.67$, $SD = 3.88$). Their length of stay in an institution ranged from 2.5 months to 14 years ($M = 3.43$, $SD = 2.76$). The average length of time spent in the adoptive home ranged from one month to 8.22 years ($M = 2.78$, $SD = 2.03$).

**Survey Responses**

Regarding parents’ knowledge of their child’s orphanage experience, many reported some desirable conditions and a plethora of undesirable conditions (see Table 1). When parents were asked to think back about their child’s behavior, many parents reported that their child displayed many internalizing behaviors (e.g., anxious, excessive eating, etc.) during the initial months after adoption. Although parents’ reported improvement in internalizing behaviors of their child, they reported deterioration in most of their child’s externalizing behaviors (e.g., manipulation, attention deficit, lying, etc.). Parents did report improvement in most of their child’s pro-social behaviors since the adoption, and significant improvement for talkative, extroversion, and outgoing behaviors (see Table 2). Unfortunately, between 20 and 30 percent of these children continued to be at risk. These percentages were calculated from parents reporting three or more internalizing behaviors, three or more externalizing behaviors, and/or one or fewer pro-social behaviors (see Table 3). In addition, approximately 27 percent to 44 percent reported that their child continued to experience delays of some kind (e.g., communication skills, developmental skills, height or weight compared to peers, and academic or social participation), and mostly multiple delays (see Table 4 and Figure 1).


Factors Related to Behavior

Analyses were computed to determine whether or not certain variables qualified as risk factors for these adopted children’s behaviors. Length of adoption was examined and was found to be significantly correlated with change in overall combined developmental delays ($r(48) = -.32, p < .05$) and with change in overall combined externalizing behaviors ($r(49) = .32, p < .05$), but not with change in internalizing or pro-social behaviors ($p > .50$). These statistically significant correlations indicate that children who had been with their adopted families the longest were somewhat more likely to show improvement in delays, but deterioration in externalizing behaviors. Although length of adoption was the only variable to predict change in overall combined externalizing behaviors, change in overall combined delays was predicted also by age at adoption ($r(48) = .34, p < .05$), suggesting that children who were older at the time of adoption were somewhat less likely to show improvement in delays.

Change in overall combined pro-social behaviors correlated with length of institutionalization ($r(48) = -.39, p < .05$), age at adoption ($r(48) = -.32, p < .05$), and current age ($r(48) = -.34, p < .05$), indicating that children whose pro-social behaviors improved the most were more likely to (a) have shorter institutional stays, (b) be younger when adopted, and (c) be younger when the survey was administered. These overall findings are consistent with others’ findings that children adopted at an older age are more likely to have persistent problems.\(^{21,22}\)

Intervention Strategies

Parents reported the interventions they had attempted and how effective those interventions were at meeting their adopted child’s needs. On average, parents reported that they had tried approximately four different types of interventions ($M = 4.3, SD = 2.8$). The number of interventions attempted ranged from zero to 14 (see Figure 2). Parents rated their interventions on a scale of one (counterproductive) to four (very effective). Detailed interventions attempted by families can be seen in Table 5.

Children’s overall combined developmental delays were significantly related to the number of interventions tried at the time of adoption ($r(47) = .49, p < .001$) and at the time of the survey ($r(47) = .35, p = .015$). This suggests that parents who reported significantly more delays also attempted more interventions.

Familial Stress

Thirty-five percent of parents surveyed reported financial stress from adopting their child. Thirteen percent reported significant financial loss. Forty-two percent of the parents reported having to cut back their work hours, or quit their jobs to care for their child. Statistical analyses revealed that stress was highest during the initial period following adoption rather than prior to adoption, or at the time of this survey (see Figure 3).

Sources of Support

Parents answered questions regarding the social, emotional, and physical support that they received from their spouse, friends, children, parents, extended family, and neighbors prior to adoption, during the period initially following the adoption, and currently (see Figure 4).

Parent Preparation by Adoption Agency

Fifty-five percent of parents surveyed believed they were not well prepared for their adoption. Only seven percent reported that they were “definitely” prepared. Furthermore, most adoptive parents believed they were uninformed about the potential consequences


of institutionalization, and some thought they had inadequate information regarding their adopted child.

**Encouraging Findings**

Nearly two-thirds of the parents surveyed reported that their child showed significant improvements in behavior from the time that they were adopted until the time of this survey. Again, these findings were more pronounced for children who had shorter institutional stays, were younger when adopted, and were younger when the survey was administered. Children adopted at younger ages tend to develop normally in many domains.23

**Conclusion**

Further research is needed regarding internationally adopted children and what types of interventions are most effective for them. Moreover, there is a need for adoptive parents to be better informed concerning the effects of institutionalization as well as the health and wellbeing of their adopted child. The Trust Based Relational Intervention® (TBRI℠) developed at the TCU Institute of Child Development is an emerging intervention for a wide range of childhood behavior problems. The TBRI℠ approach emphasizes the integration of a research–based framework to utilize when working with at-risk children. TBRI℠ helps to inform parents and professionals about the complexities, skills and strategies designed to help create healing environments for these adopted children. For a complete description of TBRI℠ and principles and practices used to help caregivers empower their children see Cross, Parris, and Purvis in this edition, *Adoption Factbook V* (Section 8).

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<table>
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<th>Orphanage Conditions</th>
<th>% “Yes”</th>
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<td>Bathing &amp; Grooming</td>
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<td>47</td>
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<td>Availability of Toys</td>
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*NOTE: Percent of parents who responded “Yes” to each question, and on the far right, the number of parents who were confident in their reports.*
### Table 2. Reported behavior characteristics of the adopted child

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<tr>
<th>Time Frame</th>
<th>Type of Behavior</th>
<th>Adoption</th>
<th>Survey</th>
<th>Chi-sq.</th>
<th>Sig.</th>
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<td>22.4</td>
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<td>Excessive Eating</td>
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<td>Shy</td>
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<td>8.2</td>
<td>11.27</td>
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<td>Rocking</td>
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<td>32.7</td>
<td>4.57</td>
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<td>Bold</td>
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NOTE: Percent of families who reported each behavior during the initial months after adoption and at the time of survey (N=52).

### Table 3. Overall combined score for reported itemized internalizing, externalizing, and pro-social behaviors of adopted children after the initial months of adoption and at the time of survey

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Type of Behavior</th>
<th>Adoption</th>
<th>Survey</th>
<th>% At-Risk</th>
<th>Mean (S.D.)</th>
<th>% At-Risk</th>
<th>Mean (S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internalizing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.2 (2.1)</td>
<td>1.2 (1.5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Externalizing</td>
<td></td>
<td></td>
<td></td>
<td>1.9 (1.7)</td>
<td>1.8 (1.8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pro-social</td>
<td></td>
<td></td>
<td></td>
<td>1.8 (1.7)</td>
<td>2.7 (1.5)</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Includes percent of children considered at risk during both time periods.

a “At-Risk” is defined as three or more behaviors checked by the parent.
b “At-Risk” is defined as one or fewer behaviors checked by the parent.

### Table 4. Percent of families who reported delays at the time of adoption and at the time survey was completed (N=50)

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Type of Delay</th>
<th>Adoption</th>
<th>Survey</th>
<th>Chi-sq.</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internalizing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communication Skills</td>
<td>46.9</td>
<td>26.5</td>
<td>11.00</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Developmental Skills</td>
<td>58.0</td>
<td>32.0</td>
<td>11.33</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Height Compared to Peers</td>
<td>58.0</td>
<td>34.0</td>
<td>12.74</td>
<td>**</td>
</tr>
<tr>
<td></td>
<td>Weight Compared to Peers</td>
<td>64.0</td>
<td>32.0</td>
<td>16.50</td>
<td>**</td>
</tr>
<tr>
<td></td>
<td>Academic Participation</td>
<td>62.8</td>
<td>44.2</td>
<td>7.53</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Social Participation</td>
<td>62.0</td>
<td>40.0</td>
<td>9.57</td>
<td>*</td>
</tr>
</tbody>
</table>

NOTE: McNemar’s Test of Symmetry (df=5)

a Statistical Significance: +p<.10, *p<.05, **p<.01
Table 5. Average ratings of how effective the interventions attempted were as well as the number of families trying them (scale of 1 to 4)

<table>
<thead>
<tr>
<th>Type of Intervention</th>
<th>Avg.</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Intervention</td>
<td>3.7</td>
<td>27</td>
</tr>
<tr>
<td>Early Childhood Intervention</td>
<td>3.6</td>
<td>10</td>
</tr>
<tr>
<td>Parent Counseling</td>
<td>3.6</td>
<td>8</td>
</tr>
<tr>
<td>Literature Resources</td>
<td>3.5</td>
<td>15</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>3.4</td>
<td>16</td>
</tr>
<tr>
<td>Special Education</td>
<td>3.4</td>
<td>29</td>
</tr>
<tr>
<td>Child Care Facility</td>
<td>3.4</td>
<td>13</td>
</tr>
<tr>
<td>Sensory Integration Therapy</td>
<td>3.3</td>
<td>6</td>
</tr>
<tr>
<td>Parent Support Group</td>
<td>3.2</td>
<td>14</td>
</tr>
<tr>
<td>Family Counseling</td>
<td>3.1</td>
<td>7</td>
</tr>
<tr>
<td>Parent Education</td>
<td>2.8</td>
<td>10</td>
</tr>
<tr>
<td>Child Counseling</td>
<td>2.8</td>
<td>13</td>
</tr>
<tr>
<td>Play Therapy</td>
<td>2.3</td>
<td>8</td>
</tr>
<tr>
<td>Inpatient Treatment</td>
<td>1.7</td>
<td>9</td>
</tr>
</tbody>
</table>

NOTE: Only interventions tried by six or more families are shown.
Figure 1. Percent of children with reported delays at the time of adoption and at the time of survey. This figure illustrates significant improvement in all six delay variables.

Figure 2. Number of interventions attempted, as well as the number of adopting families who attempted each intervention (N=51).
Figure 3. Parents’ reported levels of stress for the mother, father, and siblings prior to the adoption, during the initial months after adoption, and at the time of survey (4 = “Very High”, 0 = “Very Low”).

Figure 4. Reported levels of support from spouse, friends, children, parents, extended family, and neighbors prior to the adoption, during the initial months after adoption, and at the time of survey.
What Adoption is…and is Not

*Eric Weiner*

Adoption is not what many people think it is. That is a bold statement, yes, but one I am willing to bet on. As the parent of an adopted child, I am consistently astounded by the misperceptions surrounding adoption, particularly international adoption. So here are my thoughts on what adoption is *not*—and, by extrapolation, what it *is*.

Adoption is not charity. There are people who are genuinely interested in saving the world, and there are people who adopt children. Rarely, in my experience, are they the same people. My wife and I did not adopt our daughter to “save” her (whatever that means) or to demonstrate our innate goodness. (We’re not that good. Trust me.) We adopted her because we wanted a child and couldn’t have one biologically. *That’s* why we filled out endless reams of paperwork, underwent a background check, and spent thousands of dollars we couldn’t really afford. *That’s* why we endured the uncertainty, the weeks holed up in a Kazakhstan apartment, waiting for a court date that we feared might never come. Kazakh officials did not kow-tow to us, or even thank us for adopting one of their children. They made it clear it was we, not them, who had to prove ourselves worthy. That is precisely the way it should be.

Adoption is not an ailment. It is not a syndrome or a pathology, and it certainly is not a disease. Our daughter has been with us for many years now, but some people still ask, “How is she doing?” as if she just broke her leg or is getting over a bad case of the flu. She’s doing just fine, I tell these people. Why shouldn’t she? Children aren’t stupid. They pick up on our signals, verbal and otherwise. If we treat adoption like a problem to be solved, they will see it that way too. To be clear: I’m not suggesting that adoptive parents dodge the subject, but nor should we dwell on it unnecessarily.

Adoption is not easy. It is not *supposed* to be easy. The bureaucratic slow dance is not intended as a test, I know, but that is its result. Throughout the process, the unspoken question is: How badly do you want this? It’s a fair question, and in our case, as I suspect with most adoptive parents, the answer was: very, very much. We wanted it badly enough to keep going even when Kazakh authorities threatened to suspend adoptions in Almaty, the city where our daughter was waiting for us. “Think of this as your labor,” said one friend to my wife. It was the best advice she heard, and kept her going in the darkest hours.

Adoption is not something that you “get over.” It is never finished. Our daughter will always be adopted, just as our eyes will always be brown. It’s part of who she is. My wife and I do not hide that fact, but nor do we dwell on it. It is just one more thing, we tell her, that makes her special. Once, we were on vacation in San Diego and the server at an ice cream parlor asked my daughter, “Where are you from, little girl?” She was probably expecting to hear “Dallas” or “Seattle.” “Kazakhstan,” my daughter replied proudly. I can still recall the shocked expression on the server’s face.

There will be other, less enjoyable moments, I’m sure. I’m dreading the day, the day when my daughter scowls and says, “I don’t have to listen to
Adoption is not easily understood. There is something mysterious and wonderful about the bond between an adoptive parent and child. For me, that bond gelled as soon as I saw her photo—sent by e-mail from the adoption agency. She had bright eyes and a huge bald head—“Buddha Baby,” we called her. Normally I am not one to believe in fate, but at that moment, I knew, just knew, she was destined to be my daughter.

Adoption is not a consolation prize. We do not think of our daughter as our “back-up plan.” She is not, in any way, second best to the biological child we never had. She is simply our daughter.

Adoption is not important. By this, I mean that it is not central to my relationship with my daughter. It does not define our relationship. As I said, my daughter is my daughter. I don’t think of her as my “adoptive daughter” or my “daughter from Kazakhstan.” The fact that she is Kazakh is just one more thing I love about her. Only now is she beginning to understand that we don’t look alike, she and I. Coursing through her veins is the blood of Genghis Khan and the Mongols. Coursing through my veins is the blood of the Jews of Eastern Europe. It doesn’t matter, though. Love trumps genetics. Every time.

Adoption is not newsworthy. Like our case, the vast majority of international adoptions end happily. Of course, you rarely hear those stories. Good news is not news. Which is a shame, really, because every time there is an adoption scandal, countries overseas get spooked. Sometimes, they suspend all adoptions. When that happens, the victims are the children sitting in orphanages, waiting for parents who may never arrive. That is what nearly happened to us. At the time, there was a case involving a Russian child adopted by an American parent who had allegedly beaten the child to death. It was a terrible story, and Kazakh officials—very much in the Russian orbit—were threatening to suspend all adoptions, including ours. My wife and I spent several tormented weeks holed up in an apartment in Almaty, wondering if we would be allowed to bring our Buddha Baby home.

Adoption is not glamorous. Do not be seduced by those photos of Angelina Jolie or Madonna jetting off to some far-flung country to adopt one more child. Adopting a child is a painstaking, laborious process—no more glamorous than giving birth to one.

So what is adoption? Adoption is—and I don’t use this word lightly—a miracle. Not necessarily a divine miracle, but the kind of miracle that my dictionary defines as “an amazing or wonderful occurrence.” Every time I look into my daughter’s curious, mischievous, kind, Genghis-Khan eyes, those are exactly the words that come to mind.
Section 5

Birthparents
Introduction

Facing an unintended pregnancy has the potential to leave women—or couples—frightened and confused. If you are facing an unintended pregnancy, you deserve accurate information about all of your options, compassionate support, and the space to make your own decisions. The information presented here is intended to help you understand the option of adoption, help you consider whether adoption is for you, and provide some suggestions that will help to ensure a positive experience should you choose to make an adoption plan.

What is Adoption?

If you make an adoption plan, you are deciding that someone else will parent your child after he or she is born. Adoption is the legal process by which all parental rights and responsibilities are transferred to an individual or couple who has agreed to adopt. Adoption is permanent and grants a child full membership in a family, equal to children who are born into a family. For you, the birthparent, adoption means you will not be required to parent the child. After the child is born, you will go through a process that ends your legal responsibilities as a parent.

Is Adoption For Me?

There are many questions to consider when facing an unintended pregnancy. Below are some of the different questions birthmothers ask about adoption, and some resources to help you better understand the adoption process as you consider whether it is the right option for you.

Whose Decision Is it to Make an Adoption Plan?

The decision to make an adoption plan belongs to you—the birthparents. While support systems consisting of family members and friends can be helpful and important to help you think things through, ultimately the decision belongs only to the birthparents. Both the birthmother and birthfather have the right to be involved in this important decision. Birthfathers have the right to be notified if a child has been conceived and an adoption plan is being made. In many states, if the birthparents are not married, birthfathers may assert this right to notification by registering with a putative father registry. (For further information, see “Section 9: Putative Father Registries” in this edition of the Adoption Factbook.) By registering, a birthfather is provided with the right to notice of court proceedings regarding the child, including petitions for adoption.

Will I Parent?

Women should carefully weigh all three of their options. For women who are trying to make the decision between parenting and adoption, the
following questions may help you think about what parenting involves and whether it is the right choice for you.

- What do I want out of life for myself?
- What would I have to give up in order to parent? (School? Career plans? Social life? Free time?)
- Could I handle a child and a job and/or school at the same time?
- Can I financially support a child?
- Can I provide for a child’s health and safety?
- Am I patient enough to deal with the noise, confusion, and 24-hour responsibilities of parenting?
- Will I be a single parent?
- Who will help care for the child, and how often will they be available to help?
- Am I willing to spend a significant part of my life—at least 18 years—raising a child?3

Who Chooses Adoption?

For many women it is helpful to hear from and talk to other birthparents that have faced an unplanned pregnancy and chosen adoption. Understanding why other birthparents chose adoption, how they feel about their decision, and what their life and the child’s life is like because of adoption may help you better understand whether making an adoption plan is right for you.

Adoption agencies can often connect you with a birthparent that is willing to share her adoption experience. You can find an adoption agency near you by searching local listings or by using the agency database available at: http://www.ichooseadoption.org/members/index.php

You may also find it helpful to read about the experiences other birthmothers have shared here:

- https://www.adoptionscouncil.org/infant-adoption/testimonials.html
- http://www.openadoptioninsight.org/

What Happens After I Make an Adoption Plan?

It is natural to want to know what will happen to you and your child if you make an adoption plan. While every story is unique, below are some facts about women who choose adoption and children who are adopted that may help to answer some of your questions.

Women Who Choose Adoption…

- Are more likely to finish school and obtain a higher level of education;4
- Attain better employment, earning more than twice the per capita income and achieving greater financial stability;5
- Are less likely to receive public assistance;6
- Are more likely to marry in the future—and when they do, are more likely to delay marriage until an older age;7 and
- Report a high level of satisfaction with their decision to make an adoption plan.8

Children Who are Adopted…

- Are all around us! Two-thirds of Americans have had a personal experience with adoption9 and approximately seven percent of the American population is adopted;10

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5 Ibid.
6 Ibid.
8 Ibid.
Are less likely to have divorced parents;\(^{11}\)
Are more likely to be raised by parents with college degrees;\(^ {12}\)
Score high on indicators of wellbeing including school performance, friendships, volunteerism, optimism, self-esteem, social competency, feelings of support from others, and low levels of anxiety;\(^ {13}\)
Are less likely to have high risk behaviors such as alcohol use, depression, vandalism, group fighting, police trouble, theft, weapon use, driving/riding while drinking, and not wearing a seat belt;\(^ {14}\)
Are as well integrated into their families and schools as children who are not adopted;\(^ {15}\)
Often have a greater range of childhood experiences and opportunities than would have been available had the child not been adopted. These include a higher standard of health care, access to higher education, and greater family stability.\(^ {16}\)

Who Can Answer the Rest of My Questions?

Adoption professionals are also a helpful resource and can answer any of your remaining questions about adoption. Information and counseling is provided for free to women, no matter what decision they make. Adoption professionals at licensed, accredited adoption agencies will help you understand the following:

- **How it Works:** An adoption professional will be familiar with the adoption process and can answer your questions about what happens at different stages of the adoption process.

**Local Laws:** A local adoption professional will know about the laws and procedures that apply to you. Every state has different laws about adoption and it is the professional’s job to understand and explain the system to you.

**Local Resources:** A local adoption professional is often familiar with services in your area that may be of help to you during your pregnancy as you consider your options.

There are many more questions that may come to your mind when considering adoption. Often the best way to find answers is to ask an adoption professional. They can help you find the answers you need to make a fully informed decision.

You can also find answers to some common questions at iChooseAdoption.org’s Frequently Asked Questions: [http://www.ichooseadoption.org/info.php](http://www.ichooseadoption.org/info.php)

**How Do I Choose an Adoption Agency?**

If you have chosen to make an adoption plan, you might already be working with an adoption agency, or you might still be looking for one. Adoption agencies are the most common way adoptions are facilitated and typically provide a wider variety of services, but attorneys can also facilitate adoptions. The following services are helpful to consider in either case. Know that you have the option to choose the professionals you work with based on the services and assistance they provide to you and how comfortable you feel there. You may discuss the services that are provided by different agencies and determine which services are important to you. Some common services to consider include: financial assistance with pregnancy-related medical expenses and reasonable housing costs during pregnancy, counseling services, and the number and type of adoptive parent profiles available for you to review.

When choosing the adoption agency you will work with, keep in mind that you have the following rights. You have the right to:

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12 Ibid.
13 Ibid.
14 Ibid.
- Be free from any pressure or coercion;
- Choose your own attorney or to refuse legal representation if you choose;
- Counseling before, during, and after the adoption;
- Approve the parents who will adopt your child and meet them if you choose to;
- Create a written adoption agreement that allows you to share pictures, letters, and have possible future contact with the adoptive family;
- Financial help with certain reasonable expenses;
- See your child before he or she is adopted;
- Decide to parent your child any time before you sign a consent or surrender and complete the revocation period.\(^{17}\)

**How Do I Choose an Adoptive Family?**

Adoption agencies have profiles of potential adoptive parents hoping to adopt a child. Through a process called a homestudy, the agency has already determined that these potential adoptive parents are appropriate to parent children. A homestudy involves extensive interviews of potential adoptive parents, background checks, character references, and an actual examination of the house where a child would live with the potential adoptive parents.

You will be given the chance to identify qualities that are most important to you in an adoptive family. The adoption agency or attorney can then help you find potential adoptive parents who match your preferences. Here are some questions that may help you consider which characteristics are most important to you in an adoptive family:

- Do you want the child to have both a mother and a father?
- Do you want the mother and father to be married?
- Should one parent be a “stay-at-home” parent or should both parents work?
- Is the income level of the family important to you?
- Is the age of the adoptive parents important? What age do you think is appropriate?
- Is it important to you that a child be raised with a strong religious faith? Do you have a preference for a specific religious faith?
- Do you want the child to have brothers or sisters?
- Are there certain interests or opportunities that you believe add to a child’s experience in a family (such as music, art, sports, politics)?\(^{18}\)

You can view some sample adoptive parent profiles here: http://www.ichooseadoption.org/families.php

Additionally, many adoption agencies provide profiles of adoptive parents that you may review on their agency website.

**Will I Know My Child?**

You and the adoptive parents will decide upon the continued relationship you might have with your child. An adoption agency can help direct you to adoptive parents who will be comfortable with the type of relationship that you decide is right for you. There are three common arrangements regarding birthparents continued knowledge of and relationship with a child that has been adopted:

**Confidential Adoption**

Confidential adoption is an adoption in which only non-identifying information about the birthparents is shared with the adoptive family. Only social and medical information is given to the adoptive parents through the adoption agency.

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\(^{17}\) See: http://www.ichooseadoption.org/resources_birthmother.php


\(^{19}\) These profiles are fictional and only to give an example of what parent profiles might look like.
There is no continued relationship between the parties. Confidential adoption is also sometimes referred to as “closed adoption.”

**Semi-open Adoption**

Semi-open adoption describes any situation in which birthparents and adoptive parents have an ongoing relationship and exchange information, but there is not full disclosure of identifying information such as full names and addresses. Some examples of semi-open adoption arrangements might include: anonymous meetings, sharing pictures and development information through periodic letters, or occasional phone calls to report on the development of the child.

**Open Adoption**

Open adoption is an adoption in which all identifying information is exchanged between the birthparents and adoptive parents, and birthparents are able to remain fully aware of the child’s development and stay involved in the child’s life.

**Conclusion**

As you face this important decision, please remember that the decision is yours to make, but you don’t have to make it alone. There are many organizations and individuals who are committed to helping you understand the option of adoption. Don’t hesitate to take advantage of the many resources available to you as you consider what decision is right for you.

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21 Ibid.
Every day, 8,458 American women discover they are pregnant though they did not plan to be—women like Sherrie. Sherrie, a 28-year-old professional, was raped and became pregnant. Fortunately, she called Birthmother Ministries, Inc. (Birthmothers) and was matched right away with Janice, a trained volunteer Birthmothers Friend. Janice stood by Sherrie during the months that followed, listening, offering practical help, giving Sherrie information about adoption options, and providing spiritual support. The two women developed a deep bond that helped to carry Sherrie through her crisis.

Sherrie chose to make an adoption plan and selected an adoptive couple to raise her baby. “Placing my baby was an incredibly hard decision,” she says. “But I was able to process that choice with Janice. I know I did the right thing.”

Sherrie’s daughter is thriving with her adoptive family. And Sherrie herself has gone on to focus on healing and rebuilding her life. She credits the personal support of a Birthmothers Friend as instrumental in her choice to give her baby life and place her in the loving arms of an adoptive family.

One-on-One Support Means More Women Choose to Give Birth

Things could have turned out far differently for Sherrie—as they often do for so many other women. Forty-nine percent of American pregnancies are unplanned. Four in ten of those end in abortion. That translates into 1,234,800 abortions each year from unplanned pregnancies.

So many women believe abortion is the only option available at the time of their decision. While an overwhelming number don’t want to make the choice to terminate their pregnancies, they lack information and resources, as well as emotional support. “Women need an advocate when they face an unplanned pregnancy because so many of them feel completely alone,” says Julie Villa, a volunteer Birthmothers Friend. “They’re shocked. They didn’t see it coming. Many times, they have no support from family, friends, or the birthfather.”

The surprise is just one stress factor. Often a pregnant woman must also contend with the birthfather’s rejection, her family’s shunning, and personal shame. Job loss, eviction from home, loss of financial support, and lack of insurance, transportation, and child care are other common, practical challenges pregnant women face. On the surface, abortion appears to be “an easy fix.”

Relational support—or lack thereof—can be a critical factor in a woman’s decision of whether or not to carry a pregnancy to term. According to The Elliot Institute, 83 percent of women who struggle after an abortion say they would have

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2 Birthmother Ministries, Inc. is located in Vienna, VA. More information available at: http://www.birthmothers.org
made a different choice if they had support from a partner, family member, or friend during their pregnancies.  

An advocate can make all the difference. When a woman is matched with a caring, trained friend who provides practical, emotional, and spiritual support, she is much more likely to carry the pregnancy to term. Birthmother Ministries, Inc.’s reports of women matched one-on-one with a specially-trained volunteer during 2007 show that 95 percent carried their babies to term and chose parenting or adoption—a full 45 percent more than those not matched.

**One-on-One Support Means Increased Adoption Education**

The number of women who choose adoption has decreased dramatically in the last several decades. From 1952 to 1972, 8.7 percent of all out-of-wedlock births were placed for adoption. Currently, just two percent of unmarried women who give birth place their children for adoption.

The legalization of abortion was among the reasons for the initial downward trend. But today, more and more women who face an unplanned pregnancy choose parenting. Observers attribute that trend to the declining stigma of unwed motherhood, increased use of contraception, declining pregnancy rates, and fewer abortions. Education is another key factor; women who voluntarily place their children for adoption are likely to have greater educational and vocational goals for themselves than those who keep their children. Adoption.com cites a study which found that women whose mothers completed at least one year of college were three times more likely to place their babies for adoption than women whose mothers did not complete high school. Exposure to concepts and ideas beyond the immediate opens the door to the possibility of adoption.

Many women, particularly those not exposed to a high level of education, are unaware of the array of adoption options available to them. But in a safe, one-on-one friend relationship, pregnant women can receive information about adoption. A well-trained mentor provides the missing link in presenting the adoption option to women who may not have otherwise considered it.

**How an Effective One-on-One Relationship Works**

Agencies provide services, but a woman in crisis needs one-on-one support. The Birthmothers Friend model was developed to meet that need. Professionals recognize both the uniqueness and effectiveness of the Birthmothers Friend model. “Our ministry is focused on helping a woman at her moment of crisis—when she’s undecided about what to do,” says Mary Hager, assistant director of Rockville Pregnancy Center in Rockville, MD. “Birthmothers complements us beautifully. They help a woman long-term by matching her with a mentor. I don’t know of any other organization like it.”

Pregnant women, their partners, and their family members who contact Birthmothers are matched one-on-one with a trained volunteer Friend who provides emotional, practical, and spiritual support in a personal relationship—for as long as the client needs or chooses.

**Matches**

When women, partners, or family members contact Birthmothers’ 24/7 helpline (1-877-77-BIRTH), they speak with a caring staff member. Callers are encouraged to share as much or as little as they choose about their situation. In order to protect both the caller and the organization

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5 Reardon, D. C. (1978). *Aborted women, silent no more (Appendix Two)*. Chicago, IL: Loyola University Press.


and have an accurate record of information, staff members complete a confidential Client Intake Form. The staff member then asks the caller if she would like to be matched with a Friend. Callers can choose to be matched with a Friend right away, or they may choose to wait. Birthmothers staff match Friends and clients based on geographical proximity, situation, background and, if possible, personality traits. There is no charge for Birthmothers services.

**The Friend Relationship**

The matched Friend contacts the birthmother within 24-48 hours. Her first role is to provide emotional support by listening as the birthmother sorts out her feelings and options. Together, they discuss her immediate, short-term, and long-term needs.

The Friend then works with the birthmother to connect her with practical resources appropriate for her situation, including prenatal care, ultrasounds, housing resources, legal aid, Food Stamps, counseling, adoption resources, transportation, and other social services.

Concurrently, the Friend provides spiritual support. Some pregnant women initiate discussions about spiritual matters; others welcome the offer from the Friend to provide prayer.

All throughout, the birthmother defines the Friend relationship—whether it becomes intensely personal, just an occasional call for information, or anything in between. The Friend regularly checks in with her matched birthmother and stands ready to provide her unconditional support and acceptance, no matter what the woman chooses. That is why the Birthmothers’ motto is *A Friend Loves At All Times.*™

**Support**

The Friend/client relationship can be intense. In order to provide the highest level of care and prevent burnout, volunteer Friends are supported throughout their match. They are issued a Friends Resource Manual, which includes an exhaustive listing of local medical, legal, vocational, counseling, and social service resource providers. The manual is updated regularly. Friends consult the manual as they work to connect birthmothers with local services.

Staff members routinely check with volunteer Friends who are in active client relationships to see if they need ideas and guidance. In a severe crisis, staff members equip Friends to refer birthmothers for professional help. Friends in active care-giving relationships submit a monthly update to the ministry office for tracking and record-keeping. Birthmothers Church Teams—small groups of congregation members who minister to local pregnant women—support Friends with prayer and encouragement.

**Close Outs**

Placing a time frame on the Friend/client relationship provides for healthy boundaries and prevents volunteer burnout. A Friend/client match is closed out no sooner than when the baby is three months old. If special circumstances mean that a Friend continues to provide a considerable amount of support after that time, the relationship is maintained. When the relationship moves into a friendship emphasis (versus a care-giving/care-receiving relationship), a client indicates she is ready to close out the relationship, or the Friend and client no longer regularly communicate, the staff officially close out the relationship.

Many Friends and birthmothers develop deep, personal relationships which last for weeks, months, and years after close out.

**Identifying and Equipping Effective One-on-One Volunteers**

The intensive nature of one-on-one relationships and the large number of women served require considerable numbers of quality, dedicated volunteers. Interestingly, Birthmothers has never recruited volunteers, but rather receives regular inquires from individuals who express an interest.
in mentoring pregnant women. Many potential volunteers have faced an unplanned pregnancy themselves or have a personal connection to adoption, abortion, unplanned pregnancy, or infertility via a friend or family member. Others simply have a heart for hurting women. All understand the selflessness required in a relationship with a woman in crisis.

Local churches are another significant volunteer source. Congregations’ motives are rooted in serving the vulnerable and needy in their midst. Birthmothers has a proven track record and an operational infrastructure in place, which churches find appealing. Often, congregations launch a completely new Birthmothers chapter in their churches by identifying, training, and mobilizing entire teams of new volunteer Friends at one time.

Quality training equips volunteers with the practical skills and information necessary to help meet women’s specific needs. Volunteers undergo rigorous background checks prior to being matched with clients, and Birthmothers retains liability insurance coverage to protect itself and its volunteers. Counseling professionals developed Birthmothers’ volunteer training materials, and qualified staff members conduct training sessions.

**Initial Training**

Friends Certification Training is an intensive course that leads volunteers step-by-step through learning how to be a Friend: engaging the birthmother, listening and responding empathically, practicing spiritual care, role playing, connecting with community resources, and handling crises. Volunteers are specially equipped to understand the adoption options available so they can explain these clearly to their matched birthmothers. Although an overwhelming number of volunteer Friends are women, some men are also trained to provide one-on-one support for birthfathers involved in an unplanned pregnancy.

**Ongoing Training**

After certification, Birthmothers Friends regularly attend in-service trainings to receive current information about pregnancy, childbirth, adoption, services, and resources associated with pregnant women and families. Friends share experiences and offer each other support and mutual encouragement.

**Conclusion**

Over the last thirteen years, volunteer Birthmothers Friends have successfully ministered to hundreds of pregnant women and their families. Each story is unique, but the response from birthmothers is always a version of this sentiment: “I’m so grateful for my Birthmothers Friend. She stood by me during my darkest hour and supported me so I could make the best decision for myself and my child.”

Unplanned pregnancies need not end in tragedy. Sherrie, for instance, chose to make an adoption plan. She did not go through her ordeal alone. Janice coached her through labor and delivery, and stayed close to Sherrie after the baby was placed. A special one-on-one relationship with a trained mentor can make all the difference for a pregnant woman and her baby—and for adoptive families waiting for a child to love.
As a professional who has worked in the field of reproductive health for over 30 years, I have extensive experience with women and men facing unintended pregnancies. I believe my role as a counselor and health educator is to respect and value a woman’s personal choice regarding her pregnancy, whether she chooses to continue the pregnancy and parent her child, terminate the pregnancy, or place the baby for adoption.

With a background in counseling and human services, I believe it is our responsibility as professionals to provide compassionate, non-judgmental, client-centered counseling as we explore this complex and often difficult decision. For any experienced counselor, the skills utilized in client-centered care are the foundation of any counseling session. Yet when it comes to pregnancy options counseling, I believe we do, at times, allow our own personal beliefs to affect our ability to be objective, and thus fail to enable our clients to fully explore all of their options. This can be true when it comes to our personal values as well as our understanding of abortion and adoption. In the family planning world, it is important to enhance our skills in order to counsel women about all their options, and not be limited by either personal beliefs or lack of knowledge.

Always looking for opportunities to expand my expertise, I was pleased to be invited to participate in the Infant Adoption Awareness “Train the Trainers” program sponsored by the National Council For Adoption (NCFA). I was both curious and a bit skeptical: Would the training really be open to all the options? Or would it suggest that counselors should “encourage” their clients to consider adoption above other options? I attended the training with a curious yet critical eye.

Now, several years later, I find myself using many elements from that NCFA curriculum to train family planning providers. One of the things I appreciate about the curriculum is that it offers a balanced approach to adoption counseling, one that is consistent with client-centered care. While the activities and information in this curriculum are adoption-focused, they serve to educate the client about adoption, rather than promote adoption as the best or only choice.

I have integrated several of the activities used in my Infant Adoption Awareness training to provide family planning staff with the knowledge, language, and skills to feel better prepared to discuss all options with their clients. These trainings have been very well received and are often requested by our provider network.

By providing our clients with more comprehensive information about current trends in adoption practice, we are able to dispel myths about adoption as well as offer resources they may not have previously considered. Not only do I believe that we assist our clients by giving voice to the option of adoption, I also believe that doing so strengthens our effectiveness as counselors.
I Always Celebrate Mother’s Day

Kelsey Stewart

Being a mother without her children is a very difficult life to lead. It is never set in stone, no matter how many pieces of paper are signed. It does not give up, it does not let up. It is a lifelong journey that teaches lessons everyday. It is ever evolving, forever changing, and always a different situation for everyone at any given time. It is a life of uncertainty, of longing, of grieving and analyzing one’s true being. It is not at all what people think, or expect. I am in my 20th year as a birthmother, and I am still learning and growing every day.

I have been through two adoptions. At 19 and unmarried I found myself pregnant, even though I was on birth control, and I wanted to consider adoption. There were many reasons why I chose adoption for my daughter, and in the late 1980s the concept of open adoption was just coming to light in the eyes of the law. I searched and found a family that I connected with, who understood that I was a compassionate, caring woman who was not able to raise her child and looking for a possible relationship with their family to see her grow. I wanted to be available to them if she had medical issues, questions about her heritage, questions about her parents, anything at all that she might want to know. I was open to keeping in touch with them to make those moments easier in her life, in their lives. I was very fortunate to have found them, and their support was unbelievable. We were on track for a wonderful private open adoption.

Enter the State of Missouri. They saw things differently and began a process, in the last month of my pregnancy, to change everything we had previously arranged to accommodate our needs. We had to scramble to find an agency that would take me and my parents, scramble to get more home studies done; it was a mess. My daughter went into foster care for weeks while I fought the system, and I was eventually able to place her with the family that I chose. Once the waiting period was over, after the relinquishment, we threw away their guidelines and quietly lived our open adoption by our terms, the terms of those involved and only those involved.

Two years later I had finally embarked on the relationship with my soul mate. We were off to a great start when a surprise came along. I found out I was pregnant. I was thrilled and excited, and thought, “We can make this work.” Then I found out there were two babies: I was pregnant with twins. I was barely 21, and my man was only 19. We were still in school, had no home or savings; we were just kids and just starting a relationship. We both came from divorced mothers, and had seen with our own eyes what life is like when a family is broken. We were determined not to let that happen in our own adult lives. And there were other reasons, other factors that came into play.

We decided adoption would be the best choice for us. I was not staying in Missouri for the second one. I had learned my lesson and was still healing from that experience when I found out I was pregnant with twins. I had family in California who had just adopted a child, so with a heavy heart I left my boyfriend and my close family behind to head west.
The contrast between California and Missouri was astounding! Never once did I feel pressured; not once did someone tell me that I was an awful person for choosing to live life without my children. No one told me what I could or could not do. I told them what I would like: to have an open adoption, including correspondence through the mail. I stressed that I needed to know who my children are through the years. The agency presented me with some couples, and after meeting with a few of them, I chose my children’s family. I got to know them as much as I could in the time that we had. I visited their home and their town, and asked endless questions that were important to me. I told them that I had been through this before, and I knew how my other adoption had worked. I reassured them that I would not bother them or change my mind in any way, and that all I needed in return was just to see pictures and hear about my children. I stressed that it is the not knowing that kills a mother, the wondering, the questions of what they are like, the worrying that they will not understand why I chose this that creeps in for years and years.

The adoptive parents were in the delivery room when their sons were born. This had not happened with the first adoption, and I was very grateful that they were able to witness that. It is a bond that I think adoptive parents never forget, and can help them grasp what their birthmother is giving them—and what she is losing.

My children’s adoptive parents were instantly taken with being parents, and it was a beautiful beginning for me to see. They were there from the moment the boys entered the world, bonding with them, taking it all in slowly. But they also allowed me to let go. I had alone time with my sons; I had time to say goodbye in my own words, my own heart. It was a totally different experience from my first adoption, and I am glad for the second in California because it gave me new hope for the adoption system as a whole. I saw that not all states treated birthmothers as voiceless, insignificant, or ignorant. They asked me what I wanted, I told them, and we left having agreed upon those terms.

I make it sound easy, but it is not. What followed was nothing short of heartbreak: very dark times, deep sadness, tremendous guilt, self-loathing, loneliness and depression, trying to live life with a gigantic hole in my heart. The worst part, it seemed to me, was that this was my own doing; I chose this for my children. I was convinced that I had done what was best given my situations. But no amount of self-convincing could prepare me for the moments along the way that threw me right back to the very start of it, right back to the raw pain. It could be a smell, it could be scenery I had not seen since I was pregnant, it could be a song. Most occurrences were in private.

I was a very pleasant person before the adoptions, so I did my best to keep it together. I found that if I wanted to talk about it, I had to be very careful. Most people who knew me were happy to listen, but not knowing what it was like to place a child for adoption, they did not know what to say or how to comfort me. I felt that I was making them uncomfortable, so I stopped talking about it. Then there were the confrontations that left me totally shaken. I was smack dab in a generational shift and everyone was voicing their opinions about the “risks” of open adoption. Not everyone was convinced that if the birthmother were to know things, personal things about the adoptive parents, that wasn’t a recipe for trouble. The role model for birthmothers then was Baby Richard’s mother who came back and “stole” her baby. It was all very negative then, and some people were not happy about birthmothers being so open about not raising their children. They were vocal, they were rude, they were relentless, they were ignorant.

In those confrontations I found the best in me. I am a great listener, a great communicator. I can take in what someone is saying to me and, while listening, figure out how to hear what is underneath the anger, the disgust. Often, people were simply scared. They did not know what to
think about someone being at peace with their decision to give their child to someone else to raise. They often could not see past the immediate situation, to see what could happen in the future.

I would tell them that I took great comfort in the fact that I could write a letter and ask what my sons’ favorite colors were; I could pull out a picture and see how much my daughter looked like me, smiled like me, sat with her legs out to the side on the floor just like me. I told these people that I had less wondering to do, because their parents were open to sharing their life with me. I told them I was proud that I was able to ask for help at a time when so many could not, or would not. I told them I believed that I was strong enough to heal my heart, not give up, and to the best of my ability I would keep in touch with the families because I wanted to let my children know that I cared about them, that I was thinking about them. I told these people about adoption, answered their questions, and in most instances they would leave with a whole new perspective on birthmothers. Education is power, especially when we begin to understand the journeys of others.

In the following years, my hopes for open adoption were validated. My children’s adoptive parents kept their promise of keeping in touch with me, sending me letters along with photos as we agreed upon. My daughter’s parents were more than gracious as they arranged visits for me to see her, as well as visits with my mother, her maternal grandmother. They realized that my daughter was curious, just like I was. I always sent her cards for her birthday and Christmas every year. I am very fortunate that the parents that I chose were so supportive and understanding when it came to allowing me to know her. I think it was also very important to my daughter that they saw me as a good person, a woman who put her child before her own thoughts, her own feelings.

My daughter grew up knowing that I cared about her, and she had the proof in letters and cards. It may not have been much, but I am sure it meant a lot to her. When I sent word that I was getting married some years after she was born, my daughter expressed an interest in coming to my wedding. I told her that I would love for her to be in the wedding, and she was. She started talking to me regularly online a few years ago, and now we tell each other that we love each other every time we chat, and we mean it. She has a wonderful outlook on adoption and tells me all the time that she is proud of the person that I have become; and, even more important, she is proud of where she came from.

I also kept in touch with my twins’ parents and received correspondence from them as well. Now in their teens, my sons recently found me on the Internet, and we talk occasionally. My relationship with them is completely different from my daughter’s, but they tell me that they understand my decision, they are proud of my accomplishments, and they look forward to knowing our family. We have been in that “getting to know you” stage for a few months, and so far, so good.

I am a success story in the world of open adoption, and I believe that it is one’s outlook that makes all the difference in the world. I did not have an easy time with the healing, and it continues to this day. I did have an incredible support system in my family and friends that helped me a great deal. I did not receive aftercare, and I did not receive counseling; I did not have those luxuries at all, and I believe that they would have been very important on the road to recovery. I was left to help myself heal and I thank the Lord above that I was able to do so. There are so many who do not heal, who do not have the success story that I have.

I chose to be happy in my life. I chose to speak out, to help others understand a little better. I chose to learn from what I have been through and be proud of the person I have become. I stayed in touch with my children’s families, as they stayed in touch with me, and that was the key to everything: open communication. I now have children of my own that know all about
their siblings. My life has been richly blessed by the family that I have, and the joy in my days is a direct result of the love I receive from my amazing boys and a soul mate in every sense of the word.

In addition to this article, I am the author of a children’s book that explains adoption from a birthmother’s point of view. I think if more people were familiar with this view, the subject of adoption would be less taboo than it is. I am a positive advocate for what adoption can be. It can be open. It can be peaceful. It can be fulfilling. It can turn lives around and help so many who dream of a family. And in my case, it can be so very beautiful. I am a fortunate woman who lives every day with love, both with me and away from me. This is why, on the second Sunday in May of every year since my daughter was born, I always celebrate Mother’s Day. Some of my children may have walked without me, but they have been in my heart every step of my journey through life.
Section 6

Legislative Issues
Adoption and Safe Families Act (ASFA): No Second Chances?
Cassie Statuto Bevan

Introduction

The Adoption and Safe Families Act (ASFA) established for the first time within federal policy the principle that maltreated children must be “the paramount concern” of the child protection system. At the same time, ASFA recognized that parents of abused children are seriously troubled and overwhelmingly plagued by mental illness, drug addiction, or criminal behaviors that lead to imprisonment. ASFA did not change the requirement that “reasonable efforts” be made to keep families together and the mandate that services be provided to these parents. However, this law unequivocally puts the child’s safety, permanency, and wellbeing above all other concerns of the foster care system.

Child Abuse Has a Lifelong Impact

Research has shown that maltreatment has a lifelong impact on the abused child. The damage is irreversible, and affects the child’s social-emotional, physical, and intellectual growth. Attachment and bonding with safe, responsive adults are essential to healthy development. A child’s growth depends greatly upon receiving “good enough” parenting to successfully meet the increasingly complex developmental challenges that he or she will face at different ages.

According to mid-twentieth century child development theorists Erik Erikson and Jean Piaget, a sequence of “critical periods” characterizes child development. How children resolve successive challenges is based on their own interactions with and experience of the world. Children in responsive circumstances with a parent who provides a stable, caring environment grow up learning to trust, feel loved, be independent, acquire language skills, and think clearly and confidently. Conversely, children who are abused or neglected learn to mistrust, feel unloved, view the world as unpredictable and unsafe, and struggle with cognitive concepts. There is no doubt that children recreate their world based on their own experiences, and maltreated children are no different.

Recent neurobiological literature on brain development indicates that the brain is not “hard wired” at birth, but instead has a “plasticity” or “adaptability” that is highly dependent on environmental and parental input at specific “critical periods.” For example, evidence shows that the simple act of singing to a six-month-old baby significantly stimulates both the auditory and visual areas of the brain, whereas the lack of such stimulation can lead to delayed language development and compromise the brain’s ability to respond to auditory stimuli (Neville, 1995).

Abused and neglected children suffer from an impoverished environment due to the absence of a loving, responsive parent. There are strong correlations between maltreatment and a host of poor outcomes for children, including cognitive impairment, school failure, lack of self-control,
behavioral disorders, and juvenile delinquency. Affected children run the risk of becoming the next generation of substance abusers, criminals, violent partners, and child abusers themselves (Office of Planning, Research, and Evaluation, Administration for Children & Families, U.S. Department of Health and Human Services, 2005; Ondersma, 2007). Poor child outcomes are associated with a pervasive failure of services for parents—services that are either lacking, of low quality, or of insufficient intensity to rehabilitate parents enough to safely return the child. At the same time, too many parents do not comply with service plan requirements, such as mandatory attendance at a parenting or anger management class.

There are no national, comprehensive figures on the number of children in foster care with substance-abusing, mentally ill, or incarcerated parents, a majority of which are single mothers. Experts estimate that the proportion of children in foster care with substance-abusing parents ranges from about half to 80 percent of the total (Berrick, Choi, D’Andrade & Frame, 2008). Research has shown that when parents abuse drugs or alcohol, they are more likely to neglect and be physically abusive toward their children (National Center on Addiction and Substance Abuse, 1999; Zuckerman, 1994).

Scant research exists on which services offered to these families are most effective in rehabilitating a longtime addict or stabilizing a parent with mental illness, nor is it clear what policy to establish when a mother is sentenced to a prison term that will outlast her offspring’s childhood. This is not to say that further research on prevention, intervention, and treatment for seriously troubled families should not be fully supported. But it is to suggest that to over-rely on these strategies at this point can put children’s safety at risk. ASFA is not an anti-family piece of legislation, as some critics argue. Instead, it is a law based on the reality that research has yet to develop successful prevention, intervention, or treatment models that will end the maltreatment of children, avert foster care placement, or ensure safe family reunification.

Some key questions arise: Without evidence that services will keep children safe, how can determinations be made about the level of risk associated with making permanency plans for the child? How does a permanency plan for a child take into account the relapses that are often part of the process, according to substance abuse treatment providers? What happens to the stability that children need in their lives during these periodic and to some degree predictable relapses? Some treatment programs call it a successful outcome when an addict has abstained from using drugs for six months. What happens to those children who have been reunited with their parents and siblings, but may then have to reenter foster care in six months or so? ASFA was established to shorten the length of time that children were spending in foster care while waiting for anger management or parenting classes to make it safe for them to return home. ASFA promotes adoption as a better option for ensuring the safety, permanency, and wellbeing of many children lingering in foster care.

Legislative History of ASFA

The origins of ASFA (P.L. 105-89) can be traced to the Republican “Contract with America” in 1994 and the “Adoption 2002” directive of President Bill Clinton in 1996. The “Contract with America” included four pro-adoption provisions, including one calling for a reduction in the length of time that children in foster care waited for permanency. Too many children suffered too many placements, waiting for years for a permanent family. Many children “aged out” of the system at 18, literally growing up with no more than “three hots and a cot.”

The “Adoption 2002” initiative pursued the goal of doubling the number of adoptions out of foster care by the year 2002. The legislation was developed by a bipartisan group of members
of Congress and their staff, as well as officials from the Clinton administration. Taking the lead on the House Committee on Ways and Means were Representatives Dave Camp (R-MI) and Barbara Kennelly (D-CT); and on the Senate Finance Committee, leaders included Senators John D. Rockefeller IV (D-WV), Mike DeWine (R-OH), John Chaffee (R-RI), and Charles E. Grassley (R-IA).

During the 104th and 105th Congresses, the House Committee on Ways and Means held eleven hearings focused on adoption. Witnesses painted a tragic portrait of the near doubling of children in foster care from roughly 1983 to 1993. Over the same period, adoptions out of foster care remained fairly level, at around 15,000 children per year. Patrick T. Murphy testified that the foster care system was worse in 1995 than in 1980, in part because the system too often assumed that “there is no such thing as a bad parent.” Albert J. Solnit stated that the child welfare system should “respect the child's sense of time” and “develop a fast track” to permanency to avoid poor outcomes for children. Richard Gelles asserted that the main goal of a child-centered welfare system should be to act as expeditiously as necessary to achieve permanency, so that children can have a nurturing relationship with an adult during the critical period of development. I also testified at the hearings that “child protection not family preservation or family reunification must be the guiding principle of any child welfare reform” (Federal Adoption Policy: Testimony before the House Committee on Ways and Means, 1995).

Shortly afterward, I joined the House Ways and Means Committee staff to help set in motion the drafting of a bill that would meet children’s developmental needs by putting child protection first, reducing the average length of time spent in foster care, and increasing the number of adoptions out of foster care.

**Policy: What ASFA Did**

For the first time in federal child welfare policy, deadlines were put into the statute to clearly establish that foster care was a temporary placement for children. The making of “reasonable efforts” to keep families together was clarified by requiring that such efforts must maintain the child’s health and safety as “the paramount concern.” This provision was aimed at reducing the length of stay for children in foster care and expediting the movement of more children toward adoption. Toward this latter end, the statute mandated (with certain exceptions) a deadline for the termination of parental rights and placement into adoption if the child has been in care for 15 out of the past 22 months. Clarifying “reasonable efforts” and the 15/22 standard were measures geared toward respecting the child’s sense of time and recognizing the great harm that can be done to a child living in a setting designed to be temporary.

As a result of the enactment of ASFA, adoptions out of foster care increased from 15,000 children in 1988 to a high of 53,000 children in 2002, maintaining nearly equally high numbers (51,000 to 52,000) over the following four years (Maza, 2008). ASFA’s provisions doubled the number of children adopted out of foster care, changing the lives of tens of thousands of children (Maza, 2008). Since the passage of ASFA, there has been a significant decline in the average time between removal of a child from his/her home and termination of parental rights (TPR), going from more than three years down to two years (Maza, 2008). There has been an equally significant decline in the average time period between removal from the home and adoption, from more than four years to about three years (Maza, 2008).

Maza’s analysis of Adoption and Foster Care Analysis and Reporting System (AFCARS) data indicates that children who were removed before the age of seven account for most of the reduction in average waiting time for adoption. On average, then, it is likely that abused children will spend one less year in a temporary placement, without a family and a place to call home.

These significant achievements, produced by ASFA’s requirements to impose a deadline on the
length of time a child spends in the limbo of foster care and to provide incentives for states to move more children into adoptive families, represent life-altering “second chances” for children who have been abused and cannot safely return to their families. The increase in adoption out of foster care means that tens of thousands of children will, as a result of ASFA, have the opportunity to form attachments to loving, responsive parents and grow up in stable and permanent families.

Policy: What ASFA Did Not Do

While ASFA recognizes the child’s needs as overriding, it does not relieve states of the duty to provide services to parents. In fact, lack of service provision to parents can qualify as a “compelling reason” for the state not to move toward TPR and adoption. Under ASFA, states receive an illustrative list of the types of services that could meet this requirement, including 24-hour emergency caretaker and homemaker services, crisis counseling, home-based family services, and mental health, drug, and alcohol abuse counseling (Committee on Ways and Means, U.S. House of Representatives, 2008).

ASFA did not specifically address the effectiveness of treatment services for parental substance abuse. The congressional committees heard scant research findings as to how parental readiness to change might be determined, which factors were relevant to successful rehabilitation (e.g., length of drug use, specific drug use in question, ages of children involved), which treatment programs were most likely to work for which type of client, or whether rehabilitation can take place within a timeframe that respects the child’s sense of time.

ASFA did not specifically address parental mental health or imprisonment issues, since strategies for meeting these challenges were not available in the evidence-based research literature. ASFA does not require that termination of parental rights automatically take place after a child has been in care for 15 of the last 22 months. Rather, ASFA allows states to use three reasons they consider “compelling” for not moving to TPR: (1) if the child is living with kin; (2) if a determination is made that TPR is not in the “best interest of the child”; or (3) if timely family services were not provided.

ASFA does allow states to bypass reasonable efforts to preserve and reunify families when a parent has subjected the child to “aggravated circumstances” as defined by the state, which may include but are not limited to abandonment, torture, chronic abuse, and sexual abuse (Sec. 101 (a)(D)(i)). Efforts to preserve and reunify families are not required when the parent has committed the murder of another child of the parent; committed voluntary manslaughter of another child of the parent; attempted to commit the murder or manslaughter of another child; or committed a felony assault that results in serious bodily injury to the child or another child of the parent. Such efforts may also be bypassed when the parental rights of the parent to a sibling have been terminated involuntarily (Sec. 101 (a) (D) (ii) (iii)). Interestingly, it appears that states are routinely using the “compelling reasons” provision for not moving to TPR, while the “aggravated circumstances” provision to expedite TPR is rarely invoked.

Where Do We Go From Here?

The debate over ASFA continues. Members of Congress still want answers regarding how to reform what is supposed to be a system to protect children from harm. Is the financing of the child welfare system the problem? Is the system inequitable in guaranteeing room and board for the child, but not drug rehabilitation or mental health services for the parent? Does the woeful lack of effective treatment for substance abusers and parents with mental illness or violent histories “cause” children to be “unnecessarily” removed and placed into adoption? Policymakers remain concerned about the instability of the foster care system, which is producing such poor outcomes for so many children.
Research on family support, family preservation, and family reunification programs since the enactment of ASFA suggests that these services alone are unlikely to be effective in protecting abused children from harm. An evaluation by Westat, Chapin Hall, and Bell Associates (2002) found these programs to be only “marginally beneficial,” and argued that they should not be solely relied upon to keep families safely together and avoid foster care placement. Another study by Abt Associates (2001) cited the effectiveness of these programs as “mixed” (see also Committee on Ways and Means, U.S. House of Representatives, 2004). In the decade since passage of ASFA, there are still no better answers on how to protect children from harm. Thus, the best policy would seem to be expediting TPR and promoting adoption for more children in care who are not likely candidates to be safely returned to their families.

Research on effective family treatment modalities needs to continue and be brought to the attention of policymakers. However, adoption must not be viewed as a last resort or an option resulting from the system’s failure to effectively preserve the biological family. This view will continue to condemn thousands of children to government care and lifelong damage. In circumstances in which a sibling has already been victim to murder, manslaughter, or serious bodily harm, adoption ought to be the first option for the child removed, for his or her own safety.

My Specific Recommendations:

- Recalibrate the “15/22” rule based on the age of the child: the younger the child, the shorter the timeframe to move toward TPR and adoption.
- Examine states’ use of the “compelling reasons” and “aggravated circumstances” provisions to ensure that the flexibility allowed is not being used to prevent or fail to expedite adoption when it is appropriate.
- Value adoption as a better option for all children in foster care, since thousands of children are growing up without permanency, spending almost three years on average in care—a protracted wait that should take into account the child’s sense of time and critical periods of development.
- Encourage voluntary relinquishment, recognizing that parenting is not for everyone; this option can be positive and life-altering for both the parent and the child.
- Offer up-front, high-quality, intensive services to parents who indicate they are ready to change and are complying with treatment plan requirements.
- Develop risk-assessment models based on empirical data to predict the level of risk attached to the range of decisions: to remove the child; not to remove the child; to return the child to the family.

Conclusion

Maltreatment has a lifelong, deleterious, and irreversible impact on a child. All children have an inherent right to grow up free from abuse. Parental rights are not inalienable, and children are not property. ASFA recognizes these facts by establishing policies intended to expedite the legal decisions surrounding the placement of a maltreated child. Adoption is a “second chance” for the child to grow up healthy and emotionally stable.

Researchers must be funded to develop effective prevention, intervention, and treatment services and demonstrate to policymakers and providers-at-large that there are some substance abusers, parents with a mental illness, and incarcerated parents who have the will and determination to put their child ahead of their own needs. These parents can change, given their own second chances.

ASFA is a highly successful law, meeting the expectations of both the “Contract with America” and the “Adoption 2002” directive. With its provisions that led to Child and Family Service...
Reviews—the ongoing evaluation of state foster care programs in achieving permanency, safety, and wellbeing—there is every reason to be optimistic about identifying what is working or not working to make children “the paramount concern” of the system.

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Meeting the Educational Needs of Youth in Foster Care: A Proposal of Solutions Including an Individualized Education Advocacy Program

Rebecca Hampton

Introduction

The United States’ foster care system was created to be a safe haven for children experiencing abuse and/or neglect. When child welfare officials believe a child cannot live safely with his family, a judge is asked to remove the child from his home and place him in foster care. Once a child is placed in foster care, the state stands in loco parentis, or “in the place of a parent,” granting the state the responsibility of being the child’s caretaker. For a foster youth attending the public school system, this means the state serves as both parent and educator.

This article suggests that states are not rising to the challenge of being both a parent and an educator to our youth in foster care: the current system in place for educating children in foster care is ineffective and must be changed. To support these assertions, this article points to data that illustrates the grim educational outcomes of America’s youth in foster care. In addition, it points to a new study by the California Partnership for Achieving Student Success (Cal-PASS) as an example of properly linking educational data with child welfare system data to better understand how our educational system can better serve children in foster care. This article also seeks to educate the reader on current federal legislation that promotes educational stability for children in foster care, including common criticisms of the legislation.

Finally, the following recommendations for the improvement of education for children in foster care are made:

1) To better understand how our educational system is failing children in foster care, the federal government must require states to collect data regarding foster youth education outcomes.

2) The federal government must place a mandate on local education agencies to ensure they collaborate with local child welfare agencies to promote educational stability and future academic success for children in foster care.

3) The federal government must establish an “Individualized Education Advocacy Program” for each child in foster care to ensure states serve as an effective parent and educator to the child while she is in foster care.

Historical Background

The U.S. Supreme Court’s decision in Brown v. Board of Education highlighted a turning point in America’s public education system. In a unanimous opinion written by Justice Earl Warren, the highest court in our country declared that separate educational facilities are inherently unequal.1

Today, education is perhaps the most important function of state and local governments. Compulsory school attendance laws and the great expenditures for education

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both demonstrate our recognition of the importance of education to our democratic society. It is required in the performance of our most basic public responsibilities, even service in the armed forces. It is the very foundation of good citizenship. Today, it is a principal instrument in awakening the child to cultural values, in preparing him for later professional training, and in helping him to adjust normally to his environment. In these days, it is doubtful that any child may reasonably be expected to succeed in life if he is denied the opportunity of an education.\textsuperscript{2}

In the years following the\textit{ Brown }decision, parents of minority students fought to ensure desegregation was properly implemented in American classrooms. All the while, children with special needs\textsuperscript{3} were being systematically excluded from their classrooms.\textsuperscript{4} Accordingly, throughout the civil rights era, parents of students with special needs fought alongside parents of minority students to ensure that all children had equal access to the public education system.\textsuperscript{5}

The efforts of these dedicated parents paid off: the “separate but equal” doctrine eventually became a distant memory, and federal legislation was drafted to promote equal access to education for students with special needs.\textsuperscript{6} This historical backdrop illustrates how compassionate and dedicated parental advocates can correct shortcomings in the classroom. But what happens to children without such dedicated parents when the public education system fails them? To answer this question we need only look at the negative educational outcomes for America’s youth in foster care.

\textbf{Foster Care Data}

\textbf{The General State of Foster Care}

Hundreds of thousands of American children are currently languishing in the U.S. foster care system.\textsuperscript{7} With each passing year, as many as 30,000 of these youth will “exit the [foster care] system without a permanent connection to a family or a caring adult (p. 1).”\textsuperscript{8} Many of these young adults have already experienced abuse, neglect, separation, and/or impermanence, and suffer from significant educational deficits as compared to their peers in the general population.\textsuperscript{9} A 2009 study by Chapin Hall\textsuperscript{10} illustrates that by 23 or 24 years of age, nearly one-quarter of these young adults will not have a high school diploma or GED.\textsuperscript{11} This statistic demonstrates that youth in foster care are three times more likely as their general population peers not to receive a high school diploma or GED.\textsuperscript{12}

As a result of educational deficits that persist into their adulthood, former foster care youth are at
risks of experiencing homelessness, drug addiction, and/or criminal activity at some point in their lives.\footnote{13}

Unfortunately, the educational deficits for children in foster care are not recent news. Ten years ago, a study in Washington State concluded that children in foster care in third, sixth, and ninth grade scored 16 to 20 percentile points below their peers on standardized tests.\footnote{14} In addition, a 2004 Chapin Hall study on youth in out-of-home care in Chicago’s public school system revealed these youths are at least half a school year behind similarly situated children in the same schools.\footnote{15}

Perhaps the most disturbing recent news about our youth in foster care is that most report “postsecondary educational aspirations similar to those of young people in the general population (p. 1).”\footnote{16} The statistics outlined above demonstrate that most foster youth will not realize their dreams. They are victims of a system that fails to provide them with the educational support they need to succeed under their unique life circumstances. While “educational success can be a positive counterweight to their [negative life] experiences . . . the educational outcomes of most children in foster care are dismal (p. 2-3).”\footnote{17}

\section*{Cal-PASS Results}

On September 23, 2010, the Congressional Coalition on Adoption Institute (CCAI) and Fostering Media Connections (FMC) released the preliminary findings of a study funded by the Stuart Foundation\footnote{18} entitled Investigating California Foster Youth High School & College Education Outcomes. Conducted by the California Partnership for Achieving Student Success (Cal-PASS) and researchers from the University of California, Berkeley, this study links data from the California Child Welfare Services/Case Management System (CWS/CMS) with education data.\footnote{19}

The Cal-PASS results\footnote{20} reinforce what previous studies have concluded about our child welfare system: foster care is broken and youth in foster care are in an educational crisis. According to the Cal-PASS results, children in foster care in grades eight through 11 struggle in math and English, and are less likely than their peers to achieve proficiency in these subjects at all grade levels.\footnote{21}

To ensure the study produced accurate results, Cal-PASS and Berkley researchers compared the educational outcomes of youth in foster care to those of “at-risk” children as defined by the No Child Left Behind Act of 2001 (NCLB 2001). Foster youth were compared with subgroups of school children with low socioeconomic status, nonwhite school children, neglected or delinquent children, children with disabilities, and English language learners: “Sample preliminary result found that one in 10 foster youth are proficient in

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\begin{itemize}
\item \footnote{13} Senate Caucus on Foster Youth. (October 7, 2010) Options for Child Welfare Reform: A CALL TO ACTION. Retrieved from http://finance.senate.gov/newsroom/ranking/download/?id=58c7ad48-3b5a-4877-8f80-4c4d77a808
\item \footnote{16} Dworsky, A. & Courtney, M. E. (2010). Does extending foster care beyond age 18 promote post secondary educational attainment? Emerging findings from the Midwest Study. Chicago, IL: Chapin Hall at the University of Chicago. (Page 1 discusses foster youth academic aspirations.)
\item \footnote{17} United States House of Representatives Committee on Ways and Means (2009). Testimony of Kathleen M. M. McGough on behalf of the American Bar Association for the hearing on “Implementation of the Foster Care Connections to Success and Increasing Adoptions Act.” Retrieved from http://www2.americanbar.org/BlueprintForChange/Documents/aba_fca_testimony_9_15_09.pdf
\item \footnote{18} The Stuart Foundation is dedicated to the protection, education and development of children and youth in the States of California and Washington. For more information about the Stuart Foundation visit http://www.stuartfoundation.org/AboutUs.aspx
\item \footnote{20} The full findings of this pilot project will be released this winter.
\end{itemize}
math by the 11th grade; just over two in 10 foster youth will be proficient in English by the 11th grade.\textsuperscript{22} These results signal a need for reform, and simultaneously illustrate that child welfare and educational data can be linked to better understand the plight of America’s children in foster care.

\textbf{Instability as the Root Cause of Poor Educational Outcomes}

On average, youth in foster care currently have one to two home placement changes per year.\textsuperscript{23} Accordingly, these youth lack the permanence that their peers experience. “A study of 479 alumni of foster care in Oregon and Washington found that 65\% [percent] experienced seven or more school changes from elementary through high school (p. 2).”\textsuperscript{24} As Kathleen Strottman, Executive Director of the Congressional Coalition on Adoption Institute, said, “[t]he fact that they can perform at all, in light of the constant changes in school and other trauma in their lives, is alone a testament to their ability.”\textsuperscript{25}

Statistics show that removing a child from his home has the strong possibility of negatively impacting his academic career. Multiple educational and home placements create instability and instability leads to poor life outcomes.

\textbf{Legislation Promoting Educational Stability}

The issue of educational instability has not been completely overlooked by our leaders on Capitol Hill. Laws such as the McKinney-Vento Homeless Assistance Act (McKinney-Vento) and the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Fostering Connections) were enacted to provide educational stability for children in out-of-home care. “Both laws recognize the need for school stability and continuity for highly mobile children. However, each provides a different set of rights and responsibilities (p. 1).”\textsuperscript{26}

\textbf{McKinney-Vento\textsuperscript{27}}

\textbf{General Information}

In 1987, the McKinney-Vento Education for Homeless Children and Youth Program (EHCYP) was authorized to promote educational stability for homeless children. EHCYP was reauthorized by NCLB 2001 to ensure homeless children continue to receive the free and appropriate public education they are entitled to. Pursuant to Title VII-B, McKinney-Vento requires states to review laws and policies that prevent the enrollment, attendance, and success of eligible children in the public school systems. Accordingly, schools are not allowed to separate homeless children from their peers in the general population based solely on their status as homeless.

\textbf{McKinney-Vento Services}

Children eligible under McKinney-Vento are entitled to services such as: (1) remaining in their school of origin if it is in their best interest, unless their parent disagrees; (2) transportation to the school of origin; (3) immediate enrollment without the typical documentation, such as immunization records and birth certificates; and (4) timely transfer of school records to the new school. In addition, every state has a McKinney-Vento State Coordinator and each school district must designate a McKinney-Vento liaison.

\textsuperscript{22} Ibid.
\textsuperscript{24} Ibid.
McKinney-Vento Eligibility
McKinney-Vento defines homeless children as those individuals lacking a fixed, regular, and adequate nighttime residence. The law accomplishes its goal of assisting homeless children by providing federal grants to states, which supplement services for eligible children.

McKinney-Vento defines eligible children as children who are: (1) homeless but not in foster care; (2) “awaiting foster care placement”; (3) homeless and also in foster care; or (4) children in foster care living in emergency or transitional shelters. The phrase “awaiting foster care placement” is not defined by statute; either the state or school district policy or the McKinney-Vento Liaison defines this phrase.

Although children “awaiting foster care placement” are considered eligible children for McKinney-Vento, children already placed in foster care are not considered eligible for services. Accordingly, children already placed in foster care rely on Fostering Connections to promote educational stability.

McKinney-Vento "Best Interest" Determination
Best interest determinations regarding whether a child stays in his/her school of origin is made by the McKinney-Vento liaison. “Best practice suggests that the McKinney-Vento liaison should gather information about a child from the child, foster parent, child’s caseworker and child advocate or attorney in making a best interest determination (p. 3).”

As stated above, children already placed in foster care are unable to receive McKinney-Vento services. Accordingly, they rely on Fostering Connections to promote educational stability.

Fostering Connections

General Information
On October 7, 2008, President George W. Bush signed the Fostering Connections to Success and Increasing Adoption Act (Fostering Connections), making it Parts B and E of Title IV of the Social Security Act. At the time of its enactment, Fostering Connections was supported by 500 organizations (including the National Council For Adoption) and established the most significant improvements to child welfare in more than a decade. Proponents of the new law had hopes that it would break the cycle of poor educational outcomes for America’s youth in foster care.

Fostering Connections was drafted to address the needs of children and youth in the American foster system by changing policies in the following areas: (1) support for kinship care and family connections; (2) support for older youth; (3) coordinated health services; (4) improved educational stability and opportunities; (5) incentives and assistance for adoption; and (6) direct access to federal resources for Indian tribes.

The educational provisions of Fostering Connections are essential to the child welfare reform legislation. The primary focus of the educational provisions is to decrease instability and ultimately promote future academic success for youth in foster care.

Fostering Connections Educational Provisions
Fostering Connections requires the state child welfare agency to develop a case plan for each child in foster care. A case plan is a written document that, among other things, includes:

28 Ibid.
29 An example would be children in the child welfare system that have run away.

32 Ibid.
33 See 42 U.S.C. § 675(1).
To promote educational stability, each child’s case plan must include:

- Assurances that the placement of the child in foster care takes into account the appropriateness of the current educational setting and the proximity to the school in which the child is enrolled at the time of placement.

- An assurance that the State has coordinated with appropriate local educational agencies (as defined under section 9101 of the Elementary and Secondary Education Act of 1965) to ensure that the child remains in the school in which the child is enrolled at the time of placement.

- If remaining in [school of origin] is not in the best interests of the child, assurances by the State agency and the local education agencies to provide immediate and appropriate enrollment in a new school, with all of the educational records of the child provided to the school.

Fostering Connections also expanded the permissible uses of SSA Title IV-E administrative dollars to include reasonable travel for the child to remain in the school in which the child is enrolled at the time of placement. Accordingly, after the inclusion of Fostering Connections into the SSA, “foster care maintenance payments” were defined, by the statute as “payments to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, and child’s personal incidentals, liability insurance with respect to a child, reasonable travel to the child’s home for visitation, and reasonable travel for the child to remain in the school in which the child is enrolled at the time of placement.”

Under Fostering Connections, Title IV-E funding is made dependent on a state providing “assurances that each child who has attained the minimum age for compulsory school attendance under State law and with respect to whom there is eligibility for a payment under the State plan is a full-time or elementary or secondary school student or has completed secondary school.” Lastly, Fostering Connections education provisions give states the ability to extend foster care up to the age of 21, and created a new requirement for a “transition plan” to be developed before a child in foster care exits the system. The “transition plan” is to be developed 90 days before a youth exits the system and should be personalized to the child by including specific options that meet the child’s needs with regard to housing, health insurance, education, local opportunities for mentors, continuing support services, work force support and employment services.

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40 Title IV-E refers to the programs and requirements under the SSA that encompass foster care and adoption assistance funding.
42 Ibid. (emphasis added).
43 Fostering Connections defines “elementary or secondary school student” as a child that is:
   • enrolled (or in the process of enrolling) in an institution which provides elementary or secondary education, as determined under the law of the state or other jurisdiction in which the institution is located;
   • instructed in elementary or secondary education at home in accordance with a home school law of the State or other jurisdiction in which the home is located;
   • in an independent study elementary or secondary education program in accordance with the laws of the State or other jurisdiction in which the program is located, which is administered by the local school or school districts; or
   • incapable of attending school on a full-time basis due to the medical condition of the child, which incapability is supported by regularly updated information in the case plan of the child.]
47 Ibid.
Fostering Connections Eligibility
Eligibility under Fostering Connections is not limited to those children “awaiting placement” as the case is under McKinney-Vento. Every child in out-of-home care is eligible for services under Fostering Connections, including those children already placed in foster care.

Criticism of Fostering Connections
The passage of Fostering Connections highlighted the educational crisis of America’s youth in foster care. Some states responded to the passage of the federal law by adopting state legislation and regulations to guide implementation of the new federal law. Unfortunately, despite all efforts, the educational provisions of Fostering Connections are not being effectively implemented in American classrooms. “Many states are reporting common and sometimes insurmountable barriers to effective implementation of [Fostering Connections] (p. 1).” Until Congress reexamines child welfare education legislation, proper implementation of the educational provisions for youth in foster care is impossible.

Below are common questions that arise when state child welfare advocates attempt to implement Fostering Connections. These questions highlight the weakness of Fostering Connections as well as areas that need reform.

A. What is the role of local education agencies in implementing Fostering Connections?

Fostering Connections places a mandate on child welfare agencies to communicate with education agencies when creating a case plan for each child in foster care. Since this mandate is placed solely on the child welfare agency, the education agency is not legally required to promote school stability and continuity for children in foster care.

Without a legal mandate requiring local education agencies to assist in the implementation of Fostering Connections, child welfare agencies are left to complete this task alone. Many education agencies feel unable to help the child welfare agencies implement Fostering Connections, because they believe “residency requirements bar them from accepting foster youth from out of district, and documentation or record requirements bar them from immediately enrolling students changing schools (p. 1-2).”

To ensure school stability and future academic success becomes a reality for children in foster care, a mandate to promote the implementation of Fostering Connections must be placed on both child welfare agencies and local education agencies.

B. What is an “appropriate” education setting?

Fostering Connections requires the child welfare agency to create a case plan that takes into account the “appropriateness” of the current educational setting of the child in foster care. Under the current law, child welfare agencies are not given any direction regarding whose input is required when making this decision. For example, does the child welfare agency need to speak with a youth’s parent? What about a youth’s teacher?

In addition, who ultimately makes the “appropriateness” determination? Does one single person make this “appropriateness” determination, or does a team of individuals make this determination? What standard is used to assess “appropriateness” of an educational placement? Without resolutions to these questions, Fostering Connections will not realistically be properly implemented.

Fortunately, the legal concept of an “appropriateness” standard for public education

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48 Legal Center For Foster Care & Education. (2010). State legislation chart: Providing school stability and continuity for children in foster care. (This document provides an up to date chart of existing laws and policies that provide rights and protections to foster youth in the context of educational stability). Retrieved from http://www.abanet.org/child/education/publications/state_legislation_chart_10_5_10_final.doc

49 Legal Center For Foster Care & Education. (2010). State and federal implementation of the education provisions of the Fostering Connections Act: Progress and challenges. Author: Chicago, IL.

50 42 U.S.C. § 675 et seq.

51 See Legal Center For Foster Care & Education, note 46, at 1-2.

has been recognized outside of the foster care context. Pursuant to the Individuals with Disabilities Education Act (IDEA) a “free appropriate public education” occurs when the individualized and unique circumstances of a student with special needs is taken into consideration by a team of individuals. Thus, under IDEA, determining what an “appropriate” public education is requires a case-by-case assessment for each student with special needs.

The case-by-case approach taken under IDEA ensures each child with special needs has meaningful access to the public education system. While implementing this standard under Fostering Connections would not answer questions as to who should participate in the “appropriateness” determination, it would promote school stability and future academic success by requiring an individualized look at the education of each child in foster care.

C. How is the best interest of the child determination made?

Fostering Connections requires a local child welfare agency to keep a child in foster care in his school of origin until it is determined that remaining enrolled is not in the best interest of the child. But how does the child welfare agency make this “best interest” determination?

To date, Fostering Connections, federal regulations and policies do not provide local child welfare agencies with any criteria to reference when making “best interest” determinations. In addition, Fostering Connections does not explain who will be involved in the “best interest” determinations. Should the school take part in this deliberation? What about the child’s foster parent or his biological parent? What if a disagreement arises as to what is the “best interests” of the child? What type of dispute resolution process should be undertaken?

In addition to the problems arising from implementing the “best interest” mandate, clarification is needed to ensure child welfare agencies are applying this mandate correctly. Fostering Connections does not require a “best interest” showing in order for the child to stay in his school of origin. Instead, Fostering Connections mandates that the child stay in the school of origin unless remaining there is not in his “best interest.” Following this provision as written promotes stability and future academic success because it ensures that a child in foster care will remain in her school of origin unless it is necessary to remove her.

Recommended Actions

The “Criticisms of Fostering Connections” section of this article lists important questions that need to be answered before proper implementation of Fostering Connections is possible. Below, flaws of Fostering Connections that are in need of immediate remedy will be discussed. In addition, recommended actions to solve the problems will be listed.

Collect Comprehensive Data on Foster Care and Education

Fostering Connections does not require states to collect data regarding the educational outcomes for youth in foster care. Accordingly, improvements in the educational outcomes of children in foster care are difficult to track.

Federal law should require states to engage in comprehensive research of educational outcomes for youth in foster care. “Tracking data such as attendance, the number of school changes, and enrollment delays is necessary to show improvements in education outcomes for children in care and must be addressed in both child welfare and education agency data systems.

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55 There is no standard definition of “best interests of the child.” However, this legal concept typically refers to the deliberations that occur when deciding what type of actions, placements, or services will best serve a child’s needs. Such determinations are made after considering a number of factors related to the child.
State collection of foster care data is crucial to continuing the discussion on how to best provide services to America’s youth in foster care.

The Cal-PASS study in California demonstrates that linking data between child welfare agencies and educational agencies is both possible and replicable. In 2011, the Cal-PASS pilot project will be expanded to serve all of California. Other states should note this study and find a similar path that will allow them to effectively analyze and assess the educational needs of their youth in foster care. Without comprehensive research on this topic we will not have a benchmark for policy and practice change.

**Federal Mandate on Local Education Agency**

Fostering Connections does not currently require local education agencies to collaborate with child welfare agencies to promote educational stability and future academic success. Such a mandate must be established.

However, child welfare agencies need not wait on federal reform before attempting to solve the programs plaguing children in foster care. By contacting their local education agency, child welfare agencies may be able to work out common sense solutions to fixable problems. For example, Molly McGrath, director of Baltimore City’s Department of Social Services, has had great success in establishing communication between her department and Baltimore City Public Schools. The two departments currently share information that helps track the educational success of youth in foster care.

An example of the novel inter-department collaboration involves students’ emergency contact cards. In Baltimore, the public school system notifies the child welfare system of the name of the person listed by students’ parents as the “emergency contact.” This “emergency contact” is usually a family member or friend within the same school district. Accordingly, when a child is taken from his home, child welfare workers reach out to the emergency contact before attempting to place the child elsewhere. This common sense solution developed through inter-departmental collaboration allows the student to remain in a familiar environment that is within the district of her school of origin.

**Establish an Individualized Education Advocacy Program within Local Child Welfare Agencies**

Social workers in many child welfare agencies are overworked and underpaid. This combination, along with a lack of resources, often causes issues of abuse and neglect to be the main priority in case management, and the educational needs of youth in foster care become an afterthought. Dismal statistics regarding the educational outcomes for youth in foster care and their continuing negative impact into adulthood demonstrate that the time for reform of our foster youth’s education is now.

A federally mandated Individualized Education Advocacy Program (IEAP) for each child in foster care will ensure that education of America’s children in foster care does not continue to fall by the wayside.

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56 Legal Center For Foster Care & Education. (2010). *State and federal implementation of the education provisions of the Fostering Connections Act: Progress and challenges.* Author: Chicago, IL.


58 E-mail from Daniel Heimpel, Project Director, Fostering Media Connections, to Rebecca Hampton, National Council For Adoption Public Service Law Fellow (Oct. 27, 2010).


60 Ibid.
Case Study: Washington State’s Education Advocacy For Foster Youth

The Washington State Department of Social and Health Services (DSHS) has funded education advocacy services for youth in foster care since 2006.61 By employing Treehouse, a Seattle based non-profit organization, Washington State’s DSHS ensures that these youth have access to services that promote their educational success.

Washington’s Treehouse Educational Advocacy Program (EAP) coordinators promote the educational success of children in foster care by intervening in school settings when foster youth experience educational challenges.62 EAP coordinators do for youth in foster care what parents of minority and special needs students did for their children during the civil rights era: they give the students a voice.

Much like the Individualized Education Plan (IEP) mandated under special education law, Washington’s Treehouse EAP is an individualized program; as such, the services provided to a child in foster care depend on his/her unique life circumstances.63 Each foster youth’s EAP is organized around four goals:

1) Improve access to services;
2) Stay enrolled in school and improve attendance;
3) Maintain academic progress; and
4) Reduce school disciplinary actions.64

Youth in foster care and EAP coordinators discuss each child’s individualized needs and address the goals as necessary to fit his or her unique circumstances.

EAP coordinators also periodically complete an assessment for youth in foster care. The assessment form describes the youth’s educational goals as well as how each goal will be measured. In addition, the assessment form states whether the youth requests consultation or direct services.

Consultation services provide the child in foster care, his caregivers, and/or his caseworker with information on how to address conflicts within the school system.65 “For example, a coordinator might explain to caregivers how to initiate a change in special education services (p. 2).”66 Coordinators are also available to provide information regarding: (1) tutoring and mentoring programs; (2) advanced placement programs; and (3) alternative education programs.

Direct services are provided when the EAP coordinator works directly with the youth’s school staff to ensure the goals are met.

The Individualized Education Advocacy Program67

The Washington State EAP takes into account the educational needs of youth in foster care. Unlike minority children, children with special needs, and other children in the general population, children in foster care do not have parental advocates fighting to ensure the public education they receive is meaningful. Instead, America’s youth in foster care rely on child welfare agencies to ensure their educational needs are met. The establishment of an Individualized Education

62 Ibid.
63 Ibid.
64 Ibid.
65 Ibid.
66 Ibid.
67 The author would like to thank Lily Eagle Dorman Colby for proposing the idea of an Individualized Educational Advocacy Program for foster youth at a Senate Caucus on Foster Youth hearing. Lily entered the California foster care system at age 12 after her parents were unable to care for her due to drug abuse and mental illness; she clung to school as the only constant in her life. It paid off: Lily was ultimately awarded a full scholarship to Yale and in the Fall of 2011, Lily plans to attend U.C. Berkeley Law School. Lily recommends the development of an Individualized Educational Advocacy Program due in part to her experience as a foster youth and in part to her experience as serving as mother to her autistic brother.
Advocacy Program (IEAP) for children in foster care will ensure that child welfare agencies rise to the challenge.

**Purpose of an Individualized Education Advocacy Program**

Much like the IEP established under IDEA, a youth’s IEAP will analyze what services he needs in order to have meaningful education within the public education system. Similar to the purpose of the IEP, the purpose of a youth’s IEAP will be to ensure schools provide the federally mandated “appropriate” public education that each child is entitled to. In addition, the IEAP should focus on meeting the unique needs of the child and preparing her for further education, employment, and independent living.

**IEAP Goals**

Like the Washington State EAP program, a federally mandated IEAP should establish educational goals for children in foster care as well as a means of measuring progress made towards the stated goals.

Basic IEAP goals, such as those in the Washington State EAP program, include:

1) Improving access to services;
2) Staying enrolled in school and improve attendance;
3) Maintaining academic progress; and
4) Reducing school disciplinary actions.

To ensure the IEAP is reflective of the individualized needs of each child in foster care, a list of possible goals should never be exhaustive. In addition to the educational goals listed by Washington State’s EAP, IEAP goals could include:

1) Improving participation in extra curricular activities;
2) Meeting age/grade appropriate benchmarks such as getting a driver’s license/identification card or registering/taking standardized tests for college admission.

Educational goals should not be strictly construed to mean academic goals. Promoting the social-emotional development of youth in foster care is also the job of the local child welfare agency when it stands in loco parentis or “in the place of a parent.” Accordingly, IEAP educational goals may be a means of ensuring the child welfare agency provides the appropriate social-emotional support to which a youth in foster care is entitled.

**IEAP Coordinators**

Like Washington State’s program, a federally mandated IEAP should establish an IEAP Coordinator. The IEAP Coordinator should work within the local child welfare agency and in conjunction with the foster youth’s case worker and the local education agency. The IEAP Coordinator should ensure the educational provisions of Fostering Connections are being properly implemented by periodically completing an assessment of the child in foster care and her educational needs. During this assessment, the IEAP coordinator will be able to determine whether the child is receiving an “appropriate” public education. In addition, the IEAP can make “best interest” determinations.

Through the creation of the foster care system, our state and local governments have taken on the responsibility of providing for our society’s most defenseless citizens. The establishment of an IEAP for each youth in foster care will ensure that the education of these vulnerable children does not continue to be an afterthought in the child welfare system.

**Conclusion**

In *Brown v. Board of Education*, the U.S. Supreme Court stated that education is arguably the most important function of state and local governments. The evolution of legislation that led to the Individuals with Disabilities Education Act reiterated the importance of education in
American society, and established that every child is entitled to an “appropriate” public education. Unfortunately, the grim educational outcomes for America’s youth in foster care illustrate that when the state and local government is your “family,” educational success is not a priority. Statistics regarding the educational outcomes of youth in foster care demonstrate that the time for reform of foster youth education is now.

Federal legislation such as McKinney-Vento and Fostering Connections laid the foundation for reducing educational instability for the foster care population, however, implementation issues at the state level have caused educational instability and educational deficits to persist. To rectify this problem, the federal government must require states to collect comprehensive data on the educational outcomes of youth in foster care. This data could be used to track programs and could serve as a basis for policy reform and best practices. In addition, the federal government must require local education agencies to work in collaboration with child welfare agencies in implementing Fostering Connections. Without a mandate on both departments, educational stability for youth in foster care is unrealistic.

Lastly, the federal government must implement an Individualized Education Advocacy Program for each youth in foster care. An IEAP will ensure that state and local governments do not just meet the basic needs of children in foster care, but also take into consideration each child’s unique life circumstances. As a result of this process, the IEAP will ensure the government actually provides children in foster care with the “appropriate” education to which they are entitled under Fostering Connections. After all, with regard to youth in care, our government stands in the place of the child’s parent. It is time for our government to rise to that challenge.
NCFA Supports the Families for Orphans Act (FFOA) and the Foreign Adopted Children Equity Act

Elisa Rosman

The Families for Orphans Act (FFOA)

Research and common sense make clear that permanent homes and families are good for children. The Families For Orphans Act (H.R. 3070 and S.1458), sponsored by Representatives Diane Watson (D-CA) and John Boozman (R-AR) in the House and Senators Mary Landrieu (D-LA) and James Inhofe (R-OK) works towards permanency for all children on an international level. FFOA establishes the Office of Orphan Policy, Diplomacy and Development within the Department of State and provides diplomatic authority to help the millions of children orphaned worldwide and the millions upon millions of vulnerable children who have lost one parent or are at risk of losing parental care.

In the legislation the term ‘orphan’ means any child:

- who lacks permanent parental care because of the death, the disappearance of, or the legal, permanent relinquishment of such child by both biological parents;
- who is living in the care and custody of an institution;
- whose biological parents’ rights have been legally terminated; or
- whose country of origin has determined lacks permanent parental care.

The new office would be responsible for developing and implementing a comprehensive strategy to support diplomacy and policy focusing on the preservation and reunification of families and the provision of permanent families for orphans. FFOA presents a continuum of options for children which the new office will promote, from reunification, to legal kinship or legal guardianship, to domestic adoption, to international adoption.

The new office will elevate the plight of children, giving the United States a clear, dedicated diplomatic authority to represent the interests of orphaned children. The office will advise the Secretary of State and President in all matters related to global family preservation and permanent parental care options for orphans. The new office will also conduct research designed to better understand the size of the population of children living without parental care and global efforts to support these children. Finally, the office will also oversee three grant programs to encourage foreign governments to meet minimum standards in terms of child permanency, to support NGOs that are setting the standard for providing services to preserve families and provide permanent parental care for orphans, and to implement a pilot of a model program designed to preserve and reunify families and provide parental care for orphans.

Terry Baugh, President of Kidsave, highlights the activities supported by the Families for Orphans Act, in the children’s countries. These include:
- improving public policy in support of the preservation and reunification of families and permanent parental care for orphans reducing the number of children abandoned;
- reducing the number of families at risk of dissolution;
- increasing the number of children reunified with their parents;
- increasing the number of children obtaining legal guardianship and kinship care;
- increasing the number of children placed for adoption domestically;
- supporting international adoption for children who cannot be adopted domestically, or reunified with their biological parents;
- drafting laws and develop systems designed to promote ethical, evidence-based practice in international adoption;
- increasing the level of expertise and understanding of foreign governments working to preserve and reunify families and promote permanent parental care for orphans;
- creating and supporting connections with caring, committed adults to older children at risk of or in the process of aging out of institutional care;
- developing mentoring, visitation and foster adopt programs aimed at recruiting a larger number of individuals willing to provide permanent parental care for orphans;
- increasing adoption support services; and
- creating and improving child welfare and judicial infrastructures, that strengthen and support permanent family care for orphans.

For the full text of the bill, see: http://www.govtrack.us/congress/billtext.xpd?bill=h111-3070

The Foreign Adopted Children Equality Act (FACE)

The Foreign Adopted Children Equality Act (FACE, H. R. 3110 and S.1359) was also introduced by Representatives Diane Watson (D-CA) and John Boozman (R-AR) in the House and Senators Mary Landrieu (D-LA) and James Inhofe (R-OK). It allows for a child adopted internationally to acquire U.S. citizenship at the time his/her adoption is finalized in the country of birth through family preservation, domestic adoption, legal guardianship and kinship care, are always the preferred child welfare methods. However, when these are not timely options, a family through international adoption is clearly in the best interests of those children languishing in orphanages or living in temporary foster care.”

For the full text of the bill, see: http://www.govtrack.us/congress/billtext.xpd?bill=h111-3070
internationally adopted children will be classified as “citizens from birth” and able to travel home as Americans, and not on immigration visas.

FACE brings needed changes to the Child Citizenship Act of 2000 (CCA). The CCA was originally enacted to provide automatic U.S. citizenship to internationally adopted children of American citizens. As it stands now, however, the internationally adopted child of a U.S. citizen only receives U.S. citizenship once the child enters the U.S. to reside permanently. If enacted, the FACE Act would allow such children to acquire U.S. citizenship at the time their adoptions are finalized in their country of birth. The child would then enter the U.S. as a U.S. citizen with citizenship documentation in hand. This removes internationally adopted children of American citizens from the immigration process saving time, money and, for many, travel costs. Passage of the FACE Act also fixes one unintended consequence of the current system. That is, there are large numbers of internationally adopted children that have lived most of their lives in the United States but unknowingly are not citizens because their parents failed to take the necessary steps at the time of adoption to acquire citizenship status for their children. These individuals are not entitled to the basic rights of U.S. citizenship, and have been denied scholarships, military service, and some have been deported for committing minor crimes despite being the children of U.S citizens and having lived in the U.S for the majority of their lives.

FACE makes an additional change impacting older orphans and allowing for them to be adopted. These children were overlooked in the Hague Convention on Intercountry Adoption. “Prior to the Hague’s passage, children age 16 to 18 whose younger siblings had been adopted by an American were able to be adopted by the same American family,” said Terry Baugh, President of Kidsave. “The Hague eliminated all adoption opportunities for children 16 and over. The FACE Act will fix this oversight and expand the opportunity of a permanent family to all children up to age 18.”

Detractors are concerned that passage of FACE would eliminate safeguards that are in place to protect children adopted abroad and would diminish the birth histories of adoptees and ties to their countries of birth. NCFA, as well as numerous other adoption advocates, disagrees with these arguments. FACE does not alter any requirements for adoptive parents. It also continues to uphold all safeguards that are currently in place to ensure that fraud and trafficking are not involved with placing a child for adoption. As for the argument that FACE will erase a child’s birth history and ties to his/her country of birth, McLane Layton, the president of Equality for Adopted Children (EACH) eloquently counters this argument. “Granting of citizenship from birth cannot eliminate the fact of where a child was born, or to whom that child was born, or deprive them of their original citizenship rights any more than what occurs now when U.S. citizenship is granted to them under the CCA. To the extent a foreign country allows dual citizenship and the privileges that accompany that citizenship, that child will always have those privileges as a citizen of that country in the eyes of that country. No legislation passed by the U.S. Congress can change citizenship laws of other countries.”

This bill is another important step forward for internationally adopted children and their families. As McLane Layton concludes in her open letter to the adoption community, “The sponsors of the FACE Act – Senator Mary Landrieu, Senator Jim Inhofe (S.1359) and Representative Diane Watson and Representative John Boozman (H.R. 3110) are great friends and supporters of the adoption community and have crafted a bill that will provide equality under the law for our internationally adopted children and allow them to benefit in all ways from full American citizenship.”

http://www.govtrack.us/congress/bill.xpd?bill=h111-3110
Conclusion

Both of these bills are wholeheartedly endorsed by the Families for Orphans Coalition, a group formed to focus attention and resources on the plight of orphans worldwide. Member organizations are: Buckner International, EACH, Joint Council on International Children's Services, Kidsave International, NCFA, The Institute for Human Services/North American Resource Center for Child Welfare, The Institute for Orphan Advocacy, Weaving Families, and Worldwide Orphan Foundation.
Options for Child Welfare Reform: A Call To Action

Senator Charles E. Grassley and Senator Mary Landrieu, Co-Chairs, Senate Caucus on Foster Youth

Executive Summary

Two years ago, on October 7, 2008, bipartisan leaders from Congress enacted and President George W. Bush signed the “Fostering Connections to Success and Increasing Adoptions Act of 2008.” This bill had the support of more than 500 organizations across the country and established the most significant improvements to child welfare in more than a decade. The Fostering Connections Act made improvements to a range of federal policies, including adoption, kinship care, Tribal foster care, health care, and education. The Act included a number of provisions aimed at addressing the special needs of older youth in foster care and those transitioning out of care.

However, as important a reform as “Fostering Connections” was, it was but a down-payment. The need for comprehensive reform of the child welfare system is undisputed. Reforms need to reflect a broader array of services needed to support children and families, and also to improve the underlying financing structure that governs the way the federal government pays for these services. Analysis by experts as well as testimony by current and former foster youth highlight the many ways in which the system is antiquated and does not effectively address the emotional and physical well being of children and young people in foster care. Incentives to help keep fragile families together are scarce. The least desirable outcome: removing a child from the home and placing her in foster care, is the activity that is the most highly subsidized.

Every year, as many as 30,000 youth exit the system without a permanent connection to a family or a caring adult. These young people often end up homeless, addicted to drugs, and engaged in criminal activity. Youth in foster care are more likely to get pregnant or cause a pregnancy than youth who have not been in care, and they are less likely to complete college than their youth counterparts in general.

We established the Senate Caucus on Foster Youth to break down the arbitrary silos of public programs and closely examine the experiences of a young person aging out of foster care so that the Congress and stakeholders could better understand how to address the problem of increasing numbers of young people aging out of care without a permanent family to call home. At our direction, Members of the Caucus staff met with Foster Care Alumni, child welfare researchers, think tank associates, advocates and government officials for a series of working groups designed to address issues relevant to children and youth in foster care and to develop a variety of proposals for Members of Congress to consider as a CALL TO ACTION for child welfare reform.

Current and former foster youth participated in every working session and contributed
significantly to refining and enhancing the proposals. During these working sessions, several themes emerged that the proposals included in this CALL TO ACTION attempt to address. Youth in care report often feeling powerless and disconnected to supports and resources. Actions are taken on their behalf without their knowledge, understanding or consent. Age appropriate activities such as summer camp, after school activities, and social events, normal parts of the lives of most young people, are often not available to them. In many cases, they are isolated, prevented from attending regular school and limited in their ability to participate in recreational activities, a part-time job, or playing sports. These activities could help facilitate a mentorship relationship with a caring adult.

While permanency is the stated goal of every child in foster care, oftentimes that goal is not attained and, in many cases, youth in foster care report that they do not have an understanding of what “permanency” means. Despite federal policy requiring both the development of a plan to achieve permanency for each child or youth in foster care and a review of that plan at least annually, testimony from former foster youth suggest this doesn’t always happen in a meaningful way.

The Caucus learned about significant gaps in the oversight of policies and procedures affecting youth in care. An area where concerns were repeatedly expressed related to the possible over-reliance on psychotropic drugs as a means to manage and control the behavior of youth, especially in group homes or other congregate care facilities.

The financing of child welfare programs does not appropriately target resources to activities that produce the best outcomes for children and families.

Comprehensive child welfare reform cannot be done piecemeal. Financing reform cannot be effective without systemic reform and vice versa. We hope this work and the proposals resulting from it will be useful as members of Congress contemplate the next phase in child welfare reform.

Quotations included in this document were shared with the Caucus with the understanding that they would be made public. We are deeply indebted to the youth, who demonstrated leadership and great courage and offered profound insights, for their willingness to engage in this effort.

Youth Participants:

Tiesha Davis, Colorado
Isha-Charlie McNeely, Oregon
Faith Slater, South Carolina
Nicole Dobbins, Oregon
Dan Knapp, New York
Kayla VanDyke, Minnesota
Ashley Jackson, Missouri
Darrell Moorer, New York
Lupe Tovar, Arizona
Nicole Marchman, Florida
Serena Vidaure, California
Jeremy Long, Colorado
Janessa Senter, Iowa
Marcus Brown, Michigan
Jessica Adams, Maryland
Breuna Heater, West Virginia/Florida

Crystal Lipek, Wisconsin
Joscelynn Murdock, California
Anthony Reeves, Georgia
Chantel Johnson Crockmon, California
Mandy Baldwin, Montana
Raif Walter, Montana
Eric Lulow, Tennessee
Christina Miranda, Pennsylvania
Luis Beltran, Nevada
Tracye Redd, Iowa
Amanda Metivier, Alaska
Lily Eagle Dorman-Colby, Connecticut

Sincerely,

Senator Chuck Grassley (R-IA)
Senator Mary Landrieu (D-LA)
Co-Chairs, Senate Caucus on Foster Youth
Group Homes/Congregate Care/
Psychotropic Medications

Youth Experiences

Growing up, I was placed in six group homes/treatment facilities. In many of these placements I faced things that a young person should not have to experience, particularly when placement is primarily due to a lack of family placements. One of the biggest factors was the feeling that you are living in a separate world—without interaction with the community. I was not able to go to a public school, which left me behind in my education. In the group home environment, I was often deprived of having my own personal belongings…. I also was not allowed the privacy of reading my mail by myself.

Tiesha Davis; Age 19,
14 years in foster care

My experience with congregate care—at a “lockdown” facility in particular—was very scary. I didn’t want to stay in the foster home I was in because it was abusive so I had my caseworker remove me immediately. My caseworker said the only placement she could find for me was at a lockdown facility/shelter. I was there from mid-December to mid-January, I spent Christmas and New Year’s there, I was 15. After that, I spent a lot of holidays in group homes and congregate care. I was placed in this setting with girls who had been expelled from schools for fighting, girls who just got out of jail for stealing, selling dope, prostitution, etc., simply because there wasn’t a suitable family foster home for me to go to. I was not allowed to have my cell phone or any outside contact. I could use the landline phone but only if I was talking to someone that my caseworker put on the list when I first arrived, which had been only my younger sister. All calls were supervised. Once my belongings arrived from my old foster care home, the staff took my cell phone, my nail polish, nail remover, razors, shoestrings, and anything they thought I could use to harm myself. Communal showers were common unless you had progressed to a certain level of responsibility. At any group home or lockdown facility you start off at the lowest level (level 1) and you have to prove that you can be trusted and if so you move up.

Charlie McNeely; Age 23,
15 years in foster care

Options for Reform

Protections for Children at Risk of Placement in Congregate Care

Current Law

Each child or youth in foster care is to have a case plan that describes the type of home or institution where he or she is to be placed and the safety and appropriateness of the placement. The placement is to be the least restrictive (most family-like) and most appropriate setting available that is in close proximity to the parents’ home and consistent with the best interests and special needs of the child or youth. At least every six months, the case plan is to be reviewed by a court or administrative body to determine, among other things, the safety of the child and the continued appropriateness of the placement (Section 475(1)(A) and Section 475(5)(A) and (B)).

2 Unless otherwise noted, all statutory citations refer to the Social Security Act.
States are required to make diligent efforts to identify all adult relatives of a child within 30 days of the child’s removal from the home and to notify those relatives of options for participating in child’s care as appropriate (Section 471(a)(29)).

Under the Adoption and Foster Care Analysis Reporting System (AFCARS) states must report case-level data to the U.S. Department of Health and Human Services (HHS) twice a year on each child in foster care. Required data elements include: age of the child; the county with responsibility for the child’s placement; the current placement setting of each child; and diagnosed disabilities or other special needs. States must also report data needed to track a child or youth’s length of stay in foster care, but not length of stay by specific placement setting. Further, while states must report whether a child in a congregate setting is placed in a group home or an institution, no other information about the kind of congregate setting must be reported (Section 479).

Proposal
Require that states demonstrate that each decision to place a child or youth in a group home, or other forms of congregate care, is preceded by a family group decision-making meeting or efforts to find an alternative placement for the child or youth by someone experienced in intensive family finding.

Require that the decision to place a child or youth in congregate care be reviewed by the commissioner or a regional administrator and that the recommendation for the placement be accompanied by a statement as to why it is the least restrictive setting appropriate for the child. Require that this decision be revisited every 90 days and that the child or youth’s permanency plan is updated concurrent with the process.

Require states to report data on children in congregate care that records county by county: the numbers of children, by age and special need(s); type of group homes or other congregate care settings; and duration of placement in congregate care.

IV-E Reimbursement for Congregate Care

Current Law
Under Title IV-E, states3 are required to make foster care maintenance payments—sometimes referred to as a room and board payment—for each eligible child in foster care (Section 471(a)(1)), and they are entitled to federal reimbursement for part of the cost of providing that payment on behalf of each eligible child. The federal reimbursement rate for these payments—that is, the part of cost reimbursed by the federal government—is equal to a state’s federal medical assistance percentage (FMAP). Each state’s FMAP is adjusted annually and may range from 50 percent (in states with higher per capita income) to 83 percent (in states with lower per capita income) (Section 474(a)(1)). Federal reimbursement under Title IV-E is generally not available for services of any kind, including prevention or treatment services for families at risk of having a child placed in foster care (Section 474(a)(1)-(3) and (5)). Some federal Title IV-E support is available related to finding relatives of children or youth who entered foster care (Section 471(a)(29) and Section 474(a)(3)(E)).

Children for whom states may seek federal reimbursement for foster care maintenance payments must meet various eligibility criteria. These include placement setting requirements, among others. To be Title IV-E eligible, a child must be placed in a foster family home or a congregate care setting (referred to in the law as a “child care institution”) that is licensed according to state standards for such a home or facility. Children placed in “detention facilities, forestry

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3 “States,” when used in description of current child welfare law included in Title IV-E of the Social Security Act, refers to any of the 50 states and the District of Columbia, as well as any tribe or territory with an approved Title IV-E plan.

4 Tribes with an approved Title IV-E plan are entitled to reimbursement at a separately calculated Tribal FMAP rate. That rate may be more than, but not less than, the FMAP of any state in which the tribe is located (Section 479B(d)).
camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent” are not eligible for foster care maintenance payments. Neither are children placed in a public facility that houses more than 25 children. Federal child welfare policy, however, does not limit the number of residents in a private facility (Section 472(a)(2)(C)).

States are required to establish and maintain standards for foster family homes and “child care institutions” that are “reasonably in accord” with standards recommended by national organizations that are concerned with standards for such homes or institutions, including standards related to admission policies, safety, sanitation, and protection of civil rights (Section 471(a)(10)).

**Proposal**

Federal reimbursement for room and board in group homes and other congregate care settings will be limited to facilities that have met requirements for accreditation by a national organization that provides accreditation of congregate care settings. After a one-time 90-day period, the federal IV-E reimbursement rate for room and board in congregate care settings will be reduced over time. Exceptions will be made for homes that specialize in providing post-pregnancy supports for parenting teens and other youth with special needs. Federal savings from this reduction can be used to support recruitment of minority families as well as families willing to adopt older children in care (Section 203(b)(2),(10) and (11) of Adoption Opportunities and Section 330G of the Public Health Service Act). As part of responding to these requirements, HHS supports the National Resource Center for Recruitment and Retention of Foster and Adoptive Parents at AdoptUsKids (www.adoptuskids.org).

States are required to provide for the diligent recruitment of potential foster and adoptive families that reflect the ethnic and racial diversity of children in the State for whom foster and adoptive homes are provided (Section 422(b)(7)).

**Proposal**

To help reduce the need for the use of congregate care, the Secretary of HHS must use a portion of the Department’s discretionary funding to develop and air Public Service Announcements to highlight the need for nurturing foster family parents to provide safe homes for children and youth in foster care, particularly older youth and other special populations.

**Restrictions on “Another Planned Permanent Living Arrangement” (APPLA) as a Permanency Option**

**Current Law**

Within 12 months of the child or youth entering foster care, the state must ensure that a hearing is held to establish a permanency goal for that child or youth. The permanency goal established may be return to parent(s), placement for adoption, or placement with a legal guardian. Alternatively, the state may establish “another planned permanent living arrangement” (APPLA) as the child or youth’s permanency goal. However, it may only do this if it can document to the court (or court-approved administrative body) a compelling reason that none of the other permanency options is in the child or youth’s best interests (and that placement with a fit and willing relative is also not in the child or youth’s best interests) (Section 475(5)(C)(i)). HHS has promulgated regulations noting the following situations as examples of compelling reasons to establish APPLA as a child

**Improved Recruitment of Foster Family Homes**

**Current Law**

HHS is required to support projects (local and/or national) to increase awareness of the need for adoption of children from foster care and to support recruitment of minority families as well as families willing to adopt older children in care.
or youth’s permanency plan: 1) an older youth specifically requests emancipation as a planned outcome; 2) a child and parent have a significant bond but the parent is unable to care for the child because of an emotional or physical disability and the child’s foster parents have committed to raising him/her to the age of majority and to facilitate visitation with the disabled parent; or 3) an Indian Tribe has identified another planned permanent living arrangement for the child (45 C.F.R. 1356.21(h)(3)).

**Proposal**
Eliminate “another planned permanent living arrangement” (APPLA) as a permanency option.

Alternatively, modify the option. Make APPLA available only for youth older than 16 or 17 years of age, only after efforts at intensive family finding have been undertaken, and only if APPLA is determined or re-determined necessary by the court at each permanency hearing held with regard to the youth. This must include a judicial determination, at each permanency hearing for a youth with APPLA goal, that there are compelling reasons why each of the preferred permanency plans (reunification, adoption, and guardianship) are not appropriate at this time.

**Federal Reimbursement for Post-permanency Supports**

**Current Law**
States are entitled to receive partial federal reimbursement under the Title IV-E program for foster care maintenance payments, adoption assistance payments, and (if the state has elected to provide them) kinship guardianship assistance payments made on behalf of eligible children. States are further entitled to claim partial federal reimbursement for eligible costs in administering the Title IV-E program, including some program costs related to data collection, training, child placement activities, and any other expenses related to the “proper and efficient administration” of the Title IV-E plan. States cannot claim administrative cost reimbursement under the Title IV-E program for any services provided to children in foster care or those leaving foster care, including post-permanency services (Section 474(a)(1)-(3)and (5)).

For federal fiscal year 2009 states submitted total Title IV-E foster care claims of $8.6 billion and expected to receive federal reimbursement for about $4.6 billion (or 54 percent) of those program expenditures. Also for federal fiscal year 2009 states submitted total Title IV-E adoption assistance claims of $3.9 billion and expected to receive federal reimbursement for about $2.3 billion (or about 60 percent) of those program expenditures.5

**Proposal**
Allow federal Title IV-E dollars to be used to support the provision of post-permanency supports for a period of time when children are reunited with their families, adopted or placed permanently with relative guardians to help reduce reentry and the placement of children in congregate care.

**Report on the Use of Psychotropic Drugs by Children and Youth in Foster Care**

**Current Law**
No provision.

**Proposal**
The Department of Health and Human Services will conduct an analysis of the types of psychotropic drugs prescribed to children and youth in foster care, determine what, if any, consistent and medically valid criteria are in place for prescribing these drugs, and determine how frequently states review and monitor the policies and practices relative to the use of psychotropic drugs for children and youth in foster care. HHS will report findings to the Congressional Committees of jurisdiction.

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5 U.S. Department of Health and Human Services, Administration for Children & Families, Office of Legislative Affairs and Budget, *Title IV-E State Claims for Expenditures, FY2009*, compiled as of May 3, 2010. The Title IV-E kinship guardianship assistance component was established in early federal fiscal year 2009 and most states had not yet made the necessary changes to their Title IV-E plans to make this kind of Title IV-E claim during that year.
HHS will also consult with the Food and Drug Administration (FDA) to determine the percentage and types of drugs prescribed to children and youth in foster care that are used for “off label” purposes or that have not been tested and approved for children.

Health Plan for Children and Youth in Foster Care

Current Law
State child welfare agencies are not required to provide a health care assessment for children in foster care. However, the case plan for each child in foster care must include his or her health records, including a record of immunizations and medications, and other health information that the state child welfare agency determines to be relevant (Section 475(1)(C)).

Separately, each state must develop a plan for the ongoing oversight and coordination of health care services for children in foster care. The oversight plan must be developed in collaboration with the state child welfare agency and the state agency that administers the Medicaid program (and in consultation with other relevant experts and stakeholders). Among other things, the strategy and plan must outline: a schedule for initial and follow-up health screens; how the health needs identified by those screens will be monitored and treated; how medical information for children in care will be updated and appropriately shared; steps to ensure continuity of health care services; and oversight of prescription medicines (Section 422(b)(15)).

Proposal
In order to qualify for federal reimbursement under Title IV-E, a state must provide and regularly update a health assessment for each child or youth in care. This assessment must include a description of the medications prescribed to the child or youth, the conditions they are meant to address and updates on the continued need for medication.

Networking/Sibling Connection/Youth Engagement/Mentoring

Youth Experiences

When I went into foster care, my two older sisters and I were separated from our four younger brothers. It was difficult to find a home that would take all seven of us, so in all but one home I was placed in, we were all separated from one another. Though I was always placed with my two older sisters, I was never in contact with my brothers. The only time that I got to see them was on visits with our biological mother, which were not that often. I never knew where they were living, who they were with or how they were doing. There was one home that I was placed in that did take in all seven of us. It was a great time for me because I was back with all my siblings and we would laugh, play and just be with each other. However, after about two years, we were suddenly and without explanation taken away and separated again. My sisters and I were dropped off first and there were lots of tears as we hugged our brothers goodbye, not wanting to let go. How can anyone possibly know how it feels to have your best friends/playmates taken away from you? To have half of you ripped away from you? I went from seeing them every day to never seeing them at all. No one told us anything and we didn’t really know what was going on. I was so confused and didn’t know how to ask to stay connected to my brothers, even though I suspect they were living only blocks away. I feel that it is very important for siblings to be connected with one another, especially when separated when in foster care.

Darrlyn “Dee” Moorer; Age 22, 10 years in foster care
Options for Reform

Foster Care Bill of Rights

Current Law
No provision.

Proposal
As part of its Title IV-E plan, a state must describe to HHS the measure undertaken to engage with youth advocacy groups to develop, design and distribute an easy-to-read Foster Care Bill of Rights. The Foster Care Bill of Rights must detail the age-appropriate rights of all children and youth in foster care, provide a list of resources they can use to address grievances, include the names and contact information of youth-focused supports within the state, and list options available to youth in care to access social network sites on the Internet. Included, as appropriate, must be a compilation of all federal and state educational opportunities, programs, and scholarships available to youth currently or formerly in foster care.

The state must certify that no later than two years after enactment, this brochure will be made available to all youth in care, regardless of placement setting and to youth stakeholders, such as foster parents, Court Appointed Special Advocates, and mentoring organizations. Further the state will be required to ensure that the brochure is posted in all foster care placement settings and is made available on the Internet. Failure to comply would result in a pro rata reduction in the state’s FMAP for IV-E for the period of one year.

Additional Steps to Help Youth Benefit from What Federal Law Provides

Current Law
Not applicable.

Proposal
The Government Accountability Office (GAO) shall review state practices in place to ensure that children and youth; providers, including foster parents, congregate care personnel, and agencies that provide foster care placements; and staff, including child welfare caseworkers and their supervisors, know about the rights youth have and the agencies’ obligations to children and youth while in foster care. The GAO shall identify, and report on, the degree to which states:

- notify staff, providers, and youth that children must (as required by Section 475(5)(A)) be placed in a safe setting that is the least restrictive (most family-like) and most appropriate setting available and in close proximity to the parents’ home, consistent with the best interest and special needs of the child;

- notify these same stakeholders that (as required by Section 471(a)(31)) reasonable efforts must be made to place siblings removed from their home in the same foster care, kinship guardianship, or adoptive placement unless the state documents that such joint placement would be contrary to the safety or well-being of any of the siblings; and when they are not jointly placed, provide for frequent visitation or other ongoing interaction between the siblings, unless such activity would be contrary to the safety or wellbeing of any of the siblings;

- assure that the placement of the child or youth in foster care takes into account the appropriateness of the current educational setting and the proximity to the school in which the child or youth is enrolled at the time of placement (as required by Section 475(1)(G)(i));

- before establishing a youth’s permanency plan as APPLA, determine that there are compelling reasons that a permanency plan of reunification, adoption, guardianship, or
placement with a fit and willing relative would not be in the child or youth’s best interests (as required by Section 475(5)(C)(i)) and, if this determination is made, reasonable efforts are made to finalize APPLA for the youth (as required by Section 471(a)(15)(C));

- have (as required by Section 475(5)(C)(iii)) procedural safeguards in place so that in any permanency hearing held with respect to a child or youth in foster care, the court or administrative body conducting the hearing consults with the child or youth in an age-appropriate manner regarding the proposed permanency plan or transition plan;

- ensure that (as required by Section 475(5)(D)) a child or youth’s health and education record is reviewed and updated and a copy of the record is supplied to the foster parent or foster care provider with whom the child is placed, and, is supplied, at no cost to any youth who reaches the age of majority and leaves foster care;

- have procedures in place that allow the state child welfare agency (as required by Section 475(1)(G)(ii)) to coordinate with local educational agencies to enable a child or youth to remain in the school he or she was enrolled in at the time of foster care placement, or, if this is not in the child or youth’s best interests to ensure immediate and appropriate enrollment in a new school; and

- ensure that the state child welfare agency and the state agency that administers Medicaid are developing, in consultation with other relevant stakeholders, a coordinated plan to identify and respond to the health care needs of children in foster care (as required by Section 422(b)(15)).

**Proposal**

States should clarify or implement policies so that foster parents and group home administrators are encouraged to assist children in their care to participate in age-appropriate extracurricular enrichment and social activities, and activities designed to assist older youth make the transition to independence, build life skills, and to enhance opportunities to make positive connections.

Courts, as part of their oversight function, must inquire of case workers, foster parents, children and youth, and other relevant individuals involved with the case (such as Court Appointed Special Advocates), what strategies are in place or underway to develop or promote appropriate extracurricular enrichment and social activities, and activities designed to assist older youth make the transition to independence, build life skills, and enhance opportunities to make positive connections.

**Personalized Transition Plan for Older Youth**

**Current Law**

The law requires that a youth’s caseworker and, as appropriate, other representative(s) of the youth, assist and support him or her in developing a transition plan. The plan is to be directed by the youth, and is to include specific options on housing, health insurance, education, local opportunities for mentors, workforce supports, and employment services. The plan must be implemented 90 days prior to the 18th birthday of a child in care (or the 19th, 20th, or 21st birthdays of youth in states that take up the option to extend foster care). Beginning with federal fiscal year 2011, the transition plan must address the importance of designating another individual to make health care treatment decisions on behalf of the youth if he or she becomes unable to participate in these decisions and does not have a relative who would be authorized to make these decisions under state law, or he or she does not want a relative to make such decisions. In addition, the transition plan must provide the youth with the option to execute a health care
power of attorney, health care proxy, or other similar document recognized under state law (Section 475(5)(H)).

This transition plan is separate from the youth’s case plan. Each child or youth in foster care is to have a case plan and specific requirements are provided for youth in care at age 16 or older. For those youth the state must “where appropriate” include in the case plan a description of the programs and services that will help the child prepare for the transition from foster care to independent living (Section 475(1)(D)). Further, the status of each child in foster care must be reviewed no less often than every six months by a judge or an administrative review panel to determine the extent of compliance with the case plan. In addition, the child’s permanency plan, which addresses the child’s permanency goal(s), is to be reviewed by a court (or court-approved administrative body) no less often than every 12 months after the child enters foster care. For a child age 16 or older, the permanency plan hearing must consider “the services needed to assist the child to make the transition from foster care to independent living” (Section 475(5)(B) and(C)).

Proposal
Require the establishment of a personalized transition plan when a youth in care is 16 years of age or older and require states to update that plan every six months until the youth finds permanency or is emancipated. Amend the plan to offer opportunities for mentors to older youth in care.

Grants to States to Form Youth Engagement Partnerships

Current Law
The law does not address youth engagement activities; however, select provisions of the law seek to involve children in decisions about their placement in foster care. As part of the annual permanency hearing, the court or administrative body conducting the hearing must consult, in an age-appropriate manner, with the child regarding the proposed permanency plan or transition plan for the child (Section 475(5)(C)(iii)). In addition, the Chafee Foster Care Independence Program, which provides independent living services to children likely to age out of care and children who have emancipated from care, addresses youth engagement and relationships. One of the stated goals of the program is to provide personal and emotional support to participants, through mentors and the promotion of interactions with dedicated adults. States must certify that participants are directly engaged in designing their own program activities to prepare them for independent living (Section 477(b)(3)(H)).

States receive federal Social Services Block Grant (SSBG) funding to provide services to meet five general purposes, including reducing dependency and improving self-sufficiency of individuals; preventing or responding to abuse, neglect or exploitation of children or the elderly; preventing institutional placement through provision of other kinds of services or placements; securing referral for admission to institutional care, if appropriate; and providing services to individuals in institutional care (Section 2001).

States receive federal Temporary Assistance for Needy Families (TANF) block grant funding to meet four basic purposes: provide assistance to needy families so that children may be cared for in their own homes or the homes of their relatives; end dependence of needy parents on government benefits by promoting job preparation, work and marriage; prevent and reduce the incidence of out-of-wedlock pregnancy; and encourage the formation and maintenance of two-parent families (Section 401(a)).

Proposal
The federal government must dedicate a percentage of the SSBG and/or TANF block grant for competitive grants to states, Indian tribes or tribal consortiums, non-profit child welfare service providers with experience in youth engagement strategies or to a consortium of these
eligible entities to quantify the existing status of youth engagement in a state and develop and disseminate innovative strategies for improvement in the areas of: involvement; adult-youth relationships; frequency of youth involvement; diversity and ongoing input and feedback.

Permit demonstration grants for the purposes of determining the best case planning strategies for all youth in care.

**Tax Incentives for Businesses**

**Current Law**

Under current law, businesses making in-kind charitable contributions to registered 501(c)(3) tax-exempt organizations may be eligible for a deduction. Corporations cannot claim a deduction in excess of 10 percent of their taxable income. In-kind donations, such as household items (furniture, electronics, etc.) may qualify for a deduction. Generally, donors can deduct the fair market value of donated property. Gifts of clothing and household items in excess of $500 must be accompanied by a qualified appraisal. Currently, gifts made directly to individuals are not tax deductible. However, gifts made to a qualified charity that facilitates donations to individuals in need, may qualify for the charitable deduction (Internal Revenue Code (IRC) Section 170).6

**Proposal**

Provide tax incentives to businesses that provide cell phones, computers and other social networking infrastructures to foster families and group homes.

Provide tax incentives to businesses, such as hotels, that contribute furniture to youth transitioning out of care.

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**Pregnant and Parenting Youth in Foster Care**

**Youth Experiences**

I was 15 years old and pregnant when I arrived at Crittenton Services, Inc. in West Virginia in 2008, and on May 5, 2009, my daughter Alexis was born. I was angry, aggressive and using drugs, even while I was pregnant. Prior stays in foster homes were just temporary places—no connections or support and they really couldn’t handle me. I would leave them and go back to my mother but things always fell apart. If I hadn’t been pregnant I probably would have ended up in a detention facility because I had seven criminal charges pending against me. It’s not an excuse, but I had a very tough childhood without any stability or structure because my mother had problems with alcohol and she was always in unhealthy relationships. I needed the structure provided living at Crittenton to support me in breaking old patterns and to help me learn to be a good parent. While I was there I quit using drugs, was in therapy and caught up academically so when I was discharged I was at grade level. I decided to go and live with my grandparents when I left Crittenton because I knew living with my mother would not be good for my daughter and me. Today I am drug free, happy being a good mother and continuing to pursue my educational goals. I know that I could have ended up losing custody of my daughter and living on the streets as a drug addict and I’m grateful I got the support I needed.

Breanna, mother of 16-month-old Alexis

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6 See IRS Publication 526 “Charitable Contributions” for additional information.
Options for Reform

Improved Data Collection

Current Law
States are required to collect case-level data concerning each child or youth in foster care and to report those data to HHS via the Adoption and Foster Care Analysis Reporting System (AFCARS) (Section 479). There is no required AFCARS data element for reporting on pregnancies or births among youth in foster care, services provided, or outcomes specific to this population.

Beginning with October 1, 2010 states are required to survey youth who were in care at age 17 and to track the outcomes for those same youth (or a sample of the youth) at ages 19, and 21. Data collected must be reported to HHS via the National Youth in Transition Database (NYTD) and, among other outcomes, states must report case-level data on the number of children fathered or birthed by these youth (Section 477(f)).

A significant data gap exists in the child welfare field about the number of pregnant and parenting youth in care. This has resulted in inadequate services and supports that could have reduced the entrance of their children into the system by keeping families together.

Proposal
Require states to collect and report data about the number of pregnancies of youth in foster care, births to youth in foster care, children living with a parent who is in foster care, alternative permanency plans made for children of youth in foster care, services provided to pregnant and parenting youth in foster care, and outcomes for these young parents and children.

Specialized Care for Parenting Youth in Foster Care

Current Law
There are no federal training standards specific to foster family homes that provide care to a Title IV-E eligible foster youth who is a parent and whose child lives with the foster youth. At the same time, federal law authorizes additional support for these minor parents in foster care. Specifically, Title IV-E foster care maintenance payments are defined to include both a room and board payment for a Title IV-E eligible minor parent in foster care and those same costs for the child of that minor parent provided the child is not placed in foster care (i.e., under the care and placement responsibility of the state) but lives in the same foster care placement setting as the minor parent (Section 475(4)(B)). Federal law also mandates Medicaid coverage for both the Title IV-E eligible minor parent who is in foster care (Sections 472(h)(1) and 1902(a)(10)(A)(i)(I)) and the child who is living with that minor parent (Section 472(h)(2)).

Proposal
Foster home placements for minor parents in foster care and their children should be considered “specialized,” with additional training required of foster parents and social workers who care for and work with them. Clear standards for “certification” should be developed and monitored.

Resource Center

Current Law
HHS funds multiple national child welfare resource centers—on a range of topics—as part of its larger network of information, training, and technical assistance intended to improve child welfare knowledge, practice, and state implementation of federal child welfare policy. Authority and funding for individual parts of this network may be generally authorized or specifically authorized in federal child welfare law. As specifically required under the Chafee
Foster Care Independence Program, the National Resource Center for Youth Development is intended to increase the capacity and resources of states and tribes to provide high-quality services to youth in care, former foster youth, and older youth in at-risk situations. However, it does not have a specific mandate related to pregnant and parenting youth in foster care (Section 477(g)(2)).

Proposal
Establish a resource center for organizations that serve pregnant and parenting youth in the child welfare system. The dual development of very young parents with children makes this population a unique challenge to families, organizations, and communities who want to support them. Additionally, this center could oversee standards and provide information for those wanting to establish programs to support young families.

Use of Chafee Foster Care Independence Program Funding

Current Law
The Chafee Foster Care Independence Program provides funding for independent living services to children likely to age out of care and children who have emancipated from care. (Federal fiscal year 2010 funding for this program was $140 million.) States are authorized to use those funds for a variety of purposes. Parenting education is not explicitly listed in the law as a service that can be provided. However, states may use the funds for preventive health activities, which includes pregnancy prevention (Section 477(a)(1)).

Proposal
The allowable uses of Chafee Foster Care Independence Program funding could be expanded to explicitly include parenting education.

Education

Youth Experience

Another key contributor for me while in care was being engaged at school. Early in my education I began getting involved with extracurricular activities. It was my outlet to direct the negative situations I experienced at home. Entering care I was not certain how that would be affected. However, I was allowed to remain involved at school—something many foster youth are unable to do. During my high school career I served on leadership teams for my class, student council, and the Future Business Leaders of America. I was actively involved in the National Honor Society, acting in drama club, Upward Bound, and Science Olympiad. Having the opportunity to explore my interests and build on my strengths was a priceless experience for me. It provided me with support and stability, which I feel are two key elements to learn in order to have a successful transition from foster care. Youth engagement also allowed me to build confidence in myself and taught me that I can be successful. My experience with engagement also prepared me for leadership opportunities in college. For example, I have served on executive boards for Phi Sigma Pi, a co-ed national honor fraternity, the Student Community Action Team, and the International Association of Business Communicators. If I hadn’t had the opportunity to be involved while I was in foster care I know I would not be in the position I am today.

Ashley Jackson; Age 21, 5 years in foster care
Options for Reform—
Elementary and Secondary Education

Clarification of Education Policy from
Fostering Connections to Success and
Increasing Adoptions Act of 2008

Current Law
When a child is placed in foster care, states are
required to take into account the appropriateness
of his or her current educational setting and its
proximity to the foster care placement setting
(Section 475(1)(G)(i)). Further, as added by the
Fostering Connections to Success and Increasing
Adoptions Act of 2008 (Section 204 of Public
Law 110–351), states, through their child welfare
agencies, must plan for the educational stability
of children in foster care by coordinating with
local educational agencies (LEAs) to ensure that
a child remains in the school in which he or she
was enrolled at the time of foster care placement,
or, if this is not in the child’s best interest, to
provide immediate and appropriate enrollment in
a new school, with all of the education records of
the child provided to that school (Section 475(1)
(G)(ii)).

States are permitted to seek Title IV-E
reimbursement for a part of the cost of providing
transportation that enables a child to remain in
the school in which he or she was enrolled prior
to placement in foster care. States may claim this
federal Title IV-E support as part of a child’s
foster care maintenance payment or as a general
administrative cost under the Title IV-E program,
but only on behalf of those children in foster
care who meet federal (Title IV-E) eligibility
criteria (Section 475(4), 474(a)(1), and 474(3)
(E)). Currently it is estimated that less than half
of all children in foster care meet those federal
eligibility criteria.

Under the McKinney–Ventō Education for
Homeless Children and Youth program, a state,
through its state educational agency (SEA) and
local educational agencies (LEAs), must take steps
to ensure that children who are homeless (defined
to include children or youth “awaiting foster
care placements” and those “living in emergency
or transitional shelters”) have equal access to
the same, free and appropriate public education
as other children. Among other things, this
includes granting a homeless child or youth the
right to remain in the school he or she attended
before losing permanent housing (“school of
origin”), requiring LEAs to provide a homeless
student with transportation to his or her school
of origin, and providing immediate enrollment
for a homeless student who does change schools.
Further, each SEA must appoint a coordinator
who is required to develop and carry out a state
plan for the education of homeless children
and youth. McKinney–Ventō grants (FY2010
funding: $65 million) are allocated to SEAs in
proportion to grants made under Title I–A of
the Elementary and Secondary Education Act
(ESEA). SEAs subgrant McKinney–Ventō funds
to LEAs competitively to be used to facilitate
the enrollment, attendance and success in school
of homeless children and youth. Each LEA—
whether or not it receives such a subgrant—must
establish a local liaison for homeless children
and youth. For school year 2008–2009, approximately
1,700 LEAs, out of a total of more than 15,000
in the nation, received McKinney–Ventō funding.
(Sections 721–726 of the McKinney–Ventō
Homeless Assistance Act).

As a condition of receiving partial federal
reimbursement under Title IV-E (for foster care,
adoption assistance and kinship guardianship
assistance costs incurred on behalf of children
who meet the relevant federal eligibility criteria)
states are required to develop a Title IV-E state
plan that is approved by HHS as meeting the
federal program requirements (Section 471(a)).

Federal funding under Title I–A of the Elementary
and Secondary Education Act (ESEA) is provided
to LEAs with high numbers or percentages of
economically disadvantaged children to ensure
that all students meet the same challenging state
academic content and achievement standards.
As a condition of receiving this funding, the SEA
in consultation with LEAs and other stakeholders must develop a state plan that is approved by the Department of Education as meeting the federal program requirements for receipt of the funding (Section 1111 of the ESEA).

Proposal

By the beginning of the school year after the date of enactment, a state’s education agency, working with the state’s local education agencies and a state’s child welfare agency, in consultation with the state’s juvenile justice agency, must develop a plan to comply with Section 204 of the “Fostering Connections to Success and Increasing Adoptions Act of 2008,” which requires that states provide for the educational stability of children and youth in foster care.

Specifically, a state’s education agency working with the state’s local education agencies and a state’s child welfare agency, in consultation with the state’s juvenile justice agency must develop an equitable system for: the reimbursement of costs associated with the reasonable travel of children and youth in foster care; the determination of best interests with regard to enrollment of a child in a given school; sharing of necessary records to allow education planning and immediate enrollment as appropriate; and any other issue that arises as part of complying with the law. This system must also include a mechanism for dispute resolution in the event there is a disagreement between the SEA and the state child welfare agency.

The SEA and state child welfare agency may extend protections under the McKinney-Vento act in order to comply with this requirement.

If the SEA and the state child welfare agency cannot develop a mutually agreeable plan by the beginning of the school year after the date of enactment, the Governor will establish a dispute resolution protocol and has the option to either:

- Extend protections under the McKinney-Vento Act in order to comply with this requirement.

The state must comply with this provision in order to qualify for Title I education funds as well as to qualify for reimbursement under Title IV-E of the SSA. Finally this proposal would clarify that states are required to plan for educational stability for children entering foster care as well as those who are in foster care but are moved to a different placement while in care.

Options for Reform—Post-secondary Education

Education and Training Vouchers (ETV)

Current Law

The Chafee Education and Training Voucher Program (ETV) is available for children who left foster care after reaching the age of majority or those who left foster care for adoption or guardianship after attaining 16 years of age. The program is administered within HHS by the Children’s Bureau, (which also administers the Title IV-E foster care program). The ETV program authorizes provision of vouchers, worth up to $5,000 annually, per eligible youth, for the cost of attendance at an institution of higher education (as defined by the Higher Education Act). “Cost of attendance” refers to tuition, fees, books, supplies, equipment and materials, room and board, and related expenses. Students are eligible for the vouchers if they are in good academic standing and making progress toward completing their program or graduating, though states may have additional requirements. Only youth receiving a voucher at age 21 may continue to participate in the voucher program until age 23 (Section 477(i)). For federal fiscal year 2010 the Chafee ETV program received federal funding of a little more than $45 million.

The Higher Education Act includes several provisions intended to increase ability of former
foster youth to attend college and succeed. These include granting “independent” status to any child or youth who was in foster care at age 13 or later (without regard to the reason a youth left care) for purposes of determining eligibility for federal financial aid (Section 480(d) of the Higher Education Act) and specified access to, or priority for, services and supports provided under a range of federal competitive grant programs intended to encourage college attendance and graduation for disadvantaged youth (Sections 402A–402H and 404A–404E of Higher Education Act).

**Proposal**
Transfer jurisdiction of ETV funds for former foster youth from the Department of Health and Human Services to the Department of Education. Because the Department of Education already has the mechanism in place to disburse funds (financial aid) for higher education the administrative costs for this program could be absorbed and reduced, enabling the savings to be reinvested into the ETV allotment.

Require HHS and ED to collaboratively develop a report or other publicly accessible resource that details federal financial aid available for youth who were formerly in foster care, any special federal financial aid rules that may apply to these youth, and any federal post-secondary education supports or services available to them. Require these same agencies to establish regular communication on administration of financial aid to youth formerly in foster care and to regularly update the report or publicly available resource.

Permit a youth to receive an initial ETV any time up to the age of 25 but limit total number of years for which a youth may receive this support to a total of four years.

**Residency for Current and Former Foster Youth**

**Current Law**
Child welfare law does not address residency requirements for purposes of establishing eligibility for in-state tuition at institutions of higher education. At least one other law, the Higher Education Act (HEA), addresses such requirements for certain military-related individuals. Under HEA, a state may not charge tuition above that charged for residents of the state for any active members of the armed forces (or their spouses or children) whose domicile or permanent duty station is in the state. This provision is applicable to each public institution of higher education in a state that receive assistance under the HEA (Section 135 of the Higher Education Act).

**Proposal**
Provide a mechanism by which former foster youth can establish in-state residency in a state other than their home state, similar to dependants of military families. Former foster youth often settle into attending universities in their home state simply because they have to pay more for out-of-state tuition. This change would allow former foster youth to attend the school that best suits their academic interests and needs.

**Improvements to the Chafee Foster Care Independence Program (CFCIP)**

**Current Law**
The Chafee Foster Care Independence Program provides funding for independent living services to children expected to leave foster care because they reach the age of majority (age out) and youth who have already aged out. States are authorized to use those funds for a variety of purposes. These include: helping youth who are expected to remain in foster care until their 18th birthday prepare for and enter post-secondary training and education institutions; providing education support and services to former foster care youth between 18 and 21 years of age; and making available vouchers for education and training, including post-secondary education and training for youth who have aged out of foster care (Section 477(a)).
As a condition of receiving Chafee Foster Care Independence Program funding, states must submit a plan for providing services under CFCIP, including a number of certifications regarding how the plan will be carried out. Among these, the state must certify (through its governor) that it will make every effort to coordinate state programs that receive CFCIP funds with certain other federal and state programs for youth, including transitional youth projects funded under the Juvenile Justice and Delinquency Prevention Act, abstinence education programs, local housing programs, programs for disabled youth, and school-to-work programs offered by high schools or local workforce agencies (Section 477(b)(3)(F)).

The “TRIO” programs, administered by the Department of Education, include six federal outreach and student services programs targeted to serve and assist low-income individuals, first-generation college students, and individuals with disabilities to progress through the academic pipeline from middle school to post-baccalaureate programs. Funds are awarded competitively to institutions of higher education and/or other service organizations. The Department of Education must, as appropriate, require each applicant for TRIO program funding to identify and make available services under the program, including mentoring, tutoring, and other services a given TRIO program supports, to homeless youth, youth in foster care, and youth who left foster care after reaching age 13. In FY2010, federal funding appropriated for TRIO programs totaled more than $910 million, which was awarded to more than 2,900 grantees (Sections 402A–402H of the Higher Education Act).

Proposal
Establish competitive grants for states and other eligible entities to develop innovative educational support activities.

Add the federal TRIO and GEAR UP programs to the list of programs that States are required to certify they will coordinate with CFCIP-funded programs.

Family Preservation/Permanency
Youth Experiences
I left foster care when I found permanency at age sixteen by being adopted into my then foster family. When I was in foster care but without the permanent family, I couldn’t stop asking, “Where will I go when I turn eighteen?” I had no plan at that time, no significant savings, and felt like there was no one to help me. Sure, there were a few distant relatives that I had briefly been in touch with, but I did not feel that I could count on them to give me the long-term support I needed. I also did not want to be a burden. A fourteen-year-old should not be planning for the secondary education and options for financing a college education; as well as to provide financial assistance, academic support, counseling, mentoring, outreach, and other services to secondary school students to reduce the risk of these students dropping out of school and the need for remedial education for these students at the post-secondary education level.

Children in foster care (who are eligible for assistance under Title IV-E) are among the priority student groups to be served by certain GEAR UP grantees. In FY2010, the program received $323 million in funding, which was awarded to more than 200 grantees (Section 404A–404E of the Higher Education Act).
rest of their lives like this, rather, should be engrossed in the aspects of teenagehood. Nonetheless, I was without that permanent feeling of having a place to call home, and since leaving my birthmother’s abusive home, I was used to hearing things like ‘No one wants you anyways.’ I heard it so frequently that I started to believe it. But something in me told me to stay determined, and I did. Eventually I got involved in my own case and permanency decisions.

Crystal Lipek; Age 22, 7 years in foster care

Options for Reform

Additional Family Preservation Grants

Current Law
States receive capped funding under the Promoting Safe and Stable Families (PSSF) program (Title IV-B, Subpart 2) of which a “significant” portion (defined by HHS as 20 percent unless the state can provide good reason) must be devoted to each of four categories of services to children and families. One of those categories is family preservation services. Out of all funds provided for PSSF in federal fiscal year 2010, states received $356 million for services to children and families, of which they were expected to spend at least $71 million on family preservation services. States receive additional capped funding under the Stephanie Tubbs Jones Child Welfare Services Program (Title IV-B, Subpart 1), which is available for a wide range of child welfare purposes that may include provisions of family preservation services. Federal funding for all purposes under this program was $282 million in federal fiscal year 2010.

States are permitted to use funds provided under the TANF block grant for four basic purposes, including to “provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives” (Section 401). Further, states that provided certain time-limited emergency assistance to families under the Aid to Families with Dependent Children (AFDC) program—the predecessor to TANF—may continue to provide those same services under TANF (Sec. 404(A)(2)). Separately, states are directed to use funds provided under SSBG to meet five general goals, including “preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating or reuniting families” (Section 2001).

For state fiscal year 2006, the most recent data available, the Casey Child Welfare Financing Survey reported that states spent an estimated $2.4 billion in federal TANF and $1.6 billion in SSBG funds through their child welfare agencies. Although the significance of this funding to a given state’s total child welfare resources varied considerably, every state but one reported spending at least some federal TANF or SSBG funding in this manner. Most of this funding appears likely to have been spent on services for children (and their families) who were at-risk of entering foster care or in foster care. However some states report spending certain TANF dollars to provide foster care maintenance payments.

Proposal
Dedicate a percentage of TANF/SSBG block grants for family preservation grants, especially those targeted towards addressing substance abuse and child neglect.

Flexible Funding

Current Law
Every state is entitled to receive reimbursement for one-half (50 percent) of allowable administrative costs it incurs in carrying out the state’s Title IV-E plan related to foster care, adoption assistance and (if state elects) kinship guardianship assistance. Title IV-E administrative

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7 See IRS Publication 526 “Charitable Contributions” for additional information.
costs which are reimbursed at this rate include: caseworker activities on behalf of an individual child (e.g., referral to services; preparation for, and participation in, judicial determinations; placement of the child; development of the case plan, case reviews, and case management and supervisions); program eligibility determination; recruitment and licensing of foster family homes; rate setting; a proportionate share of agency overhead; and others costs necessary for the “proper and efficient” administration of the state plan (e.g., costs related to locating and notifying adult relatives of a child entering foster care or costs to provide transportation to permit siblings visits) (Section 474(a)(3)(E); 45 C.F.R. 1356.60)).

Proposal
Allow states to agree to a set amount of Title IV-E general administrative funds in exchange for flexibility in the use of these funds.

Family Locator Activities

Current Law
States must “exercise due diligence” to identify and give notice to the grandparents and other adult relatives of a child who enters foster care. This identification and notice must happen within 30 days of a child’s removal from his or her parents and is subject to exceptions due to family or domestic violence (Section 471(a)(29)). States may claim federal reimbursement under Title IV-E for allowable administrative costs related to locating and providing notice to adult relatives of children removed from their home, provided those children are eligible for federal assistance under Title IV-E (Section 474(a)(3)(D) of the SSA).

Proposal
Allow for federal reimbursement for family locator activities that begin after removal of the child or youth from his or her home and conclude at a certain point following the child or youth’s placement in foster care.

Youth Tools for Permanency

Current Law
No provision.

Proposal
As a condition of the receipt of Title IV-E funds, a state must develop a “permanency pact” and must encourage all youth in care to complete this pact. The permanency pact must be made available to all youth in foster care regardless of their placement setting and must also be posted on the Internet.

As a condition of the receipt of Title IV-E funds, a state must have policies and practices to ensure that all youth emancipated from care are equipped with the following: a social security number, a driver’s license, a birth certificate, all medical and education records, and a copy of the youth’s transition plan.

Reimbursement for Sibling Groups

Current Law
Under Title IV-E, states are required to make foster care maintenance payments—sometimes referred to as a room and board payment—for each eligible child in foster care (Section 471(a)(1)), and they are entitled to federal reimbursement for part of the cost of providing that payment. The federal reimbursement rate for these payments—that is the part of cost reimbursed by the federal government—is equal to a state’s federal medical assistance percentage (FMAP). Each state’s FMAP is adjusted annually and may range from 50 percent (in states with higher per capita income) to 83 percent (in states with lower per capita income). Further, under Title IV-E states may claim partial federal reimbursement for certain eligible administrative costs (50 percent), and for certain eligible training costs (generally 75 percent) under the Title IV-E program (Section 474(a)(3)).
Proposal
Increase the IV-E matching rate for states and for foster family homes that are providing care to sibling groups.

Child Support Enforcement

Current Law
Under Title IV-E, state child welfare agencies are required, where appropriate, to take all steps, including working with state Child Support and TANF agencies, to secure an assignment to the state of any rights to child support on behalf of a child receiving a Title IV-E foster care maintenance payment (Section 471(a) (17)). State Child Support agencies must send a specified part of any child support collected on behalf of a Title IV-E eligible child in foster care to the federal government (as partial reimbursement for its support of this child) and the remaining funds may be used by the state to reimburse its part of the cost of providing foster care to this child (Section 457(e)).

Proposal
Eliminate a state’s ability to collect child support payments from a parent prior to the termination of the parental rights.

Alternatively, allow a state to collect child support payments on behalf of a child in care, but require that those payments be passed through to an account set up on behalf of the child or youth in care.

Financing Reform

A key element to systemic child welfare reform will be a recalibration and a reordering of priorities in the child welfare/foster care system. These principles could provide the foundation for achieving consensus on systemic child welfare financing reform.

Principles of Financing Reform
- Abused or neglected children or youth in care should have the protection of both the federal government and the states. Unless a financing realignment occurs, the federal role in child welfare financing will continue to diminish.
- A child or youth in care or a vulnerable family should be served regardless of a family’s income. Abuse and neglect occur in all types of families with a range of incomes. If child welfare programs were not means-tested, case workers could focus more attention on the case and less on establishing a household’s income.
- No child or youth or family is the same, so child welfare and family support systems should be able to adapt to a child and a family’s unique circumstances and needs.
- Every child or youth in care can achieve measurable, positive outcomes if they are provided with the right types of supports. It is possible to hold states accountable for positive permanency and wellbeing outcomes for children and youth in care, especially if that accountability is partnered with increased state flexibility.
Children's Defense Fund

The Need for Educational Stability for Children in Foster Care: Recommendations for the Elementary and Secondary Education Act Reauthorization

April 2010

THE CHALLENGE

The nearly 800,000 children in foster family homes, group homes and child care institutions during the course of a year, many of whom have multiple special needs, often face unique educational challenges. They must confront numerous barriers to their success in school: the trauma of the initial abuse and neglect as well as the removal from their homes, separation from their siblings and often multiple moves from home to home and school to school.

School Performance Lags Behind

- Three different studies found that more than one-third of youths in foster care had repeated at least one grade. Another found that twice as many children and youths in foster care had repeated a grade compared to those not in care.

- In Washington State, research found that children and youths in foster care attending public schools scored 16 to 20 points below youths who were not in foster care on statewide standardized tests given in 3rd, 6th, and 9th grades.

- According to the Midwest Evaluation, over 40 percent of youths in foster care did not have a high school degree at age 19, compared to only 13 percent of their peers who were not in foster care. By age 21, nearly one quarter still did not have their diploma, compared to 11 percent of their peers.

Frequent Moves

- Children have an average of one to two placement changes per year while in foster care and research shows that each change in school placement for a child results in the loss of up to six months of educational progress. In at least one study of foster care alumni, youths who had one fewer placement changes per year were almost twice as likely to graduate from high school before leaving care.

- Over one third of young adults report having five or more school changes while in foster care. Another study of young adults in foster care found that more than half had experienced seven or more school changes from elementary through high school.

In order to improve educational outcomes for children in foster care, the children need the assurance of educational stability, which requires:

- Maintaining a child in his original school when an initial placement or a new placement becomes necessary unless it is not in the child’s best interest. Efforts are increasingly being made by child welfare agencies to find placements for children close to home. But where that is not possible, when a child is removed from his home or to a new placement, the child welfare agency must coordinate with the school district to ensure that the child can remain in his or her original school. There also must be a process for determining that such a placement is in the child’s best interest and for resolving disputes about what is in the child’s “best interest” when they arise.
• **Immediate and appropriate enrollment in a new school.** To keep children in foster care from losing valuable school time, enrollment in a new school must occur within days rather than weeks. Too frequently there are reports of children being out of school for months when they are moved to new foster placements.

• **Prompt transfer of school records when a school change is necessary and appropriate.** A delay in the transfer of school records may result in a child being kept out of school, placed in the wrong grade or without appropriate special education services, and experiencing lost credits or delayed graduation.

• **Payment of transportation costs.** Ensuring transportation is provided to a child’s original school prevents the lack of transportation from being a barrier to educational stability for children in foster care.

Ensuring successful educational outcomes for children and youths in foster care must be the joint responsibility of the child welfare agencies that have responsibility for the care and custody of the children and the education agencies that are responsible for providing all children a free appropriate public education. The *Fostering Connections to Success and Increasing Adoptions Act of 2008* (P.L. 110-351, *Fostering Connections*) placed the obligation on state and local child welfare agencies to coordinate with education agencies to ensure the above protections for children in their care. The act also provided federal reimbursement to state child welfare agencies to help with the transportation of about half of the children in foster care to their original school of origin when necessary.

Joint child welfare and education efforts to ensure educational stability of children in foster care are underway in some states and localities, building sometimes on relationships established under the *McKinney Vento Homeless Assistance Act* (McKinney Vento). In many localities, however, child welfare agencies have been rebuffed by education agencies that felt no special responsibility for these children or, in some cases, believed that their state education laws or policies, such as those governing residency and records requirements, would not allow them to keep children in their original schools or to immediately enroll the children in new schools.

**RECOMMENDATION**

The Children’s Defense Fund recommends that the *Elementary and Secondary Education Act* (ESEA) reauthorization includes obligations on state and local educational agencies that mirror those that *Fostering Connections* placed on child welfare agencies, so the promise of *Fostering Connections* will be fulfilled and children in foster care will be provided educational stability and opportunities to help them succeed in school and in life. These protections are similar to the education stability protections already provided to homeless children in ESEA through McKinney Vento. These obligations in ESEA must include:

• **Coordination and collaboration,** and the establishment of foster care liaisons, to ensure that children in foster care are afforded the enforceable protections they need for educational stability including, at a minimum:
  • The right to remain in the school they are enrolled in at the time of placement, unless that would not be in the child’s best interest;
  • A procedure to resolve disputes when there is a dispute about what is in the child’s “best interest”;
  • Immediate enrollment in a new school when remaining in the original school is not in the child’s best interest;
  • Prompt transfer of the child’s school records to the new school; and
  • A shared responsibility, when necessary, with the child welfare agency for transportation to the child’s original school.
• **A method for collecting data and tracking information** to document advances in providing children these educational stability protections. It is important to know about key indicators such as the number of school changes children in foster care experience and enrollment delays that occur when these children are moved to new foster family homes or group care settings.

• **Funding for states and local educational agencies** to assist them in meeting these new obligations on behalf of children in foster care and to oversee the implementation of the educational stability protections.

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3 Ibid.


7 Courtney, M.E., Terao, S., and Bost, N. *Midwest evaluation of the adult functioning of former foster youth: Conditions of youth preparing to leave state care.* Chicago, IL: Chapin Hall Center for Children at the University of Chicago, 2004.

Introduction: Title IV-E Waivers

Federal IV-E waivers (also referred to as child welfare demonstration projects) were first introduced into federal law under Public Law 103-432 in 1994. This law provided that under the Social Security Act, the Secretary of Health and Human Services (HHS) was to be given the authority to approve 10 demonstration projects for a length of five years each, funded primarily through reimbursements to states under Title IV-E.

Title IV-E, the foster care maintenance program, operates to partially reimburse states for certain expenditures made on behalf of an eligible child: administration and placement expenses, adoption assistance, payments for child welfare agency employee training, and foster care maintenance. Due to federal restrictions, IV-E funding is largely limited to services for children who have been removed from their homes rather than given to preventative and post-permanency services that help children and their families remain together.

Congress’ intention in authorizing these demonstration projects was to give states an opportunity to implement innovative programs to address their child welfare needs with less categorical funding restrictions, as well as to find more effective ways to align federal dollars with effective child welfare practices and achieve better outcomes. States with approved demonstration projects are granted the flexibility with otherwise restricted Title IV-E funding. Each demonstration project had to include an evaluation process and stay cost neutral to the federal government.

Title IV-E waivers gained momentum in 1997 with the passage of the Adoption and Safe Families Act (ASFA), which for a limited time, authorized up to 10 new demonstrations programs each year. The authority to grant waiver projects was reauthorized and expanded again by a series of Public Laws from 2003 to 2006. As of November 2010, there are active waiver agreements in seven

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1 Social Security Act, section 1130, 103rd Cong. (1994).
3 Committee on Ways and Means. (2008). Background material and data on the programs within the jurisdiction of the Committee on Ways and Means. Author: Washington, D.C.
5 Ibid.
6 Ibid.
8 Committee on Ways and Means. (2008). Background material and data on the programs within the jurisdiction of the Committee on Ways and Means. Author: Washington, D.C.
states out of 23 total States that had implemented projects—California, Florida, Illinois, Indiana, Ohio, Oregon and Wisconsin.

Resulting demonstration projects have focused on providing guardianship and kinship caregiver subsidies, intensive services options, managed care payment models to provide a network of service providers, flexible funding options, services for caregivers struggling with substance abuse, adoption and post-permanency services, and enhanced training for child welfare staff, among other more state-specific projects. Some states, such as Florida, implemented waiver projects statewide, while others like California allowed their counties to decide participation (Alameda and Los Angeles).

As of March 2006, HHS no longer has authority to grant new demonstration projects. There are five states that currently operate a waiver under the previous authority and each of these five states have expressed a desire to extend their waivers and have been granted limited extensions from HHS based on their ability to demonstrate positive outcomes for children and families. In addition, several states have expressed interest in a renewed waiver authority to support reforms and innovations. Advocates have called on Congress to renew the authority of HHS to approve waivers, crediting waivers as the impetus for many recent state-based reforms and innovations. Governors and child welfare administrators from states with ongoing demonstrations have also raised concerns that if the waivers are allowed to expire and they are forced to return to the non-waiver system, it might derail their collective success in reducing the number of children in out-of-home care.

A concern that has been raised about Congress’ continued extension of waiver authority is that the structure of federal child welfare financing “fails to support key system priorities,” and reauthorizing authority to grant more IV-E waivers prohibits or delays reformatory efforts.

Some have argued that rather than continue demonstrations, Congress should instead use the lessons learned by the 23 waiver states as a blueprint for designing national foster care financing policy.

For a full list of waiver projects and a summary of their results, please see the Appendix at the end of this report.

**Detailed Legislative History**

**Public Law 103-432 (1994)**

Established in section 1130 of the Social Security Act, Congress gave HHS the authority to grant 10 demonstration projects to experiment with different programs to effectuate federal child welfare policy goals. Some IV-E compliance is still required by federal waivers, including meeting the requirements for foster care reviews, safety in out-of-home placements, permanency hearings, and case plan documentation. States may not exceed the federal funding limits made available to them prior to the waiver enactment and are also required to conduct extensive evaluations to analyze the programs’ effectiveness.

Seven projects were approved under the initial authority established in P.L. 103-432 and implemented in five states: North Carolina,
Delaware, Illinois, Ohio and Oregon. These projects involved assisted guardianship programs, services for caregivers with substance abuse problems, and flexibility or capped allocation in IV-E funding. The investment of authority in the Secretary to approve waiver projects would have expired under this law at the end of fiscal year 2002 absent congressional action. 

**Adoption and Safe Families Act (1997)**

The Adoption and Safe Families Act (ASFA) extended and expanded HHS’s authority to grant demonstration projects by permitting up to 10 new projects lasting up to five years for each fiscal year between 1998 and 2002. ASFA also specified that if a project focused on foster care adoption, parental substance abuse issues, or kinship care, the Secretary of HHS was required to consider these project applications.

**Policy Considerations**

**The Role of Waivers in Child Welfare Financing Reform**

The federal government provides 48 percent of overall child welfare spending. The remaining 52 percent comes from a combination of state and local sources. Of all the federal funding streams for child welfare, Title IV-E represents the largest share (48 percent) at $6 billion in 2006. Other federal funding sources for foster care include Title IV-B of the Social Security Act (five percent), Social Security Block Grants (SBBG) (12 percent), Temporary Assistance for Needy Families (TANF) (19 percent), and Medicaid (13 percent). Since 1995, there has been a national increase in child welfare federal funding, but this is largely attributable to increases in Medicaid and Social Service Block Grants, as there have only been slight increases in spending under IV-E and IV-B. Unlike the other four sources listed above, IV-E is an open-ended entitlement program that supports only those children in foster care who are eligible.

Foster care for children who are ineligible to receive Title IV-E dollars is funded entirely by the state or with the assistance of TANF dollars. States report numerous factors resulting in the ineligibility of children in care to receive such federal funding, most significantly, the income of the child’s family as set out by the Aid to Families with Dependent Children (AFDC) program being too high above the July 16, 1996 eligibility standard to qualify them. Additional reasons for ineligibility include the child’s residence in unlicensed or unapproved placements, no judicial determination indicating that the child could no longer reside safely in the home, and the age of the child.

Over the past decade, child welfare advocates have called on the federal government to consider changing the way it provides funding to states for child welfare services. Suggested reforms have been aimed at making the federal financing structure more flexible, providing services to a wider group of youth, and holding states more

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16 Committee on Ways and Means. (2008). Background material and data on the programs within the jurisdiction of the Committee on Ways and Means. Author: Washington, D.C.
17 Ibid.
18 Ibid.
20 Committee on Ways and Means. (2008). Background material and data on the programs within the jurisdiction of the Committee on Ways and Means. Author: Washington, D.C.
22 Ibid.
23 Committee on Ways and Means. (2008). Background material and data on the programs within the jurisdiction of the Committee on Ways and Means. Author: Washington, D.C.
25 Committee on Ways and Means. (2008). Background material and data on the programs within the jurisdiction of the Committee on Ways and Means. Author: Washington, D.C.
26 Ibid.
accountable for outcomes. Reforming the federal child welfare financing structure has proven challenging for a variety of reasons. First and foremost, the context and needs of each state are unique, and there are significant variances among states in the degree that federal funding is relied upon, the source from which funding is drawn, and the rate of change in total spending.\(^\text{27}\) In addition, it is difficult to reach consensus on a finance structure that facilitates an appropriate balance in providing flexible assistance to states to ensure positive outcomes for children and families in need of services.

Proponents of continuing the waiver program argue that it has allowed for states to achieve some of the flexibility called for by finance reform advocates. At the same time, the demonstration aspect of the waiver program has allowed states to experiment with different models and services in a way that was cost neutral to the federal government and without permanent changes in federal law.

A recent example of the waiver process serving as an impetus for nationwide reform is the inclusion of optional federally funded guardianship programs in the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351).\(^\text{28}\) In fact, ten states had implemented such projects in the past, seven of whom had active subsidized guardianship waivers at the time this bill was passed in 2008—Illinois, Iowa, Minnesota, Montana, Oregon, Tennessee, and Wisconsin. These seven states are allowed to claim IV-E reimbursement for children who exited to guardianship under the states’ waivers prior to September 30, 2008.\(^\text{29}\) This legislation also extended another benefit often exercised under a waiver demonstration, allowing funding to be directed toward adoption assistance for children irrespective of whether their family met AFDC standards.\(^\text{30}\)

**Accountability and Evidence-based Innovations**

Waivers stemmed from concerns for the need to improve the effectiveness of how federal funds are utilized to improve the outcomes for children and families impacted by the child welfare system. The overarching objective of waivers was to test how to improve child outcomes by increasing the service array and/or service population.\(^\text{31}\) To realize this goal, IV-E waivers were designed as an intersection of flexible funding and state accountability to encourage innovation while also requiring extensive evaluations to ensure that investments were made in programs that are proven to be successful.

Waiver demonstration projects are required to include approved evaluation plans with procedural and outcome assessments as well as a cost analysis.\(^\text{32}\) Within six months of the demonstrations’ completion, states have to also issue a final report.\(^\text{33}\) Eighteen states’ projects met this requirement by using a “random assignment” evaluation, considered to provide the best indication of whether a program is an improvement from existing practices.\(^\text{34}\) This evaluation method consists of randomly assigning

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\(^{29}\) Committee on Ways and Means. (2008). *Background material and data on the programs within the jurisdiction of the Committee on Ways and Means*. Author: Washington, D.C.


\(^{33}\) Ibid.

subjects to either an experimental group (with access to waiver-funded services) or to a control group (without access to waiver-funded services).

Other states, such as New Mexico which allocated IV-E funds to improve services for Native American children, chose designs that compared two geographic regions (“comparison sites”). Additionally, Florida and California have utilized an analysis that looks at changes in child welfare outcomes over time (“time series analysis”). Indiana matches children with similar cases receiving demonstration services with those who are not (“matched cases analysis”).

While these evaluations have been helpful in assessing the success in meeting the state’s stated objectives, what is not yet clear is the degree to which the waiver demonstration programs are leading to better outcomes in national performance standards such as reduced time to reunification, reduced time to adoption and the reduction in the number of placements while in care. Some experts assert that the waiver programs that have been authorized to date have not encouraged substantial child welfare reform or innovative practices. One key factor noted after more than a decade of experience with project waivers in reviews of state evaluations and reports, was that “leadership” has proven to be essential to effective practices.

Cost Neutrality

All demonstration projects must remain cost neutral to the federal government. This means that the states cannot claim more additional federal child welfare reimbursements than they would have been able to without the waiver projects. Different means have been used to measure cost neutrality, depending on the design of the demonstration project. For projects employing an experimental design using random assignment, the states establish a control group of children and families who receive services according to the standard IV-E federal categorical reimbursements, and then multiply the cost per child in the control group by the total number of children to receive services in the demonstration project. If the states successfully implement new services that are indeed more cost-effective, then they are allowed to retain and reinvest the savings between the new costs and the higher IV-E reimbursement. If the new services were not cost-effective, no additional federal money has been spent. As a result, states are encouraged to experiment with new approaches to child welfare practice without increasing the investment risk to the federal government.

It should be noted, however, that a few states have faced difficulties in maintaining cost neutrality. For example, North Carolina terminated its flexible funding/subsidized guardianship waiver extension prematurely due to problems with adhering to the waiver’s cost neutrality requirement.


37 Ibid.


39 Committee on Ways and Means. (2008). Background material and data on the programs within the jurisdiction of the Committee on Ways and Means. Author: Washington, D.C.


41 Ibid.

42 Ibid.

43 Ibid.

44 Ibid.

45 Ibid.
Pending IV-E Waiver-Related Legislation in the 111th Congress

CCAI does not take a formal position for or against legislation. Information on legislation contained in this report is for educational purposes only. CCAI encourages congressional staff to directly contact a bill’s sponsor for additional information.

H.R.6156: To renew the authority of the Secretary of Health and Human Services to approve demonstration projects designed to test innovative strategies in State child welfare programs.

Passed in House: 9/23/10
Sponsor: Rep. Jim McDermott

This bill would renew the Secretary of Health and Human Services’ authority to approve child welfare demonstration projects from FY 2011 to 2016. Demonstration projects to be considered for approval would include those that would identify and address barriers that result in delays to kinship guardianship for children in foster care; those that provide early intervention and crisis intervention services; as well as those that address domestic violence that put children in danger and at risk of being placed in foster care. Indian tribes are considered states for the purposes of this legislation.

Other Pending IV-E-Related Legislation in the 111th Congress

S.2837: Child Welfare Workforce Improvement Act

Introduced: 12/04/09
Sponsor: Sen. Blanche L. Lincoln

Section 5 of this bill would provide for a demonstration program geared toward improving child welfare staff, which is divided into two phases—planning and implementation. The bill would give authority for 15 state agencies to initiate the planning phase and an additional 15 state agencies to initiate the implementation phase. This bill also de-links the funding provided pursuant to the act from the former AFDC program.

H.R. 3329: Look-back Elimination Act of 2009

Introduced: 7/24/09
Sponsor: Rep. John Lewis

The Look-back Elimination Act is a bill to eliminate the AFDC standard as it related to foster care maintenance and adoption assistance and to install new standards that are based on current balanced eligibility criteria.

Research & Reports

Appendix: IV-E Waiver Project Summaries*

Below please find a list of all Title IV-E Waivers to date.

Capped Title IV-E Dollars and Flexible Funding

California
Start Date: 7/1/2007—End Date: 4/30/2013
Evaluation Design: Time series analysis
This project targets children age 19 and younger and gives a capped IV-E allotment to two counties with large foster care populations. The demonstration provides funding for interventions such as pre-placement services, increased efforts to find kinship placements, efforts to decrease the time for children in out-of-home placements, assistance to relative guardianships, and a new position to help manage the waiver project. The evaluation design is set up to provide a longitudinal report on children’s outcomes.

Florida
Start Date: 10/1/2006—End Date: 7/31/2012
Evaluation Design: Time series analysis
Eligible children include those who are 18 or younger and are either receiving child welfare services in their home or in an out-of-home placement, or who have been reported to have suffered maltreatment. The state receives a capped IV-E allocation, which is utilized by contracted child welfare service providers to increase the availability of community-based services. Since the project’s implementation, the state has reported a significant decrease in out-of-home placements and improvement in permanency outcomes.

Indiana
Start Date: 1/1/1998—End Date: 5/1/2011
Project Status: Approved for 5 year extension in 2004 but terminated early.
Evaluation Design: Matched comparison
This nearly statewide project was for IV-E and a limited number of non-IV-E eligible children age 18 or younger who have reports of (or are at risk of) abuse, neglect, or delinquency. A fixed payment was allotted for developing new services to reduce the need for children’s removal from homes and the time in which children obtain permanency. Children participating in the project tended to be less likely to be removed from their family and spent less time in care. Difficulties in implementing the project included identifying IV-E eligible children and a lack of knowledge and training with respect to the waiver requirements.

North Carolina
Start Date: 7/1/1997—End Date: 2/28/2008
Project Status: Approved for 5 year extension in 2004 but terminated early.
Evaluation Design: Comparison site
Less than 20 percent of the state’s counties participated in this project, which allowed counties to create initiatives to target children who were either at risk of out-of-home placements or were already removed from their homes. The most common initiatives included encouraging court reform and creating contracts for additional services. The project

* The information under this section was gathered from the Green Book and HHS Profiles, which are cited in full in the previous section of this report. The “start date” indicates when the state implemented the project, which differs from when the project was approved.
received a five-year extension in 2004 but terminated early in 2008 due to difficulties with maintaining the waiver’s cost neutrality requirement. See the section entitled “Guardianship and Kinship Subsidies” for a description of the subsidized guardianship component of North Carolina’s waiver.

**Ohio**

Start Date: 10/1/1997—End Date: 12/31/2010
Evaluation Design: Comparison sites
The state selected a small number of counties that would receive a capped allocation of IV-E funds. In Phase I the counties implemented financing and management strategies to improve the cost-effectiveness of services provided to children in care or at risk of being brought into care. In Phase II five distinct interventions are being utilized to prevent removal and increase permanency rates. While reports assessing both phases of the project indicated that more children were able to have permanency with the demonstration in place, there were less clear findings with respect to safety outcomes.

**Oregon**

Start Date: 7/1/1997—End Date: 12/31/2010
Evaluation Design: Comparison sites
Oregon’s flexible funding waiver allows participating state child welfare agencies and Tribes to use Title IV-E funds for a variety of child welfare services, including post-permanency, maltreatment prevention, crisis intervention, and reunification services. Overall, child welfare agencies with access to flexible IV-E dollars have not observed significantly higher permanency rates than the control group. This project gave assisted guardianships to children who had been wards of the state and lived with the prospective guardian for at least one year, the project made it possible for children to obtain assisted guardianships. To be eligible, children must not have reunification or adoption as a permanency option. The program targeted children living with relatives. Evaluation findings indicated that children assigned to the experimental group that had access to assisted guardianship were 6.6 percent more likely to achieve permanency compared to children in the control group—a statistically significant difference.

**Ohio**

Start Date: 10/1/1997—End Date: 12/31/2010
Evaluation Design: Pre-post comparison
This project set out to give assistance for guardianships for ten children per year in all of the state’s three counties. To qualify for the project, children had to be IV-E eligible, have a strong bond with a potential guardian, and be identified for options other than reunification or adoption. Guardians were given subsidies equal to the subsidies given to state foster care homes. After establishing a guardianship, children could still receive certain services pursuant the project. While findings showed a positive outlook for assisted guardianships, Delaware indicated that it was difficult to implement the evaluation component of the demonstration in part due to a lack of caseworker participation.

**Illinois**

Start Date: 5/1/1997—End Date: 10/31/2009
Project Status: Completed
Evaluation Design: Random assignment
For children who have been wards of the state and lived with the prospective guardian for at least one year, the project made it possible to obtain assisted guardianships. To be eligible, children must not have reunification or adoption as a permanency option. The program targeted children living with relatives. Evaluation findings indicated that children assigned to the experimental group that had access to assisted guardianship were 6.6 percent more likely to achieve permanency compared to children in the control group—a statistically significant difference.

**Ohio**

Start Date: 2/1/2007—End Date: 9/1/2010
Project Status: Terminated early
Evaluation Design: Random assignment
Irrespective of IV-E eligibility, children whose permanency goals were guardianship or another planned permanent living arrangement, who had been a ward of the state for at least one year and had lived with a prospective guardian for at least six months, could qualify for subsidized guardianships. Eligible children were either age 12 or older, or if under age 12, were a member of a sibling group with a child who was above the age of 12. As of 2009, 20 children in the experimental group had exited to subsidized guardianship, and another 19 were being considered for an assisted guardianship.

**Maryland**

Start Date: 5/1/1998—End Date: 9/30/2004
Project Status: Completed
Evaluation Design: Random assignment
This project gave assisted guardianships to children who had been living in a kinship caregiver or relative’s home for at least six months. Demonstration participation was extended to all children irrespective of IV-E eligibility. Report findings indicated that experimental group participants were more likely to end up in the custody of relatives but the rate at which children achieved permanency—through adoption, guardianship, or reunification—did not differ largely between the control and the experimental groups.

**Minnesota**

Start Date: 11/17/2005—End Date: 9/30/2010
Evaluation Design: Random assignment
Children in five counties who had lived with a prospective guardian or adoptive parent for at minimum of six consecutive months and for whom reunification and adoption was not a viable permanency plan were eligible for an assisted guardianship or adoption assistance subsidy set at the same benefit level as the foster care payment. (Normally, subsidies for both adoption and guardianship in Minnesota are substantially lower than the foster care maintenance payments provided while a child is in care.) This project targeted certain minority children in long-term foster care as well as those children who were older, a member to a sibling group, or who had additional medical or therapy needs. This program extended benefits to foster homes who became legal guardians for children in their care. Initial numbers indicated that more experimental group participants have obtained permanency through adoption or guardianship than the children in the control group.
Montana
Start Date: 6/21/2001—End Date: 12/31/2008
Project Status: Completed
Evaluation Design: Random assignment
This project set out to provide assisted guardianships across the state and within seven Tribes for children who are IV-E eligible, considered to have special needs, and in the custody of a Tribe or the State. The project’s age restrictions were later changed to include members of sibling groups, but were eliminated entirely by the demonstration’s completion. There were no significant statistical differences between the experimental group participants and the members of the control group.

New Mexico
Start Date: 7/1/2000—End Date: 12/31/2005
Project Status: Completed
Evaluation Design: Random assignment
For IV-E eligible children who were age 18 or younger and either in Tribal or state custody, this project offered assisted guardianships. To participate in this demonstration, a child’s permanency options could not include adoption or reunification. While evaluation findings demonstrated no substantial difference in achieving permanency or length of placement, children in the experimental group tended to be placed in closer proximity to relatives and achieved permanency sooner.

North Carolina
Start Date: 7/1/1997—End Date: 2/28/2008
Project Status: Approved for 5 year extension but terminated early.
Evaluation Design: Comparison sites
This assisted guardianship demonstration, which was part of the state’s larger flexible funding waiver, was limited to certain counties and was available to children who were either in state custody or at risk of being removed from the home. Any additional eligibility criteria were left to the participating counties. A descriptive study conducted by the state suggested that assisted guardianship may be particularly appropriate for older African-American children for whom adoption or reunification are not viable permanency options.

Oregon
Start Date: 7/1/1997—End Date: 12/31/2010
Evaluation Design: Comparison sites
This guardianship project, which was part of the state’s larger flexible funding waiver demonstration, targeted children age 18 or younger, specifically between the ages of four and 17, who had been under the care of a prospective guardian for six months and resided in out-of-home placements for at least one year. Findings from the state’s most recent evaluation suggest that children who exited to guardianship on average spent less time in out-of-home placement than children who were reunified with their birth families, and that children who exited to guardianship were less likely to re-enter foster care 24 months following permanency than children who were reunified.

Tennessee
Start Date: 12/7/2006—End Date: 3/31/2009
Project Status: Terminated early
Evaluation Design: Random assignment
Both IV-E eligible and non-IV-E eligible children who are age 17.5 or younger, who have been in state custody for at least nine months, and in the care of a prospective guardian for six months can receive guardianship subsidy payments as well as other assistance and services related to the obtaining a guardianship. Findings showed significantly better permanency outcomes among experimental group participants than among members of the control group. Nearly 75 percent of children assigned to the experimental group exited to permanency, compared with 66 percent of children in the control group—a statistically significant difference of nine percent.

Wisconsin
Start Date: 10/14/2005—End Date: 7/31/2011
Evaluation Design: Random assignment
This project focuses on one county’s children who have been in foster placements with relatives for at least one year. Children who have been in such placements for less than a year are also eligible to the extent that reunification is no longer one of their permanency options or if they have a sibling who has already obtained an assisted guardianship. IV-E eligibility is not a prerequisite to participate in the demonstration. The project’s services focus on keeping children within their immediate family, or in the alternate, promoting children’s placement with extended family members. To date, reports have shown that participants of the demonstration stayed in care for shorter periods of time and were 18 percent more likely to achieve some form of permanency—a statistically significant difference.

Intensive Services
Arizona
Start Date: 4/17/2006—End Date: 12/31/2008
Project Status: Terminated early
Evaluation Design: Random assignment
This demonstration set out to provide intensive services such as individual and group counseling, family assessments, and case-specific family and child services for children regardless of IV-E eligibility in select counties. The evaluations showed that children participating in the project were more likely to remain in their homes and had slightly higher reunification rates. This demonstration was terminated early at the request of the state due to financial issues. In August 2008, Arizona’s contracted service providers (those providing the services being tested in this demonstration) requested an increase of 20-25 percent in case rates. The state felt it was unable to meet this request due to budget concerns and opted to terminate the project early.

California
Start Date: 12/1/1998—End Date: 12/31/2005
Project Status: Completed
Evaluation Design: Random assignment
California’s Intensive Service Option project targeted IV-E eligible children in seven counties to provide services geared at eliminating the need for children to be removed from their homes. The state reported several barriers faced when implementing the project, which included a lack of primary caregivers available to assist children, inadequate staffing, and inflexibility of financing structures. Findings from this project did not indicate significant differences between experimental group participants and members of the control groups.

Mississippi
Start Date: 4/1/2001—End Date: 9/30/2004
Project Status: Terminated early
Evaluation Design: Random assignment
Largely children already removed from their homes, without regard to IV-E eligibility, qualified to participate in this intensive services demonstration. The project phased in services available to families, relative caregivers, and foster homes in eight different counties. Impediments to the project’s execution included a high turnover rate of child welfare staff and a hiring freeze. The demonstration resulted in significantly less likelihoods of maltreatment recurrence and removal to out-of-home care among experimental group participants.
Managed Care Payment Systems

Colorado
Start Date: 10/26/2001—End Date: 6/30/2003
Project Status: Terminated early
Evaluation Design: Random assignment
Colorado chose to gear this demonstration toward improving outcomes for children of one county, age 10 and older, at risk of aging out of the child welfare system. Private service providers were contracted to meet the needs of these children and their families. Modest participation and insufficient lengths of implementation resulted in a lack of report findings. The project’s early termination was due to state budget problems and a lack of county interest in implementing the project.

Connecticut
Start Date: 7/9/1999—End Date: 10/31/2002
Project Status: Terminated early
Evaluation Design: Random assignment
Children between the ages of seven and 15 years with moderate mental health needs were eligible to benefit from comprehensive treatment from a coordinated effort of service providers. The state reported a difficulty in sustaining comprehensive treatments with the use of a single rate payment system. Connecticut’s demonstration was discontinued due to mental health care system reform at the state level and an insufficient number of referrals to sustain service provider contracts.

Iowa
Approval Date: 3/31/2006
Project Status: Approved, never implemented
This demonstration was intended to serve children who were considered to have enhanced needs, irrespective of IV-E eligibility, between the ages of 11 and 16. Changes in Medicaid payments and service provider system contracts resulted in the project’s termination.

Maryland
Start Date: 1/1/2000—End Date: 12/31/2002
Project Status: Terminated early
Evaluation Design: Random assignment
Maryland’s Managed Care Payment demonstration selected 1,000 children to receive certain support services through contracted child placement agencies. Upon electing not to extend the project, the state indicated that the placement agencies had not anticipated or addressed many of the children’s needs and that there was an imbalance of agency efforts toward adoption rather than reunification.

Michigan
Start Date: 10/1/1999—End Date: 9/30/2003
Project Status: Completed
Evaluation Design: Random assignment
While the demonstration originally focused on IV-E eligible children 18 years old or younger who were either removed from their homes or in immediate risk of removal, the program was later restricted only to children already in out-of-home placements. Participation in the project was significantly less than what was originally anticipated in the state’s waiver application. Project participants could receive in-home services or a managed care system for out-of-home placement and services. Evaluation findings indicated that the new services were more costly, that the services did not produce significant positive effects for children’s outcomes, and that there was little statistical difference in rates of entry into care between the experimental and control groups.

Post-Adoption Services

Maine
Start Date: 4/1/1999—End Date: 9/30/2004
Project Status: Completed
Evaluation Design: Random assignment
Title IV-E-eligible children considered to have special needs qualified to participate in this demonstration. It consisted of two components: increased education for special needs adoptions and post-adoption services. Few statistical differences were found between recipients of the project’s services and those who did not receive them.

Substance Abuse Programs

Delaware
Start Date: 7/1/1996—End Date: 12/31/2002
Project Status: Completed
Evaluation Design: Comparison site
This statewide demonstration set out to establish a multi-disciplinary service team to meet the needs of children who had either entered care or were at risk of entering care due to parental substance abuse problems. The project treated only about 30 percent of the number of families who were referred for treatment. While the length of time children spent in care decreased for those who received these services, a lack of resources and an underestimation of the length of time families would need care contributed to the program’s failure to support the vast needs families in this project faced.

Illinois
Start Date: 4/28/2000—End Date: 12/31/2011
Project Status: In progress. Approved for a 5 year extension in 2007.
Evaluation Design: Random assignment
This demonstration’s targeted population is children who entered care on account of familial substance abuse problems on or after the first day of the project’s implementation. Starting off in one county, but later expanding to two more counties, the project supplements extensive services to eligible families. While the project’s intent was to help families remain intact, evaluation reports have found that systemic problems often co-exist with substance abuse problems which do not allow for children’s return to the home. Therefore, Phase II of the project includes additional service components to address co-occurring issues such as domestic violence, mental health issues, and affordable housing.

Maryland
Start Date: 10/1/2001—End Date: 12/31/2002
Project Status: Terminated early
Evaluation Design: Random assignment
Female primary caregivers were targeted by this demonstration to receive comprehensive treatment for problems surrounding substance use. An inadequate amount of eligible cases and difficulties in project execution led to the project’s early termination. Certain barriers that were faced in implementing this demonstration included a lack of understanding of the program among participants and staff, an inability for intake workers to participate in the program due to high case volume, and difficulty in recruiting female caregivers.
New Hampshire
Start Date: 11/15/1999—End Date: 11/30/2005
Project Status: Completed
Evaluation Design: Random assignment
Families with allegations of child abuse or neglect were targeted by this project regardless of IV-E eligibility. Licensed substance abuse counselors made initial assessments and implemented treatment for families with alcohol and drug related problems. While the project did not yield significant statistical improvement among demonstration participants, the evaluations did indicate a positive trend in their outcomes.

Tribal Services

New Mexico
Start Date: 7/1/2000—End Date: 12/31/2005
Project Status: Completed
Evaluation Design: Comparison site
Children in the custody of Tribes who did not already have an agreement with the state that enhanced their involvement in child welfare cases were targeted by this demonstration. Its purpose was to improve the efficiency and effectiveness of child welfare services provided to Native American children. New Mexico faced difficulties in drawing conclusions from its project evaluations due to the small sample size. Outcomes for children in the experimental group did not differ largely from those in the control group, and some outcomes in the experimental group were actually worse.
Section 7

Health Issues in Adoption
Medical Issues in Domestic Adoption
Laurie C. Miller and Linda G. Tirella

Introduction

More than 120,000 children are adopted domestically each year in the U.S. Domestic adoptions vary widely, including adoptions from foster care, private infant adoptions, and various forms of kinship adoption. Accordingly, health issues of domestically adopted children reflect these individual situations. This article presents an overview of the health issues related to domestic adoption. Regardless of these differing circumstances, pre-adoptive parents must try to anticipate their new child’s health issues, even though complete and accurate information about medical issues is not always available. Preparation will help parents to develop reasonable expectations for the health status of their new child, plan for issues which may arise in the immediate post-placement period, and anticipate the need for possible support services.

Family History

Family history is an important part of an individual’s medical history. Family history for domestically adopted children may not be known with absolute certainty. Information on birthfathers and their families is often incomplete or missing. In younger birthparents, certain medical conditions may not yet have become apparent (e.g., certain mental health disorders do not manifest until the third or fourth decade of life). Birth grandparents may also be young, and important medical problems may not yet have been diagnosed (e.g., high cholesterol, hypertension). Most limiting is the “snapshot” nature of health histories: only current information is provided, with no mechanism to allow communication of later developing family health problems (e.g., breast cancer in the birthmother or her female relatives would be important for a daughter’s later health monitoring). Completeness and accuracy of medical records may also vary in individual situations; in some circumstances birth relatives may not have sought or received medical care. In other situations, incorrect diagnoses may have been applied (e.g., if required for eligibility for certain programs), or transient conditions assumed to be long lasting (e.g., reactive vs. major depression).

Features of family history of particular concern in domestic adoption include mental health disorders, obesity, and exposure to medications. Data on the heritability of physical health conditions are generally more straightforward; information about these is readily available and therefore not discussed in this article (see: http://www.ncbi.nlm.nih.gov/omim). Heritability of mental health disorders and obesity is less well understood. Many conditions clearly have genetic components (Table 1), but polygenic inheritance and strong gene-environment (“GXE”) interactions often strongly influence the expression of disease. Twin and adoption studies are frequently used to disentangle these variables; however, firm conclusions about risks are often lacking. Medication exposures are described separately below.
Mental Health Disorders

Research indicates that many major mental health disorders have a strong genetic component (Table 1). The level of risk is determined by the degree of relatedness to the affected individual (Table 2), and is mediated by the mental health status of adoptive family members and stability of the adoptive home. For example, adopted-away children of schizophrenic mothers have a three to fourfold increased risk of developing schizophrenia compared with adopted-away children of mothers without this diagnosis. Heritability of major depression is estimated in the range of 31–42 percent. Likewise, adverse biologic background predicts adolescent aggression and conduct disorder, as well as antisocial behaviors in adulthood. Some but not all studies suggest strong genetic components to attention deficit hyperactivity disorder (ADHD) susceptibility (e.g., dopamine DRD-4 receptor gene and dopamine transporter gene [DAT1]) and various learning disabilities. Details about specific conditions are available at http://www.nimh.nih.gov/health/publications/.

Table 1. Mental health disorders with established genetic component

<table>
<thead>
<tr>
<th>Psychotic disorders</th>
<th>schizophrenia, schizoaffective disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood disorders</td>
<td>bipolar disorder, severe depression</td>
</tr>
<tr>
<td>Personality disorders</td>
<td>antisocial personality disorder, schizotypal disorder</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>generalized anxiety disorder, obsessive-compulsive disorder (OCD), panic disorder, phobia</td>
</tr>
<tr>
<td>Substance-related disorders</td>
<td>alcohol dependence</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>anorexia nervosa, bulimia</td>
</tr>
<tr>
<td>Childhood disorders</td>
<td>ADHD, autism, chronic tic disorders, including Tourette’s syndrome</td>
</tr>
<tr>
<td>Memory disorders</td>
<td>Alzheimer’s disease</td>
</tr>
</tbody>
</table>

Table 2. Heritability of mental health disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Population Prevalence (%)</th>
<th>Fold-increase Risk in a First-Degree Relative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism</td>
<td>0.02–0.05</td>
<td>84–210</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>0.80</td>
<td>7</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>ADHD</td>
<td>7–10</td>
<td>2–4</td>
</tr>
<tr>
<td>Depression</td>
<td>5–17</td>
<td>1.1–1.6</td>
</tr>
<tr>
<td>Anorexia nervosa</td>
<td>0.10</td>
<td>41</td>
</tr>
<tr>
<td>OCD</td>
<td>2</td>
<td>4.6</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>1.7–3.5</td>
<td>3.5–7.0</td>
</tr>
<tr>
<td>Tourette’s syndrome</td>
<td>0.05</td>
<td>174</td>
</tr>
</tbody>
</table>


Obesity

Definitive separation of genetic and environmental influences on the development of obesity has not yet been determined. It is clear that this interaction is complex, and that there are only very rare forms of “monogenic” obesity. Experts estimate that obesity is likely approximately 30 percent heritable; the risk factors related to genetics decrease with age as environmental factors become more important.

Exposure to Medications

Some women ingest prescription medication during pregnancy, at times before conception is recognized. These medications may have been used continuously for treatment of chronic conditions (e.g., anticonvulsants, antipsychotics) or transiently (antibiotics, antiemetics). Any medication during pregnancy has the potential to be teratogenic (causing malformations to the embryo or fetus), contribute to obstetric and perinatal complications, and/or have long-term effects on the child. In many cases, information about these risks is incomplete.

The U.S. Food and Drug Administration classifies the specific risks of individual prescription drugs during pregnancy (Table 3). This classification of individual drugs is readily available on the
Internet (e.g., http://www.merck.com/mmhe/sec22/ch259/ch259a.html). However, new information about possible untoward effects of prescription drug use during pregnancy continues to emerge. For example, an association with the use of selective serotonin reuptake inhibitors (SSRIs—medication commonly used for treating depression) during pregnancy and the risk of persistent pulmonary hypertension in newborns has recently been noted. In many cases, it is important to balance concerns about drug exposures with the risks of an untreated medical condition. Prescription drugs used in combination with illicit drugs, alcohol, or tobacco may have additional complications.

Table 3. Rating of risks of prescription drug use during pregnancy

| Rating A | Controlled studies in women fail to demonstrate a risk to the fetus in the first trimester (and there is no evidence of a risk in later trimesters), and the possibility of fetal harm appears remote. |
| Rating B | Either animal-reproduction studies have not demonstrated a fetal risk but there are no controlled studies in pregnant women or animal-reproduction studies have shown adverse effect (other than a decrease in fertility) that was not confirmed in controlled studies in women in the first trimester (and there is no evidence of a risk in later trimesters). |
| Rating C | Either studies in animals have revealed adverse effects on the fetus (teratogenic or embryocidal or other) and there are no controlled studies in women or studies in women and animals are not available. Drugs should be given only if the potential benefit justifies the potential risk to the fetus. |
| Rating D | There is positive evidence of human fetal risk, but the benefits from use in pregnant women may be acceptable despite the risk (e.g., if the drug is needed in a life-threatening situation or for a serious disease for which safer drugs cannot be used or are ineffective). |
| Rating X | Studies in animals or human beings have demonstrated fetal abnormalities or there is evidence of fetal risk based on human experience or both, and the risk of the use of the drug in pregnant women clearly outweighs any possible benefit. The drug is contraindicated in women who are or may become pregnant. |

Social History

Social history of the birthparents—and of the child if he or she is living in foster care—is another important factor affecting medical status. Social history includes diverse areas such as substance abuse, exposure to violence and other stressors, and educational and professional achievements. As with family history, social history information is often incomplete. Birthparents may not fully disclose substance abuse, and stressors may not be completely recognized. Younger birthparents may not have completed their education or commenced working. Complete details about the social experiences of children residing in foster care are often unavailable, but the serious adverse effects of multiple foster placements on mental and physical health are well-known (see below).

Prenatal Exposure to Substance Abuse

Prenatal substance abuse is defined as the exposure of the developing fetus to a broad range of harmful and often illicit biologically active compounds, including alcohol, illegal drugs, and tobacco. “Polydrug” use (the use of compounds in two or three of these categories) is common and makes attribution of risk to one substance difficult. In addition, incomplete disclosure of use and recall bias hamper specific risk attribution. Details about doses, duration, frequency, and timing are usually lacking in both research studies as well as in individual histories. Other limitations in understanding risks include the confounding effects of the postnatal environment: outcomes of exposed children are strongly influenced by environmental factors experienced after birth, such as ongoing parental substance abuse, socioeconomic status, nutrition, and education. The quality of prenatal care also influences child outcomes, via such factors as the nutritional condition of the mother during pregnancy (including adequacy of micronutrients) and the prevention of premature birth. Regardless of substance in this category, prenatally exposed children have increased risks of poor brain growth, learning disabilities, and attention deficit hyperactivity disorder (ADHD) as compared to nonexposed children.

Alcohol

Alcohol is one of the most common teratogens worldwide; prenatal exposure to alcohol is one of the most common causes of acquired mental retardation. Prenatal alcohol exposure may impair growth, development, and neuropsychiatric and
sensory function. Children prenatally exposed to alcohol tend to be smaller, both at birth as well as through childhood. Height, weight, and head circumference (the latter reflects brain growth) may all be decreased. Alcohol exposure is also associated with certain birth defects, especially cardiac, renal, skeletal, or facial dysmorphology. In extreme cases, characteristic phenotypic changes of “fetal alcohol syndrome” develop. These typically include an elongated, flattened philtrum, absent “cupid’s bow,” and small epicanthal folds. Other dysmorphic facial features (low-set posteriorly rotated ears, ptosis, flattened midface) are less specific for this condition.

Developmental milestones of alcohol-exposed children may be delayed, particularly receptive language and cognitive skills. Sensory regulation difficulties may affect sleep and arousal, eating patterns, attachment, and behavior. At school age, neuropsychiatric difficulties become apparent, including decreased global intelligence, academic function, attention regulation, and judgment. Although many of these difficulties can be addressed with various therapies, such problems clearly represent challenges for children and their families. Adoption studies have shown the protective effects of a supportive, resource-rich environment on alcohol-exposed children, although many children in this situation still experience significant difficulties.

No amount of alcohol during pregnancy is considered “safe” for the developing fetus, although clearly a dose-effect exists. Interestingly, fetal factors (e.g., aldehyde dehydrogenase genotype) moderate the effect of prenatal alcohol exposure. For example, fetal alcohol syndrome (FAS) will develop in only four percent of children exposed prenatally to two to three ounces of ethanol (four to six standard drinks) per day, or binge drinking (more than five drinks on one occasion). However, many children may have difficulties attributable to prenatal exposure to alcohol in the absence of definitive phenotypic appearance. Various labels have been used to describe this condition, including fetal alcohol effect, alcohol-related neurodevelopmental disorder, and alcohol-related birth defect. Definitive diagnosis of these conditions in the absence of a reliable maternal history of alcohol ingestion is problematic.1

Illicit drugs

Details of dose, duration, and timing of illicit drug exposures are difficult to ascertain; as mentioned, many of these occur in the context of polydrug exposure (e.g., cocaine and tobacco). Illicit drug exposures have both short-term and long-term effects. The short-term effects relate to the adaptation of the child during labor, delivery, and early life. Depending on the drug and timing of the exposure, the child may have increased perinatal complications, including prematurity, irritability, tremulousness, and sleep and feeding problems. Newborn care may be complicated by the need to manage the infant’s drug withdrawal. After this initial period, children may remain irritable for several weeks. Prenatal exposure to cocaine, heroin, or methadone is associated with increased risk of Sudden Infant Death Syndrome (SIDS).

Numerous studies have investigated the function of prenatally drug-exposed children in the first months and years of life; fewer studies address longer-term follow-up at school age or beyond. Again, environmental factors greatly influence the outcome of these children. Long-term risks of specific drug exposures mainly relate to neuropsychiatric function (Table 4).

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1 For more information on this topic, see the chapter in this publication, “Fetal Alcohol Syndrome: The Dilemma for Adoptive Families” by Ira Chasnoff.
Table 4. Risks of prenatal drug exposure

<table>
<thead>
<tr>
<th>Drug</th>
<th>Sleep problems</th>
<th>Growth retardation</th>
<th>Irritability</th>
<th>SIDS</th>
<th>Behavioral disorganization</th>
<th>ADHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin/methadone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Tobacco**
Like alcohol and illicit drugs, prenatal exposure to maternal smoking has been linked to neurobehavioral problems including ADHD, impulsivity, aggressive and antisocial behaviors, depression, and learning disabilities. Such problems are compounded by other unfavorable prenatal exposures (drugs, alcohol, maternal stress) and adversity in the postnatal environment. Dose and duration of exposure relate to outcome.

**Infectious Diseases**

A variety of infectious diseases may be transmitted from a pregnant woman to her child, either during pregnancy or at the time of delivery (Table 5). A full discussion of these conditions is beyond the scope of this article. For prospective adoptive parents of newborns, review of prenatal testing of the birthmother and routine postnatal testing of the child will provide information about the likelihood of these infections. If this information is not available, such testing should be done immediately.

For older children, specific testing may be indicated in some circumstances. Human Immunodeficiency Virus (HIV), Hepatitis B, and Hepatitis C are notable because, unlike the other infections, these often cause no obvious symptoms at birth. Infection of the birthmother late in the pregnancy may lead to false negative results in early infancy; follow-up testing four to six months after birth may be necessary. Perinatal treatment for Hepatitis B is of particular importance, as this can reduce the likelihood of the child becoming a long-term carrier.

Table 5. Congenital and perinatal infections

<table>
<thead>
<tr>
<th>Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group B Streptococcus</td>
</tr>
<tr>
<td>Toxoplasmosis</td>
</tr>
<tr>
<td>Rubella</td>
</tr>
<tr>
<td>Cytomegalovirus</td>
</tr>
<tr>
<td>Herpes</td>
</tr>
<tr>
<td>Human Immunodeficiency Virus (HIV)</td>
</tr>
<tr>
<td>Hepatitis B</td>
</tr>
<tr>
<td>Hepatitis C</td>
</tr>
<tr>
<td>Syphilis</td>
</tr>
</tbody>
</table>

**Prematurity**

About one out of eight births in the U.S. are premature (i.e. <37 weeks gestation). Premature birth may result from maternal factors, such as medical diseases (diabetes, hypertension), low socioeconomic status (SES), age (<16 or >35 years), drug or alcohol use, or other obstetric factors (prior stillbirths, Rh negative status, premature rupture of membranes, antepartum hemorrhage). Fetal factors may also contribute to prematurity, including presentation, growth retardation, multiple pregnancies, or malformation. Prematurity has a multitude of short- and long-term medical and neuropsychiatric effects; a full discussion may be found in standard pediatric textbooks. The long-term effects of prematurity may be briefly summarized by stating that the smaller and more immature the newborn, the more likely: (1) the need for special education; (2) a diagnosis of ADHD (three times more likely if <2500 grams); and (3) learning disabilities.

**Adoption from Foster Care**

In 2009, 55,684 children were adopted from foster care. Many of these children have experienced multiple placements in addition to some of
the risk factors outlined above. Unfortunately, it is often difficult to obtain complete health records for these children, and full mental health evaluations are sometimes lacking. Studies suggest that 40-80 percent of children in foster care have one or more mental health or behavioral disorder; medical issues are also common in this group (Table 6).

Table 6. Health risks associated with multiple foster care placements (and other types of environmental deprivation)

<table>
<thead>
<tr>
<th>Exposure to infections</th>
<th>Emotional neglect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Growth and developmental delays</td>
<td>Toxic exposures (e.g., lead, secondhand smoke, pollution)</td>
</tr>
<tr>
<td>Lack of medical care</td>
<td>Delayed or deficient immunizations</td>
</tr>
<tr>
<td>Possible physical or sexual abuse</td>
<td>Attachment disorder</td>
</tr>
</tbody>
</table>

| Emotional problems |


**Summary**

Children adopted domestically may be at risk for physical and mental health problems related to their social and genetic backgrounds, adverse prenatal exposures, complications of prematurity, various infectious diseases, and experiences prior to adoptive placement. These risks vary widely in different circumstances, and they can be moderated by stability and security in the adoptive home. All domestically adopted children should undergo a thorough medical evaluation to facilitate early identification and remediation of problems (Table 7). Additional research into the health status of this population would allow more focused attention on areas of concern, both pre- and post-adoption.

Table 7. Medical evaluation after domestic adoption

| Review of all medical records including vaccinations, growth record, vision and hearing screens |
| Physical exam including assessment of risk for fetal alcohol exposure and possible signs of physical or sexual abuse |
| Developmental screening |

**Newborns**

| HIV |
| Hepatitis B sAg |
| Hepatitis C |
| Venereal Disease Research Laboratory test (VDRL) |
| Lead |
| Routine newborn screening |

**Older children**

| HIV |
| Hepatitis B sAg |
| Hepatitis C |
| VDRL |
| Lead |
| CBC |
| Sickle test (as appropriate) |
| Mantoux test if possible exposure |
| Chlamydia and gonococcus screening for adolescents or if suspected sexual abuse |
| Dental evaluation |
| Mental health screen (e.g., Ages and Stages Questionnaire or Pediatric Symptom Checklist) |

**Family health preparation**

| Consideration of Hepatitis B vaccination unless status of child known with certainty |

References


You look over your busy schedule and see that your next patient is new to your practice. You see that you have scheduled 20 minutes to meet the child and the family. You walk into the room and the couple is sitting there with their new two-year-old from China. They have essentially no medical records and they have been with her now for two weeks. They look tired and you soon find out they have been back in the United States from China for two days. You look over and see that the family is holding a yellow legal pad with what looks like several pages of questions that they want to go over with you. You take a deep breath and head into the room.

Introduction

In this article we will examine, from the perspective of pediatricians, some of the challenges typically faced by internationally adopted children and their families once they are home. As the practitioner, you will likely be one of the first people to see these children, and a good understanding of the recommended evaluation may be essential to getting the new family started on the right foot. An initial evaluation is recommended soon (within two to three weeks) after the child’s adoption.

The Post-Adoption Medical Evaluation

As with any new patient, a thorough history and physical examination is essential for getting to know the new child and parents. Unfortunately, the medical history is often very brief, as the new family may know very little about their new child. Family history is usually unknown. Prior diagnoses are either unknown or, as is the case for children adopted from Eastern Europe, they may consist of numerous arcane diagnoses that are of little practical help to you as you get started. Short-term history, including recent illnesses and medications, may be available and should be sought.

A complete physical examination should be performed, including an accurate determination of the child’s height, weight, and head circumference (when appropriate). The extent of malnutrition or dehydration should be determined and treated as needed. Identification and documentation of any scars, birth marks, or evidence of trauma should be made. Any medical findings should be addressed as would be standard for any birth child in your office. Many of the newly arrived children, however, will have few clearly obvious medical issues. Since children adopted internationally have been shown to be at increased risk for a wide variety of infections, laboratory studies will be an essential component of the initial evaluation. The American Academy of Pediatrics (AAP) Red Book publishes recommendations for the evaluation of each child adopted internationally (2009 Red Book, 28th Edition, page 177–184). The current recommendations for screening tests for infectious
diseases (page 178) are listed in Table 1, and should be performed soon after arrival. Further recommended studies are also discussed below.

**Tuberculosis Screen**

Currently, it is recommended that all children adopted internationally be screened for tuberculosis using a tuberculin skin test (TST). There has been some confusion regarding the use of the TST, since almost all children adopted internationally have likely received Bacille Calmette-Guerin (BCG) prior to their adoption. The AAP *Red Book* currently states that “receipt of BCG vaccine is not a contraindication to a TST, and a positive TST result should not be attributed to BCG vaccine” (*Red Book*, page 181).

We at the International Adoption Clinic at Fairfax Inova are currently conducting a research program, along with Dr. Bellanti at Georgetown University, examining the results of the TST when compared with the QuantiFERON Tb Gold assay. This blood study examines for activated T-cells and appears to be a more specific assay than the TST. To date, 59 children have completed the study comparing the two screening methods. When we placed the PPD in our office we had no TST negative patients who were QuantiFERON Tb Gold positive. We have had two patients found to be positive for both the TST and QuantiFERON Tb Gold assay, and we have had four patients (six percent of total patients) who were found to be positive for the TST but negative using the blood assay. In comparison, we also attempted to verify the accuracy of the TST results in the community. We have now had 23 patients sent to us with a positive TST for screening using the QuantiFERON Tb Gold assay. Of these reported TST positive patients, none were also found to be QuantiFERON Tb Gold positive, while one patient was “indeterminate” on using the assay and was treated as a positive result. These findings may point out some of the issues associated with the placement and interpretation of the TST. Our current recommendations are to rescreen any TST positive internationally adopted child with the QuantiFERON Tb Gold assay, and to consider not treating if these results are negative.

**Immunizations**

One of the most frequently asked questions relates to the interpretation of vaccine records. In the past we had often proposed that the accuracy of the vaccine records as well as the potency of the vaccines themselves could not be verified, so the child should have the vaccination series restarted upon arrival in the U.S. Growing evidence, however, suggests that this may not be the best approach. In a study presented by Crouch, et al. (2006), positive titers were found in between 81-99 percent of children who reportedly received vaccinations. Verla-Tebit and colleagues (2009) recently found that the rates of positive vaccinations varied by country and vaccine type. Of the 465 adopted children screened, and of those who had at least three doses of tetanus or diphtheria, 87.2 percent and 94.6 percent had positive antibody titers respectively. For children who had received three doses of polio, the rates for polio 1, 2, and 3 were 58.3 percent, 82.4 percent, and 51.9 percent respectively. Measles titers were positive in 80.8 percent of those reportedly vaccinated. Of the sending countries, children from China were less likely to have protective immunity than those from Russia.

The *Red Book* currently suggests that determination of antibody titers is suggested for any child adopted internationally. A second approach which may be employed is to re-immunize, but caution must be used for children who may have previously received several doses of DTaP due to increased concerns of local skin reaction. Currently, it is recommended to check antibodies for Tetanus, diphtheria, polio, and Hepatitis B for any child. Measles, mumps, or rubella antibodies can be checked for any child who may be old enough to have received these vaccines. To date, almost no sending countries are using Hib, Varicella or Pneumococcal vaccines.
Older children who may have had varicella infection may be screened using antibodies in order to determine if this vaccine is still needed.

**Vision and Hearing Screening**

It is currently recommended that each child should have his vision and hearing screened to determine any problems. Dr. Dana Johnson, founder of the International Adoption Clinic at the University of Minnesota, found that 24 percent of 2,291 children surveyed had some type of vision issue, while 12 percent had either temporary or permanent hearing loss. The most common vision problems included strabismus (50 percent), farsightedness (30 percent), astigmatism (20 percent), and nearsightedness (15 percent).

Vision and hearing examinations should be performed by someone accustomed to examining children. If possible, the examiner should also have experience with children adopted internationally.

**Developmental Screening**

Developmental delays are among the most common findings for any child adopted internationally. While the exact cause of each child’s delays will be varied, the high rates of genetic abnormalities, alcohol and drug use by the birthmothers, as well as poor living conditions and the severe isolation of many children, clearly play a role. Miller and her colleagues found in a time study in a Russian orphanage that the waking hours of 65 percent of infants, 43 percent of toddlers, and 46 percent of preschoolers were spent alone, devoid of human contact (Tirella, et al., 2008). They also examined medical records within the orphanage and reported that alcohol or alcoholism was noted for 39 percent of birthmothers, while another seven percent had reported drug use.

Screening on arrival has found that up to 80 percent of children adopted internationally are delayed when they join their new families. Several studies have also demonstrated a correlation between the child’s growth parameters and developmental levels upon arrival. Of the delays, the most consistent delay that we see is that of expressive speech. We have found that between 50-67 percent of the children were delayed in expressive language on arrival (Mason, Mullen, & Narad, 2007), with the mean delays greater for expressive language than that for any other domain (Harmelin & Mason, 2009).

Despite these delays, research has shown that if children have the cognitive ability to pick up language, they do so very quickly. Glennon has reported that children who do not make significant improvements within three months of adoption generally will need intervention. In our study, however (Harmelin & Mason, 2009), we found that 64 percent of our patients failed to demonstrate any catch-up in language development by the three-month visit. While many of our patients may have demonstrated some catch-up later, it does highlight the need for close observation of language acquisition following adoption.

**Summary**

We have seen that children adopted internationally are at-risk for a wide variety of medical and developmental abnormalities often due to their early, pre-adoptive environment. As the children’s health care providers, it is our responsibility to be familiar with how this early environment may impact the child. After a child is adopted, there is a unique set of health risks that must be addressed and monitored. Special considerations regarding infections, immunizations, and growth need to be addressed. In addition, careful monitoring of the child’s development is essential so that delays may be addressed as quickly as possible. Hopefully, by identifying and addressing these issues early, we can better help the child make the transition from an international orphanage or foster care to a family in the United States.
In addition to helping the child enter into their new family, new research is beginning to examine how the parents of internationally adopted children fare. We plan to examine current research regarding the adoptive parents and how they are doing throughout this process. It has become quite evident that how the parents cope with the stresses of adoption has a direct impact on the outcomes for their child, and only by successfully addressing the issues of each member of the family can we best help the child join and adjust to their new family.

Table 1. Screening tests

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<tr>
<th>Test</th>
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<tr>
<td>Hepatitis B virus serologic testing (Hepatitis B surface antigen)</td>
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<tr>
<td>Syphilis serologic testing</td>
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<tr>
<td>Nontreponemal test (RPR, VDRL or ART)</td>
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<tr>
<td>Treponemal test (MHA-TP, FTA-ABS or TPPA)</td>
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<tr>
<td>HIV 1 and 2 serologic testing</td>
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<tr>
<td>Complete blood count with red blood cell indices</td>
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<tr>
<td>Stool for examination for ova and parasites (3 specimens) with specific request for Giardia and Cryptosporidium testing</td>
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<tr>
<td>Tuberculin skin test</td>
</tr>
<tr>
<td>In children from countries with endemic infection</td>
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<tr>
<td>Trypanosoma cruzi serologic testing</td>
</tr>
<tr>
<td>In children with eosinophilia (absolute eosinophil count exceeding 450 cells/mm2) and negative stool ova and parasite examinations</td>
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<tr>
<td>Strongyloides species specific testing</td>
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<tr>
<td>Schistosoma species serologic testing (for sub Saharan African, Southeast Asian and certain Latin American countries)</td>
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References


Foster Care Issues in General Pediatrics

Sandra H. Jee

Introduction

On any given day, approximately 424,000 children are in foster care, with foster care placement rates of 800,000 annually in the United States. Children and youth are placed in foster care when their parents are unable to provide safe care for them. Many of these children have experienced pre-placement trauma and maltreatment. Health care providers who give medical care to children in foster care must have an appreciation for the impact of these deleterious experiences, and the resultant impact on health and psychosocial wellbeing.

Ongoing work has studied the physiological impact of child maltreatment and other adverse experiences that elucidates the pathways to poor long-term outcomes as well as some of the protective factors that promote resilience in this population. The current terminology used to describe these adverse experiences and their impact, both short-and long-term, is “complex childhood trauma.” Children and adolescents enter foster care usually after experiencing multiple traumatic events that include, but are not limited to neglect, maltreatment, unstable living arrangement(s), exposure to violence, and caregiving by a parent who may have mental health problems. The chronic stress of the complex trauma experiences affects the central nervous system of the developing child, resulting, in the short-term, in emotional dysregulation, insecure attachment behaviors, learning problems, anxiety, and developmental disturbance. Complex childhood trauma in the long-term has an impact on both physical and mental physical health.

Health Problems of Children in Foster Care

Children and adolescents in foster care are known to have high rates of chronic medical, developmental, and mental health problems. Prevalence rates for chronic conditions have ranged from 30-88 percent, depending on the sample studied and method used to ascertain

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Among health conditions, mental health problems are the most significant health problem for children in foster care, although secondary data analyses of children in the child welfare system suggest that the majority of children with clinically significant problems do not receive necessary services. For this reason, the American Academy of Pediatrics recommends adherence to recommended guidelines for screening and visit frequency.

The Medical Evaluation of a Child in Foster Care

Because children enter foster care during a time of crisis, most often as the result of neglect or abuse, many have unknown health histories and have not had ongoing primary health care. A health care provider should work with the foster care agency to jointly manage health care by: obtaining medical consent; sharing health information with foster parents; and working to provide ongoing medical care in a timely manner, and in concert with established guidelines.

Recommended health care standards published by the American Academy of Pediatrics include the following:

- Admission health series to identify emerging health needs and monitor the child’s transition into and adjustment to foster care. The admission health series includes initial screening (within 72 hours of placement), comprehensive health assessment (within one month of placement), and follow-up visit (30 to 60 days after the comprehensive assessment). These suggested intervals for visit frequency were based upon expert consensus, and have been adapted in practice by different types of health care systems, whose financial structures may not support reimbursement for this enhanced visit schedule.

- The objectives of the initial health screen are many, and include: an assessment of neglect, physical abuse, and/or sexual abuse; evaluation for exposure to contagious or infectious diseases; presence of acute or chronic health problems; an assessment of need for medications or immediate referrals to subspecialty, mental health, or other providers. The health provider should give anticipatory guidance to the foster parent or accompanying adult to answer questions on how best to manage the transition into foster care.

- Developmental or educational evaluation. Standardized developmental screening has showed to double the detection rate for potential developmental problems.

- Mental health evaluation. The health care provider should refer the child in foster care for a formal mental health evaluation, when resources are available, and offer periodic mental health screening.

- Dental assessment.

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15 AAP District II Task Force on Health Care for Children in Foster Care, District II Committee on Early Childhood A, and Dependent Care. (2001). *Fostering health.* Author: Lake Success, NY.

Focus on a Vulnerable Population

The American Academy of Pediatrics has identified children in foster care and their health needs as a top priority. Indeed, the annual National Conference and Exhibition had a daylong conference dedicated to the health and wellbeing of children in foster care. The American Academy of Pediatrics has developed a website that has multiple resources for health providers, child welfare leaders, judges, foster parents, and children in foster care, which is located at [http://www.aap.org/fostercare/]. Any person who has worked with or has contact with children or youth in foster care is encouraged to access this website, which is in the public domain.

Summary

Health care for children in foster care should be provided with sensitivity to prior experience of loss and trauma. Understanding psychosocial concerns will provide insight into how to provide comprehensive and humane care for this vulnerable population. Health care management should facilitate communication between the primary care medical home and the child welfare system, following standards for health care. A collaborative relationship between the medical home and the child welfare system improves communication and health care management, and aids in timely identifications of health problems. Finally, the health provider has an opportunity to give ongoing support to foster families and child welfare personnel in meeting the complex needs of the child in foster care.
Fetal Alcohol Syndrome:  
The Dilemma for Adoptive Families  

Ira Chasnoff

Introduction

Over the last several decades, progress has been slow in determining just how many children both in this country and abroad are affected by prenatal exposure to alcohol. A combination of legal, social, and attitudinal barriers has restrained communication on every level, starting with the health care provider and patient. Physicians, whether they are based in the United States or abroad, rarely ask a pregnant woman about her alcohol intake, leaving prospective adoptive parents without any sound information about the child’s risk status. Unfortunately, fetal alcohol syndrome (FAS) remains the most common cause of diagnosable mental retardation in the United States, as well as one of the leading causes of behavioral problems in children.

The prevalence of FAS is estimated to range from 0.2 to two cases per 1,000 live births, depending on ethnic, cultural, and regional factors. But the problem is even worse than these statistics suggest. A recent study of 4,800 women from a wide range of social and economic classes found that 22 percent of the women had used alcohol in early pregnancy, and 11 percent continued drinking even though they knew they were pregnant. Thus, about one million children across the United States may be exposed prenatally to alcohol each year.¹

Children available for adoption are at highest risk for prenatal exposure to alcohol. Several studies have estimated that 70 to 80 percent of children in the U.S. child welfare system who are available for adoption have been removed from their homes because of alcohol abuse in the family, and about 50 percent of children available for adoption through a private agency have been prenatally exposed to alcohol. Rates of prenatal exposure to alcohol among children available for international adoption are extraordinarily high, especially among children from the former Soviet Union, Eastern Bloc nations, South Korea, and South Africa. Thus, it is important for prospective adoptive parents to have a thorough understanding of the impact alcohol can have on the developing fetus and the long-term implications for children who have been exposed.

Criteria for Diagnosis²

Fetal alcohol syndrome is the original name given to a cluster of physical and mental defects present from birth that is the direct result of a woman’s consuming alcoholic beverages while pregnant. Infants with FAS have signs in three categories: (1) growth deficiencies, (2) facial dysmorphology, and (3) central nervous system impairment.

Growth Deficiencies

In the United States, the average birth weight of babies born at full term (37 to 42 weeks gestation) is seven pounds, eight ounces, with a normal range down to five pounds, eight ounces. Babies

¹ Please see the references at the end of this chapter for sources on prevalence rates.

² Please see the references at the end of this chapter for sources on diagnosis.
born to mothers who use alcohol have an average birth weight of around six pounds, and are more likely than babies born to mothers who abstained from alcohol to weigh less than five pounds, eight ounces. As children with fetal alcohol syndrome grow older, they tend to continue to be small for their age—that is, short and underweight. To meet the FAS diagnostic guidelines set for growth criteria, a child must have either reduced weight or height (at or below 10th percentile on standard growth charts) at birth or at any point in time after birth.

**Changes in Facial Features**

Facial features associated with prenatal alcohol exposure are consistent with overall flattening of the middle portion of the face. As a result, children with FAS exhibit:

- Epicanthal folds (extra skin folds coming down around the inner angle of the eye)
- Short palpebral fissures (small eye openings)
- A flattened elongated philtrum (no groove or crease running from the bottom of the nose to the top of the lip)
- Thin upper lip
- Small mouth with high arched palate (roof of the mouth)
- Small teeth with poor enamel coating
- Low-set ears

**Facies in Fetal Alcohol Syndrome**

These changes can vary in severity, but they usually persist over the life of the individual. Most people will not recognize any differences when they see the child, but physicians and other practitioners with experience in working with children prenatally exposed to alcohol will be able to detect the changes.

A problem arises when clinicians rely too heavily on changes in facial structure to recognize the child affected by prenatal alcohol exposure. In animal studies, pregnant rats given alcohol on days seven or eight after conception had newborns with facial features typical of FAS. However, giving the pregnant rats alcohol on days one through six, or on day nine or any time beyond, did not affect the facial features in any way. Thus, there appears to be a very narrow window of alcohol exposure that can affect children’s facial features.

**Central Nervous System Impairment**

Problems in the central nervous system can be manifest through structural, neurological, or functional changes. Structurally, a small head circumference (at or below tenth percentile) at birth or at any time thereafter indicates poor brain growth. For example, the average head size of term infants at birth is 35 centimeters, while the head size of a baby with FAS often is less than 33 centimeters. Neurological damage can be manifest as seizures, problems in coordination, difficulty with motor control, or a number of “soft” neurological deficits.

Functionally, the average IQ in children with FAS is about 68, compared to the general population, in which the average IQ is 100. Alcohol-exposed children, with or without the characteristic facial features or growth retardation, have consistently lower IQ scores than nonexposed children. Importantly, even alcohol-exposed children with a “normal IQ” demonstrate difficulty with behavioral regulation, impulsivity, social deficits, and poor judgment, causing problems in day-to-day management in the classroom and home.
From a brain structure perspective, prenatal alcohol exposure can not only cause the child to have a small brain overall, it can also stunt the growth of individual parts of the brain. This damaged growth may be present regardless of the child’s facial features. Problems in the formation and development of different parts of the brain can result in a wide range of behavioral and learning deficits. Many children with prenatal alcohol exposure have trouble moving information between different brain regions; they cannot effectively use information to self-direct their behavior or to think in the abstract. They may have trouble learning new information and recording it in the brain—and then have even more difficulty retrieving the information they’ve already learned.

Other parts of the brain also can be affected, impairing the child’s ability to coordinate planned motor movements and resulting in impulsive movement and clumsiness. Reduction in the size of the cerebellum in the back part of the brain, for example, produces difficulties with balance and arousal, and may be a source of sleep problems. Again, it is important to remember that such problems occur not only in children with the abnormal facial features associated with full expression of FAS, but also in many alcohol-exposed children who “look normal.”

More recently, research has demonstrated that children with FAE may have significant structural and functional changes in the brain, even though they lack overt physical manifestation of the alcohol exposure. Currently, the preferred terminology for children who have been exposed to alcohol but who do not meet criteria in all three diagnostic categories is alcohol-related neurodevelopmental disorder (ARND) or alcohol-related birth defects (ARBD). In April 2004, a group of federal agencies developed a consensus definition of fetal alcohol spectrum disorders (FASD):

> [A]n umbrella term describing the range of effects that can occur in an individual whose mother drank during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications (Bertrand et al., 2004).

Diagnostic terminology in daily use mainly focuses on FAS or ARND, both of which fall within the larger continuum of effects seen in children with FASD. FASD is not meant to serve as a diagnostic term, but rather a unifying one to help us appreciate the many ways in which prenatal alcohol exposure can become manifest in the affected individual.

**Terminology**

For the past thirty years, if a woman drank alcohol during pregnancy and gave birth to a child who showed partial or no apparent expression of physical features characteristic of alcohol exposure, her child was said to have fetal alcohol effects (FAE). These children may have had minimal to moderate facial changes or no changes at all, but usually they had some problems with intellectual, behavioral, or emotional development. These difficulties were known to have an impact on learning and long-term development, though just how extensively FAE affected the child was less clear.

The Dilemma for Adoptive Families

Diagnosis of alcohol-affected children is not nearly as easy as the terminology implies; the truth is, there is great controversy as to how and when to diagnose children whose mothers drank alcohol during pregnancy. The key barrier to diagnosis is the lack of information regarding maternal alcohol use during pregnancy. But the most important practical problem adoptive parents face relates to the lack of physical sequelae among the majority of alcohol-exposed children. Through the history of work with FAS, facial changes have been recognized as an essential component of diagnosis. However, at the same time, new
research demonstrates the primary role growth status (height and weight) has in recognizing children at risk from prenatal alcohol exposure.

In a recent study at Children’s Research Triangle, among 78 foster and adopted children with a confirmed history of prenatal alcohol exposure, the children's current growth patterns, as opposed to facial changes, provided the strongest correlations with poor neurodevelopmental functioning. In this same study, by restricting the diagnosis of FAS to children with growth below the third percentile rather than the tenth percentile for chronological age, we were able to demonstrate neurodevelopmental differences between children with FAS versus those with ARND.

The clarification of these diagnostic issues is important for all families considering adopting a child with prenatal exposure to alcohol, especially in light of the necessity to recognize, early, those children who may be at risk from prenatal exposure, as well as the need for parents to advocate for the child to ensure access to early intervention programs. Without a diagnosis of alcohol-related risk, many children will not be deemed eligible for early intervention and school-based treatment programs, nor will insurance companies pay for related health care interventions. Parents and caregivers thus find themselves in a position of advocating for children not deemed “sick enough” to receive services.

In October 2005, the Centers for Disease Control and Prevention (CDC) published guidelines for the identification and referral of persons with fetal alcohol syndrome. The underlying goal of their report was to clarify the diagnosis of FAS, so as to enhance practicing clinicians’ ability to recognize and refer patients who may have been negatively affected by prenatal alcohol exposure. However, for practicing clinicians, the CDC’s guidelines contain many confusing features. The recommendation that substantial prenatal alcohol use must be confirmed runs counter to published data that document the impact of relatively small amounts of alcohol use in pregnancy. Further, any thresholds for safe use have not been empirically validated, and as the authors of the CDC article acknowledge, it is extremely difficult to confirm prenatal alcohol use because denial, minimization, and inaccurate memories are common among birthparents.

In addition, the collection of some of the data recommended in the CDC guidelines lies outside the practice of a general pediatric office. While it is relatively straightforward to evaluate more evident changes in the midface (nose, lip), it is extremely difficult to measure palpebral fissure size (size of the eye) without special equipment and facilities. From a practical perspective, many of the recommendations are overly broad: referring all children proposed in the CDC’s 2005 published guidelines—those with alcoholic parents, a history of abuse or neglect, involvement with the child welfare system, or a history of foster or adoptive placements—simply is not viable. Presently, further research is necessary to develop a more practical and clinically appropriate approach for the recognition and diagnosis of the spectrum of alcohol-related sequelae in children. Most importantly, eligibility criteria for the various federal- and state-funded treatment programs must be expanded to include all children at-risk from prenatal alcohol exposure.

The most important things adoptive parents can do in this regard are to:

- gather as much information as possible about maternal drinking behaviors during pregnancy
- seek a comprehensive evaluation of the child from a professional who has expertise in the area of prenatal alcohol exposure
- advocate for their child so that he or she will receive the most appropriate early and ongoing interventions, and thus enhance long-term outcomes
References on prevalence of prenatal exposure to alcohol and FAS


References on diagnosis of fetal alcohol syndrome


Section 8

Adoption and Evaluation Outcomes
Introduction

Over the last century, adoption practice has moved from only closed adoptions, with no information exchanged or contact between birth and adoptive families, to availability of more open arrangements, with varying degrees of contact and information exchanged between birth and adoptive families. With these changes came the debate about the detrimental or beneficial effects of openness in adoption. Opponents of open adoption assert that all parties in the adoption will be adversely affected, with adoptive parents feeling insecure in their role as parents and birthparents being unable to “move on” with their lives. Proponents of open adoption assert that it helps adoptive parents assume the parent role by having permission to parent from their child’s birthparents. Birthparents are also thought to be better adjusted in open adoption because they know that the child is well, trust is built between birth and adoptive parents, and the decision to place has been validated.

Existing studies, however, have not reached consensus; some studies found open adoption to be detrimental to mental health while others have found it to be beneficial. Given these conflicting results, further investigation is needed to clarify how openness affects birth and adoptive parents who have completed an adoption plan.

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471 Adoption Outcomes
Empirical work to date has encountered a number of methodological difficulties that can blur our understanding of the influence of openness. Some of these challenges include small sample sizes of birth or adoptive families, the use of a single source of information to report on degree of openness (i.e., birthmother only, adoption agency report only), and varying postpartum assessment times. A recent article, written by researchers from the Early Growth and Development Study (EGDS) and published in the August 2008 issue of the *Journal of Family Psychology,* addresses many of these issues, clarifying the relationship between openness in adoption and psychosocial outcomes and providing direction for future investigations.

**An Introduction to the Early Growth and Development Study (EGDS)**

The EGDS is a nationwide longitudinal study of birth and adoptive families that began recruiting participants in 2003. The major goal of the EGDS is to examine how heredity and environment work together to influence child development. With the help of 33 adoption agencies from 10 states in three geographical regions in the United States (Northwest, Southwest, and Mid-Atlantic), the EGDS team has interviewed 361 adoption-linked sets of birthmothers and adoptive parents. Of these sets, 323 reported complete information about the adoption process and psychological functioning, allowing us to explore the influence openness has within this subgroup or “analytical sample.” In addition, the EGDS team interviewed the birthfather for 33 percent of the participating families, allowing us to examine this understudied segment of the population. Of these birthfathers, 112 reported complete information and were used in the analytical sample.

The majority of participants in the analytical sample were Caucasian: 59 percent of the adopted children, 93 percent of adoptive parents, 71 percent of birthmothers, and 84 percent of birthfathers were Caucasian. At the time of placement, birthmothers were, on average, 24 years old ($SD = 6$), birthfathers were 25 years old ($SD = 7$), adoptive mothers were 37 years old ($SD = 5$), and adoptive fathers were 38 years old ($SD = 6$). Approximately half of the adopted children were girls.

The median income for adoptive families was $100,000 per year with 70 percent of them completing at least a college degree. The modal education of birthmothers and birthfathers was attainment of a high school degree with annual incomes averaging $7,416 and $13,515, respectively. For more information about the EGDS design, see the article by Leve and colleagues in *Twin Research and Human Genetics.*

**The Strength of the EGDS: Addressing Methodological Issues in the Study of Openness**

The power to address questions in any study lies in the quality of the data and the manner in which the data were collected. In the next section we discuss specific methodological improvements employed in the EGDS that increase our confidence in the conclusions that can be drawn from this study.

**The Sample**

The EGDS draws its participants from domestic adoption agencies that were selected to reflect a wide spectrum of adoption practice and philosophy from closed to open practices, religious and secular affiliations, and private or public institutions. To allow us to determine if our sample was representative of the adoptions occurring in the participating agencies for the population we were targeting (domestic, English-speaking, nonrelative, healthy-infant placements), we compared information from those individuals who participated in our study with those who did not participate. We found no significant differences between these two groups of individuals, thereby increasing our

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configuration that study results can be applied more generally to families participating in domestic adoption placements.

**Keeping the Assessment Timing Similar for All Participants**

A second methodological issue for studies of adoption openness is that participants may respond differently about openness depending on how much time has passed since the birth or the placement of the child. The EGDS sample addresses this concern by including only infants placed within 90 days of birth, and by interviewing all birthmothers three to six months after the child’s birth and all adoptive families nine months after birth.

When we asked the birthparents and adoptive families about their levels of openness, we asked about the current level of openness (rather than about originally agreed upon levels). If each individual within an adoption triad reports a similar level of openness, our confidence in the accuracy of our assessment of openness increases.

**Asking Multiple Questions to Multiple Individuals to Assess Openness in Adoption**

The reliability of our measure of openness was improved by combining three sets of questions, including perceived openness, the amount of information shared within the adoption triad, and the level of contact within the triad. By combining questions in this way, errors that might result from differences in participants’ interpretation of specific questions are reduced. The three sets of questions used in the EGDS are described below.

The measure of perceived openness used a continuous, seven-point scale: very closed (1), closed (2), semi-open (3), moderately open (4), open (5), quite open (6), very open (7). Participants were provided with definitions for each category to assist in their responses (see original article for examples). This scale allowed us to index the variability in openness that may exist across families. Figure 1 shows our sample included the entire spectrum of openness levels from very closed to very open, allowing us to test for associations between openness and the outcome measures.

To bolster our confidence in the accuracy of perceived openness, we asked both birth and adoptive parents about their openness experience with their adoption counterpart. The amount of information each party had about the others’ physical health, mental health, ethnic and cultural background, reasons for making an adoption plan, and each parent’s extended family health history was assessed. Frequency of contact through a variety of different communication methods was also assessed via questions about receiving photos, receiving letters or e-mails, talking on the phone, and having face-to-face contact. Adoptive parents were asked two additional questions about how often they sent e-mails and how often their child received presents from the birthmother.

Each of these three sets of questions (perceived openness, knowledge, and contact) was standardized and combined into an aggregate scale of openness for each individual in the study, with higher scores indicating more openness in the adoption.

**Study Outcomes**

The outcomes of interest in this study were satisfaction with the adoption and post-adoption adjustment. Participant satisfaction was measured using several questions about how satisfied birth and adoptive parents were with the information they had received about their counterpart, the amount of contact they had with their counterpart, and the level of openness.

Post-adoption adjustment in the birthparents was measured with a series of questions about how the adoption affected their romantic relationship, financial wellbeing, physical health, mental and emotional health, friendships, the relationship with spouse or partner, general satisfaction with life, satisfaction with physical appearance,
relationships with his or her parents, sense of control over life, and ability to plan for the future. In addition, after a home visit with birthparents, interviewers rated the birthparents’ general demeanor and emotional state.

To measure adoptive parents’ post-adoption adjustment, adoptive parents reported on the effect of the adoption process and receiving the child on their lives, particularly their relationship with immediate and extended family members and friends, physical health, mental and emotional health, career or professional life, and general satisfaction with life.

**Study Results**

**How well do members of the adoption triad agree about the level of openness?**

Openness, as reported by birthmothers and their corresponding adoptive mothers and fathers, showed reasonably high correlations, ranging from .66 to .81, suggesting general agreement about the level of openness among these three informants. This agreement allowed us to combine openness reports from all three informants. We could then examine how the combined report of openness related to satisfaction and adjustment for birthmothers and adoptive mothers and fathers.

Correlations between birthfather reports of openness and those of corresponding adoptive mothers (.45) and fathers (.56) were weaker, so a combined report of openness was not created. Instead, a separate analysis for birthfather reports of openness was conducted.

**Is greater openness related to greater satisfaction and adjustment?**

Our first analysis involved the birthmothers and their corresponding adoptive mothers and fathers. The results showed more openness to be related to more satisfaction and better post-adoption adjustment for birthmothers (see Figure 2). For adoptive parents, more openness was related to more satisfaction with the adoption process, but the level of openness was not related to post-adoption adjustment (see Figure 3).

Our second analysis involved only birthfathers. Birthfather reports of openness were associated with satisfaction and adjustment, but not with interviewer ratings (see Figure 4).

**Discussion and Future Directions**

**Findings**

Our findings indicated that greater openness was related to more satisfaction with the adoption process for adoptive and birthparents, and better adjustment for birthmothers and fathers. Confidence in the results is increased by using multiple informants, using multiple sources of information to assess openness, enrolling a large sample of triads with linked birthmothers and adoptive families, and being consistent across all parties with the assessment timing.

**Caveats**

Despite our methodological improvements, the findings of this study should be considered preliminary. First, we could not examine whether the participants’ expectations and preferences for a degree of openness prior to placement affected the outcomes. Because the adoption experience of the sample was, on average, more open than closed, participants may have chosen more openness and therefore be more satisfied with greater openness. Second, our small sample of birthfathers did not allow us to examine their outcomes as completely as the other parties. Third, the study focused on birth and adoptive parents, rather than the effects of openness on the adopted child. Fourth, there is always the possibility that factors unaccounted for may influence the outcomes.

**Future Directions**

Future studies could build on this work by exploring the effects of openness on young children, including a larger sample of birthfathers, exploring openness expectations prior to
placement, exploring the effect of changes in openness over time,11 and exploring the impact of matches and mismatches between birthparent and adoptive parent preferences and expectations for openness arrangements.

Acknowledgments

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Figure 1. Percentage of individuals in our sample reporting particular levels of openness

![Bar graph showing percentage of individuals reporting levels of openness by category, including birthfathers, birthmothers, adoptive mothers, and adoptive fathers.]

Figure 2. Openness and outcomes for birthmothers

NOTE: For figures 2 through 4, each “+” indicates a statistically significant association between openness and the outcome measure. Each “0” indicates no statistically significant association between openness and the outcome measure.
Figure 3. Openness and outcomes for adoptive mothers and fathers

Degree of Openness
Reported by Birthmothers,
Adoptive Mothers, and
Adoptive Fathers

+ Satisfaction with the Adoption Process

0 Post-adoption Adjustment

Figure 4. Openness and outcomes for birthfathers

Degree of Openness
Reported by Birthfathers

+ Satisfaction with the Adoption Process

+ Adjustment to the Adoption Process

0 Positive Interviewer Impression
China Adoption Research Summary

Tony Tan

Introduction

For over two decades, families in the United States and many other countries have adopted thousands of Chinese children a year. Most of these children are girls. In this article, I briefly summarize research conducted by me and my colleagues at the University of South Florida. Our research primarily focuses on the adopted Chinese children’s post-adoption language development, social-emotional development, and academic performance.

Introduction of the Research Projects

In 2005, Dr. Kofi Marfo, Dr. Robert Dedrick, and I began the first phase of a large study that included approximately 1200 children who were adopted from China by families in the United States, Canada, and several other countries (e.g., Australia). The purpose of the study was to develop a good understanding of adopted Chinese children’s development over time. The participating families were volunteers that I recruited with the help of six adoption agencies and over 120 online groups.

The study was designed to learn about the adopted children’s development and academic performance from the adoptive parents and teachers. The children were not directly involved in answering the questions because most of them were young (about 65 percent of the children were under five years of age in the first wave of the study). I used several questionnaires to gather information and answer my research questions.

As of 2010, three waves of data have been collected (in 2005, 2007, and 2009). In each wave, the adoptive parents completed several questionnaires. In 2007, the children’s teachers also participated in the study. The teachers completed a standardized questionnaire called the Social Skills Rating System (SSRS-Teacher). It asks teachers to rate the child in comparison with other students in the class. In 2009, data for the third phase of the study was gathered from parents. Due to the fact that some families’ contact information had changed, the 2009 data included about 900 children.

More recently, I also collected saliva samples from a randomly selected subsample of about 150 children and 50 parents. The saliva samples are currently being analyzed to determine if a gene named serotonin transporter (5-HTT) might be related to anxiety levels in this group of children.

Summary of the Results from the Research Projects

Based on the reports from the adoptive parents in 2005, 2007, and 2009, as well as the children’s teachers’ reports in 2007, I have drawn some tentative conclusions about the children adopted from China in the following areas: physical development, language development, social-emotional development, and social skills and academic competence.

Physical Development

Based on parents’ recollections of their children’s post-adoption check-up results, about 45 percent
were underweight, seven percent had severe delays in gross motor skills, and about five percent had severe delays in fine motor skills when the children were first brought home. However, because different clinics differed in their experience with adopted children and used different protocols in evaluating them, how exactly each clinic determined a child’s developmental status is unknown. (It would be ideal if clinics used standardized protocols in evaluating international adoptees.)

Physical catch-up seemed to occur fairly quickly for most of these children. In my study on preschool-age children, 75 percent of the children were reported to be in excellent health. Compared to U.S. norms for girls ages two to 20 years, the adopted children were roughly at the 40th percentile on BMI, and they were roughly at the 50th percentile relative to a published index for girls ages two to eighteen in China.

**Language Development**

Most research has shown that children who were adopted as infants and toddlers learn English quickly and smoothly (Meacham, 2006). Usually about one to two years after adoption, most children’s spoken language becomes age-appropriate.

I have conducted two studies on children between the ages of 18 months and three years concerning English language development. Most of these children were adopted around six to 15 months of age. My research showed that in terms of vocabulary, about 13 percent of the children would be considered delayed based on the number of words they could spontaneously use. About 13 percent of the children in my study also received speech/language therapy. Children who were adopted at an older age tended to learn English faster, but they also had more to learn in order to become age-appropriate. Usually, a child’s age is a better predictor of how many words she can use than how long she has been at home. For example, a three-year-old is who has been home for one year is more likely to know more words than a 2 1/2-year-old who has been home for 1 1/2 years.

Table 1 illustrates the number of words that about 75 percent of children in different age groups and age at adoption groups can spontaneously say. Overall, my research, as well as research conducted by other scholars, suggests that the adopted children’s chronological age was usually positively correlated with their vocabulary size, while their age at adoption was negatively associated with vocabulary. Other factors such as pre-adoption experiences and current family demographics were not associated with the adoptees’ vocabulary size or average phrase length. Recently, there has been some research (Gauthier & Genesee, in press) that looks at the language skills when adopted children are older (e.g., six to seven years old). Results suggest that the adopted children are comparable to their peers in spoken French but have more difficulties with sentence reconstruction and reading comprehension (that is, more abstract academically related language skills).

**Social-Emotional Development**

Adopted children’s social-emotional adjustment is the area in which I am most interested. I believe

<table>
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<tr>
<th>Table 1. Number of words that 75 percent of the children can spontaneously use by age group and age at adoption group</th>
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<tbody>
<tr>
<td><strong>Age at adoption</strong></td>
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<tr>
<td>---------------------</td>
</tr>
<tr>
<td>6-12 months</td>
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<tr>
<td>12-15 months</td>
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<tr>
<td>15 months or older</td>
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<td>Overall</td>
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adopted children’s wellbeing is a critical indicator of the success or failure of the adoption. Adoptive parents also seem to be particularly keen on ensuring that their children enjoy the best possible upbringing. As a group, children adopted from China seem well-adjusted. My earlier research on the behavioral adjustment of 517 preschool-age and 178 school-age adopted Chinese girls showed that the Chinese girls had significantly better adjustment scores than comparable samples from the United States normative data. The preschool-age adopted Chinese girls also had better adjustment scores than the school-age adopted girls. For both preschool and school-age groups, their age and age at adoption were not indicators of adjustment. However, experiences of pre-adoption neglect and post-adoption initial rejection behaviors toward parents were related to more adjustment problems.

More recently, in 2007, I wanted to discover whether the adopted children’s social-emotional adjustment would continue to be positive as they grew older. I looked at data on 842 girls over a two-year period. Overall, there was a strong stability in their adjustment. In other words, most children who were doing well earlier continued to do well two years later, and children with difficulties earlier continued to have difficulties two years later. For children who transitioned into grade school, there was a big increase in their adjustment difficulties, especially anxiety. But for those who remained in the preschool-age group and those who remained in grade school, there was no increase in adjustment difficulties. For the preschool-age children, more delays in social skills, more refusal/avoidance behaviors towards the adoptive mother, and crying/clinging behaviors at the time of adoption were related to more adjustment problems currently.

Overall, about 10 to 13 percent of the adopted Chinese girls in my study showed clinical or borderline clinical anxiety/depression. The rate was lower than the U.S. norm of about 18 to 21 percent (Achenbach & Rescorla, 2000). As they get older, there seems to be a slight increase in the number of children developing clinical anxiety/depression. Currently, I have examined the children’s adjustment patterns over another two years from 2007 to 2009, and again the children seem to be doing well. I do see a tendency for the adopted Chinese girls to become more similar to other American children in their adjustment profile as they are getting older. This should not be surprising, because these children are American.

The adopted children’s favorable adjustment did not mean that their parents were not concerned about some areas of their development. For instance, about 60 percent of the 422 parents with preschool-age children in my study expressed concerns about their children. Of all the concerns, the child’s problems in forming attachment were on top of the list. Some of the attachment-related issues include lack of attachment to parents (for example, the child would walk away with adults that she has just met) or separation anxiety (for example, the child has major difficulties being dropped off at school, or sleeping alone at night). Secure attachment plays a critical role in children’s emotional wellbeing. Unfortunately, due to a variety of reasons including but not limited to suboptimal pre-adoption experience, disruption of relationships, and differences in routines, many children experience difficulties in bonding initially.

Sleep difficulty was another area that concerned parents with preschoolers. My research showed that about 70 percent had a single exclusive sleep location (e.g., solitary sleeping, sharing bedroom with a sibling, sleeping in parents’ bedroom, or co-sleeping with parents), and the rest used a combination of two or three different locations. Children with more sleep problems were more likely to have more sleep locations and to co-sleep or share a bedroom with parents. Parents of children with more sleep problems were more likely to seek advice on co-sleeping. When they did, pediatricians were more likely than extended family members and fellow adoptive parents to recommend against co-sleeping. My research concludes that the child’s sleep arrangements
reflect parents’ responsiveness to children’s sleep behaviors and emotional needs. It was not uncommon for parents to resist co-sleeping initially, but some eventually used it when they discovered that their children’s anxiety decreased as a result. Single mothers were more likely to accept co-sleeping than married mothers.

**Social Skills and Academic Competence**

In 2007, when I was collecting information on the adopted children for the second wave of my study, I asked the parents if they would be willing to ask their children’s teachers to complete a questionnaire. Most parents agreed and dropped off the questionnaire for the teachers. Only teachers provided information about the children’s academic competence (for kindergarteners and beyond) in different areas such as reading, math, motivation to learn, intellectual capacity, and parental support in learning.

With information from both parents and teachers, I compared whether parents and teachers agreed on the children’s social skills. The results showed that they only agree with each other to some extent. According to the parents’ ratings, about 16 percent of the preschool-age children, 10 percent of elementary-age children, and 19 percent of the secondary school children would be considered as having less than an average level of overall social competence (that is, they were at-risk in the area of social competence). However, teacher ratings showed that only about four percent of preschool-age students, five percent of elementary school students, and zero percent of secondary school students were considered at-risk in social competence. In terms of academic competence, about five percent of elementary school children and seven percent of secondary school children were at-risk. As to why the parents did not rate their children’s social skills as favorably as the teachers did, I suspect that this was probably because (1) the parents had higher expectations, (2) the teachers used other children as comparisons, and (3) children behave differently in school versus at home.

**Summary**

Over the past ten years since I started studying these children, I have received tremendous support from the community of parents who have adopted children from China. For that, I am very grateful. Since many of the adopted Chinese children are still rather young, there is a need for more research to further understand their development as they get older. In the future waves of my research I hope to learn more about whether certain genes might contribute to the children’s anxiety and depression. I also hope to learn if these children are indeed experiencing the onset of puberty sooner than nonadopted children (as anecdotal accounts suggest). If that is the case, I would like to study the implications of early puberty on their mental health. Nonetheless, based on the positive outcomes that my studies have shown, I feel comfortable predicting that these children, as a group, will continue to thrive.

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**Peer-Reviewed Journal Articles in Press**


Peer-Reviewed Journal Articles in Print

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Book Chapters in Print


Adopted Children’s Emotion Recognition Abilities

Karyn B. Purvis, Sheri R. Parris, Erin Becker Razuri, David R. Cross, Andrew M. Herbert, Kelly L. Reed and Tiffany Terry

**Introduction**

Many researchers believe that the emotional development of adopted children, including their ability to recognize different emotions and to identify appropriate emotions for specific situations, is greatly impacted by whether or not—and to what degree—they have experienced deprivation.\(^1\)\(^2\) Children adopted from international institutions are believed to have greater difficulty with emotion recognition because their deprivation is often greater than those adopted domestically.\(^3\)\(^4\) To explore these beliefs further, this study compared emotion recognition abilities of 20 domestically and internationally adopted children at risk for significant behavior problems to 20 nonadopted children with learning disabilities. Children in the adopted group were 3 1/2 to 13 years old (\(M = \) eight years); 12 males and eight females; 12 were adopted internationally and eight were adopted domestically; all adopted children participated in a Trust-Based Relational Intervention® (TBRI\(^{SM}\)) summer camp. (See the article “Trust-Based Relational Intervention®: Principles and Practices” in this Factbook for more information.)

Children in the nonadopted group were seven to 11 years old (\(M = \) eight years, nine months); 10 males and 10 females; all attended a school for children with learning disabilities. Both groups had similar socioeconomic backgrounds; however, unlike the adopted group, the nonadopted group did not have a history of deprivation.

After comparing emotion recognition ability between domestically adopted, internationally adopted, and nonadopted children, this study further investigated whether emotion recognition abilities improved for the adopted children after participating in the TBRI\(^{SM}\) camp.

**Emotion Recognition Measurements**

Two tasks were used to explore children’s emotion recognition abilities: (1) the same/different task and (2) the emotional vignette task. These tasks were completed approximately ten days before the adopted children participated in the summer camp. The adopted children completed these tasks again as a posttest measure within four weeks after attending camp.

The same/different task consisted of eight cards, measuring 8 ½” x 11,” each displaying two color photographs of individuals with either the same or different facial expression. Each child was presented with one card at time and told to...
The emotional vignette task consisted of 15 cards, measuring 8 ½” by 14,” each displaying three color photographs with the same individuals and same facial expressions used in the earlier task. Each child was presented with one card at a time, and told a story for that card. Next, the children were to choose the face whose expression matched the character described in the story. Ten of the vignettes displayed happy, sad, and angry facial expressions. These were created by Ribordy, Camras, Stefani, and Spaccarelli (1988)6 and were successfully utilized by Pollak and colleagues (2000).7

Trust-Based Relational Intervention® Camp

The adopted children in this study participated in a Trust-Based Relational Intervention® summer camp that was held from 8:30am to 4:00pm, five days a week for three weeks. The daily camp schedule was organized to create an attachment-rich, behaviorally-structured, and sensory-rich environment. Therapeutic activities were integrated into the schedule to promote emotional growth and development of children’s self-monitoring and self-regulating skills such as journaling, didactic interactions, and games such as The Thinking, Feeling, and Doing Game and The Angry Monster Game.8,9

Results

Adopted vs. Nonadopted

The initial goal of this study was to compare adopted and nonadopted children’s emotion recognition abilities. Analysis of Covariance (ANCOVA) was used to analyze differences between adoption status (adopted, nonadopted) and child age. For the same/different task, there were significant effects for both adoption status, $F(1,37) = 6.41, p = .038$, and child age, $F(1,37) = 10.01, p = .003$, suggesting that older children performed better than younger children, and nonadopted children performed better than adopted children.

For the emotional vignette task, the interaction between adoption status and child age was non-significant. The main effect between adopted and nonadopted status was also non-significant. However, children’s ability to recognize sad vignettes seemed to greatly influence the results. Differences in recognizing sad photographs were statistically significant for adoption status and child age interaction, $F(1,36) = 10.80, p = .002$. Adoption status was not significant for either the angry or happy vignettes. Differences also existed for the age main effect, $F(1,36) = 11.89, p = .001$, with older children better able to identify sad faces. Based on these results, and inspection of scatter plots as well as adjusted means, we concluded that the nonadopted children performed significantly better than the adopted children on the sad vignettes.

Adopted Children’s Abilities After TBRI℠ Camp

Another goal of this study was to explore whether camp was helpful in improving adopted children’s emotion recognition abilities. ANCOVA was computed with time (pretest, posttest) as a repeated measures factor and child age as a covariate. For the same/different task, the interaction between time (pretest, posttest) and child age was non-significant, yet main effects for both child age, $F(1,18) = 11.50, p = .003$, and time were significant, $F(1,19) = 9.83, p = .005$. 

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In general, the adopted children demonstrated an improvement in their emotion recognition abilities between their pretest and posttest measures on the same/different task. Older children also performed better. On the emotional vignette task, there was weak evidence of change between the pretest and posttest measures; however, there was good evidence of subgroup differences between the internationally and domestically adopted children.

**Internationally vs. Domestically Adopted Children**

To examine whether there were differences between the two adopted groups, a repeated measures ANCOVA was computed with time (pretest, posttest) as a repeated measures factor, adoption type (international, domestic) as a between subjects factor, and child age as a covariate. Findings for the same/different task indicated no significant differences between internationally and domestically adopted children’s pretest and posttest measures; however, there were significant findings for the emotional vignette task. Only the interaction between adoption type (international, domestic) and time (pretest, posttest) was significant, $F(1,18) = 5.49$, $p = .031$. Once again, children’s results for recognition of sadness seemed to strongly influence this interaction, $F(1,17) = 6.39$, $p = .022$. In general, the internationally adopted children seemed to make greater gains on the vignette task after participating in the camp intervention. Specifically, the internationally adopted children’s scores on the posttest improved by approximately one whole point on the angry and sad vignette items, while the domestically adopted children’s scores actually declined by about one-half point (See Table 1).

**Discussion**

Results of this study indicated that adopted children were less accurate than nonadopted children in differentiating between same and different facial expressions, and in identifying a facial expression to match a sad vignette/story. Many researchers have reported significant differences between adopted and nonadopted children’s ability to recognize happy emotions; however, there were no statistically significant differences between their scores on the happy items used in this study. Interestingly, in this study, the adopted children’s emotion recognition ability was best for identifying happiness on both tasks.

Differences between the findings of this study and previous studies may be accounted for by the older mean age of the children in this study compared to those in Fries and Pollak’s (2004) study and those in Sloutsky’s (1997) study. These children’s school experiences may have also contributed to the differences. In addition, our comparison sample of nonadopted children may have special needs themselves due to their attendance at a special school for children with learning disabilities. Individuals with learning disabilities are thought to have difficulty recognizing emotion in faces as well. The deficits of these adopted children may be even more pronounced when compared to a group of children without learning disabilities. However, these children were used as the comparison sample because of convenience, and because they did not have a known history of deprivation or maltreatment putting them at risk for emotion recognition difficulties.

Surprisingly, the children adopted domestically only improved on the same/different task after participating in camp. The internationally adopted children appeared to benefit more from camp, making greater improvements in emotion recognition on both tasks, and for all three emotions. Encouragingly, this improvement

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was notable after only a three-week intervention following years of deprivation or maltreatment. Creating an environment of felt-safety and facilitating healthy social interactions during camp likely contributed to these children’s improvements. Specific activities in camp, such as displaying pictures of facial expressions during the grief and loss group sessions and asking children to verbally identify emotions and to physically demonstrate those emotions themselves, also directly addressed emotion recognition skills. In other sessions, children discussed how hypothetical situations would make them feel. Children’s improvements in their emotion recognition abilities were likely the result of explicit practice, yet their improvements also suggested growth in overall social-emotional functioning. Other improvements in social-emotional functioning following camp have been documented.\textsuperscript{14,15}

**Limitations**

A larger sample size might have made it possible to clarify further emotion recognition differences between internationally and domestically adopted children. Providing a therapeutic intervention to a small group of adopted children limited the generalizability of this study. Another limitation was the lack of background information on these children, including information about abuse, neglect, and substance abuse in caregivers (especially during pregnancy), which may have explained certain findings and differences between the two groups.

**Conclusion**

The current findings suggest that interventions which provide an attachment-rich, sensory-rich, and behaviorally-structured environment, such as Trust-Based Relational Intervention\textsuperscript{®}, may be beneficial for the continued emotional development of adopted children at risk for significant behavioral problems. Results from this study suggest that internationally adopted children, specifically, may benefit the most from participating in a short-term intensive intervention like TBRI\textsuperscript{SM} summer camp, or simply from the repeated use of TBRI\textsuperscript{SM} principles and practices. For more information about TBRI\textsuperscript{SM} see the chapter “Trust-Based Relational Intervention\textsuperscript{®}: Principles and Practices” in this edition of Adoption Factbook.


Table 1. Mean task scores for adopted and nonadopted children before and after camp

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre-Camp</th>
<th>Post-Camp</th>
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<tbody>
<tr>
<td></td>
<td>Same/Diff</td>
<td>Vignette</td>
</tr>
<tr>
<td>Adopted</td>
<td>6.2</td>
<td>23.1</td>
</tr>
<tr>
<td></td>
<td>7.0</td>
<td>24.4</td>
</tr>
<tr>
<td>Int'l</td>
<td>6.3</td>
<td>22.8</td>
</tr>
<tr>
<td></td>
<td>7.1</td>
<td>25.7</td>
</tr>
<tr>
<td>Domestic</td>
<td>6.0</td>
<td>23.4</td>
</tr>
<tr>
<td></td>
<td>6.8</td>
<td>22.5</td>
</tr>
<tr>
<td>Nonadopted</td>
<td>7.3</td>
<td>24.7</td>
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</table>

NOTE: Standard deviations are in parentheses.
Neurotransmitter Levels in At-Risk Adopted Children

Karyn B. Purvis, Shanna K. Mittie, Gottfried Kellermann and David R. Cross

Introduction

Neurotransmitters (NTs) are chemicals that serve as messengers between the brain and organs. Neurotransmitters tell the heart to beat, the lungs to breathe, and the stomach to digest. Neurotransmitters affect the entire human being, emotionally (e.g., mood, behavior, social attitude), physically (e.g. sleep, cardiac function, weight), and mentally (e.g., focus, learning ability). Understanding neurotransmitter levels in at-risk children is extremely important. By understanding the basic mechanisms within at-risk children’s brain chemistry, we can help facilitate optimal levels and better serve them. Laboratory data suggests that the incidence of neurotransmitter imbalances in the population is very high. A growing body of research has documented significant alterations in hormones, NTs, and neuromodulators in children with histories of abuse, maternal deprivation, and neglect. Previously difficult to test (e.g., blood draws, spinal punctures), new advances in non-invasive testing has equipped developmental researchers to assess these biochemical markers through measurements of saliva and urine.

Our development research lab is among those employing urinary testing of neurotransmitters levels alongside other traditional behavioral measures. For the past decade we have devoted our research energies to the development of interventions for children who have come from “the hard places.” Those children include: 1) children with difficult or stressful pregnancies, including exposure in utero to drugs, alcohol, or other toxins; 2) those who had difficult births, including risks such as early induced labor or brief episodes of oxygen deprivation; 3) children who experienced early hospitalization for causes such as prematurity, low birth weight, or serious infections; 4) children who experienced abuse, including emotional, physical, and sexual abuse; 5) children who experienced neglect, including those whose needs were not met due to causes such as maternal depression, institutionalization, or parental drug use; 6) children who experienced trauma, including children exposed to circumstances such as domestic violence, natural disasters, war, famine, death of family members, and even medical trauma. Given the broad range of “hard places,” the number of children at risk is staggering.

Although scientists are still identifying NTs and neuromodulators, there are specific NTs which have already been identified in research which directly correlate to behavior. GABA and glutamate appear to be especially
GABA is the brain's primary inhibitory NT, is prominent during neural development⁶,⁷ and has been implicated in some behavior disorders.⁸,⁹ Glutamate, in contrast, is the brain's primary excitatory NT, is actually a metabolic precursor to GABA, and like GABA is crucial to neural development.¹⁰,¹¹ Epinephrine is associated with the stress-response for “challenges.” When epinephrine is released, common physiological responses are elevated (i.e., heart rate, respiration, etc.). Norepinephrine elevations are associated with stressful situations and the need for quick thought, and quick actions. Dopamine plays a vital role with memory, learning, attention, movement, pleasure, and motivation. Impaired cognition and memory processes can occur if dopamine is not at optimal levels. If dopamine levels are too high, attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD), autistic-like behaviors, and schizophrenic-like behaviors can occur. Serotonin, which is the body’s master regulator, plays a role in contentment, satiation, sleeping, eating, resting, and positive affect. The remaining two NTs in our profile are histamine and beta-phenylethylamine (PEA). That histamine may contribute to childhood behavior problems is evident from its fundamental role in arousal and memory.¹²,¹³ Histamine enhances attention, arousal, learning, sensory processing, cognition, and appetite control. If histamine levels are too high, symptoms of restlessness, irritability, asthma, allergies and urinary tract infections are probable. PEA acts primarily as a neuromodulator, including the ability to potentiate catecholaminergic neurotransmission. Although the available evidence is far from conclusive, there is a small but growing database implicating PEA in disorders such as ADHD and depression.¹⁴ Table 1 provides a list of neurotransmitters and the correlated effects with variations in relation to the optimal level.

NT testing was used with limited testing as early as the 1950s.¹⁵ Elmadjian¹⁶ investigated adrenaline and noradrenalin in athletes under various conditions. Samples of professional hockey player’s urine was measured pre- and post-game, and an increase in noradrenalin (norepinephrine) by sixfold was typically found. Athletes who sat on the bench and worried about their injuries showed no increase in noradrenalin but a significant increase in adrenaline (epinephrine). Other studies involving astronauts in training¹⁷ confirmed the general finding that noradrenalin emission is associated with active, aggressive action, while adrenaline excretion is related to anxiety and apprehension.

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More recently, Field and colleagues\(^\text{18}\) tested NT levels of pregnant women who were classified as either depressed or not depressed. Urine was taken from mothers at their sixth month of pregnancy and then from their newborns at one month after birth. Findings were sobering. Women who were simply depressed had lower levels of dopamine and serotonin but higher levels of prenatal cortisol. In addition, cortisol levels were negatively related to prematurity and the neurotransmitter norepinephrine was positively related to low birth weight. Notably, the impact of their neurochemistry was seen clearly in the NTs of their infants one month after birth with infants of depressed mothers exhibiting elevated levels of cortisol and lower levels of dopamine and serotonin, thus mimicking their mother’s prenatal levels. In addition, those infants were found to have asymmetric levels of metabolic activity had greater relative right frontal EEG.

NTs can be altered by life events such as abuse, trauma, and post-traumatic stress disorder (PTSD). Even over time, the levels do not automatically revert after trauma/abuse and both chronic and single-event traumas can have lasting impact. For example, Gunnar and her colleagues\(^\text{2}\) found elevated levels of cortisol in children adopted from Romanian orphanages more than six years post-adoption, and Ganzel and colleagues found that five years after the terrorist attacks of September 11, 2001, New York residents still had over-activity in brain threat detection regions (heightened amygdala reactivity).\(^\text{19}\)

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The thrust of this brief paper is to report our findings of NT levels in at-risk adopted children. In this study we not only describe the profile of eight NTs (epinephrine, norepinephrine, dopamine, serotonin, GABA, glutamate, histamine, PEA), but also investigate the association between these NT levels and parent report measure of child development and behavior: The Achenbach Child Behavior Checklist (CBCL). The CBCL yields a score for each of the internalizing and externalizing composite scales. Moreover, the current study assesses NT levels and behavioral problems in a sample of 97 at-risk adopted children who had early disruptions in care-giving.

Study Participants

Participants were adopted children (61 males, 36 females), from 57 families recruited through parent groups and word of mouth. The children ranged in age from three to 17. All of the parents felt their children had some special needs (e.g., behavioral problems, learning disorders, etc), varying in degree from minor to major. Parents were asked to provide histories for each child participating in the study, and from those histories it was determined that 84 children had experienced at least one significant known or suspected risk factor. The most common risk factors in order of frequency were prenatal risk, postnatal risk, abuse, neglect, and trauma. Furthermore, according to the parent reports, 48 children had at least one clinical diagnosis, with the most common diagnoses in order of frequency being ADHD, mood disorder, attachment disorder, and Pervasive Developmental Disorder (PDD). Finally, 50 children had been prescribed at least one psychotropic medication, with the most common categories being anti-depressant, anti-psychotic, and allergy.

Methods

The CBCL was completed by parents. These report forms have been thoroughly validated by its authors and include internalizing subscales with questions in regards to the child being withdrawn (e.g., would rather be alone), having somatic complaints (e.g., dizzy), and/or being anxious/depressed (e.g., lonely). The externalizing subscales include questions about delinquent behaviors (e.g., no guilt) and aggressive behavior (e.g., argues). The scale choices are “not true (as far as you know)” (0 points), “somewhat or sometimes true” (1 point), and “very true or often true” (2 points).

In order to access neurotransmitter levels, families were supplied with one urine sample kit for each child participating in the study. Parents were instructed to obtain the second urine sample of the morning, and then ship this to NeuroScience, Inc. in the provided packaging. As part of its reporting mechanism, NeuroScience, Inc. provides not only the observed values for each substance, but also an optimal range based upon extensive clinical experience (several thousand cases). These optimal ranges were used as reference bands in the reporting of the results and are based on their extensive data from over 350,000 NT tests.

Results

Cluster analysis of the neurotransmitter data yielded six clusters with distinct neurotransmitter profiles. Using the clusters as subgroups, analyses of covariance revealed that the clusters significantly differed not only on the neurotransmitter profiles but also on their Child Behavior Checklist profiles. Overall, results showed a trend for the oldest children in the

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sample to have neurotransmitter depletion in 50 percent of the NT assays, which might indicate adrenal fatigue. On the other hand, the youngest children displayed a trend of extremely higher than optimal levels in 50 percent our NT profile, which might indicate over-reactivity in the adrenals. The results from the CBCL showed a trend with the cluster of oldest children displaying significantly more externalizing behaviors than the clusters of the youngest children, whereas, the youngest cluster of children displayed significantly more internalizing behaviors than the oldest cluster of children.

Catecholamines are the family of neurotransmitters containing dopamine, norepinephrine and epinephrine, which are associated with stress-reactivity. Only 36 percent of the children sampled were in the optimal range for norepinephrine, 24 percent were in the optimal range for epinephrine, and only 13 percent were in the optimal range for dopamine. These low percentages indicate that these children have an imbalance in their catecholamines that may be directly correlated to their behavior and to their reduced ability to manage stressful situations (See Table 1).

Serotonin (the master regulator) is similar to catecholamines. It is made from the amino acid, tryptophan. In our study, only 23 percent of the children were found to be in the optimal range, suggesting that 77 percent of the children had depleted serotonin levels. We would expect children with depleted serotonin levels to potentially exhibit behavioral symptoms such as anxiety, irritability, and aggression as well as somatic symptoms such as the inability to sleep. These deficits might also be directly related to the diagnoses of emotional and mental disorders these children have received. Forty-one percent of the children were in the optimal range for histamine.

Of the last three NTs in our profile (glutamate, GABA, PEA), not a single child was in the optimal range expected; all of the children in our study had excessive levels of glutamate, GABA, and PEA. Because GABA elevations are associated with an organic attempt by the body to normalize excessive levels of excitatory neurotransmission, excessive levels of GABA have been associated with symptoms such as anxiety, insomnia, and compulsive eating disorders. Children with disproportionate levels of PEA may have been exposed to alcohol in utero (which alters phenylalanine receptor sites) and may exhibit symptoms such as mood disorders, ADD/ADHD, and autistic-like behaviors. Finally, children with extreme glutamate levels may well display learning and memory deficits and may be vulnerable to explosive outbursts of behavior and/or seizure activity. Glutamate is an excitatory NT, which means it stimulates areas in the brain and touches 70 percent of the central nervous system. In some cases, it can be an excitotoxin that appears to cause nerve-cell death in a variety of neurodegenerative disorders that affect physical and emotional wellbeing.

Conclusion

These sobering findings illustrate how early stressors can have significant implications for children's long-term outcomes. Although the primary focus of our research is on intervention, the use of NT assays has dramatically informed our insights about the risks and vulnerabilities of children and youth who have come from the hard places. However, for a child with NT depletion, there is great hope through practical intervention. Neurotransmitters can be modified by diet, physical activity, reduction of fear, and healthy touch. A diet rich in the appropriate amounts of vitamins, minerals, protein, fatty acids, and complex carbohydrates can help provide a healthy balance in brain neurochemistry. Physical activity and exercise have been shown to improve positive wellbeing and lower the stress hormone cortisol by increasing the release of endorphins.

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and catecholamines into the body.25 By reducing fearful situations, children’s excitatory neurotransmitters can be lowered to normal levels. Tiffany Field26 has done much work on massage for children. Her work suggests that healthy touch reduces stress toxins in the brain and increases psychological wellbeing by increasing serotonin and dopamine emission.27 Neurotransmitter imbalances can also be addressed naturally through nutritional treatment with a certified nutritionist or other health care provider. These products contain specific amino acids that raise neurotransmitter levels. Please see the article in this Factbook, “Trust-Based Relational Intervention®: Principles and Practices,” for additional insights on intervention.

Introduction

Numerous researchers have documented the fact that children who are adopted are disproportionately represented among those who receive services for emotional and behavioral disorders, often as a result of their life circumstances prior to their adoption. In spite of being cared for in stable, attentive homes, these children continue to be at increased risk for behavioral deterioration. A recent meta-analysis on the reports of behavior problems in internationally adopted, domestically adopted, and nonadopted control children found that adopted children showed more behavior problems (both internalizing behaviors such as depression, and externalizing behaviors such as aggression) and utilized mental health services in significantly higher numbers than nonadopted children. This meta-analysis reported on 101 sub-samples from various research studies including more than 25,000 individual cases and 80,000 controls. In addition, many of these children remain at risk for relationship-based disturbances due to their histories of abuse, neglect, and/or trauma.

During the past decade our Institute of Child Development has been devoted to creating research-based interventions for at-risk children. Emerging from our research and that of others, we have synthesized an attachment-based intervention called Trust-Based Relational Intervention® (TBRISM) which has proven efficacy for helping children heal and has been applied effectively in homes, schools, orphanages, and residential treatment facilities.

Parents and professionals trained in TBRISM are able to help their adoptive and/or foster children (a) heal from past relationship-based traumas, and (b) develop positive relationships and behaviors. TBRISM consists of three sets of intervention principles, and this paper provides a brief overview of these principles, along with a few samples for how each principle can be applied. The Empowering Principles are designed to (a) meet the child’s basic needs for hydration, nutrition, and physical activity, and (b) instill a sense of felt-safety by creating an environment that is predictable and child-centered. The Connecting Principles are designed to enhance (a) caregiver awareness of self and child, (b) engagement and nurturing interaction, and (c) dyadic attunement. Finally, the Correcting (Shaping) Principles include both (a) proactive strategies such as teaching self-regulation and prosocial skills, and (b) reactive strategies that yield effective, positive, and non-punitive responses to child misbehavior (see Figure 1 for a table of TBRI principles and practices).

Empowering Principles

The Empowering Principles address the ecological (environmental) and physiological needs of the child. These principles address the reality that a child’s mind is housed in his body and that the needs of the body influence his ability to do higher-level tasks. The Empowering Principles
are founded on research from various domains including Tiffany Field’s work on touch,2,3 Stephen Porges’s work on the polyvagal system,4,5 work carried out on regulatory and sensory processing disorders,6,7,8 and efforts to determine the effect of nutritional interventions on children’s psychopathology.9,10

Ecology

Felt-safety

It is not enough for the parents to know their children are safe — felt-safety only “registers” in the children’s physiology and neurochemistry if the children themselves know that they are safe. Hypervigilance is common among children who did not have attentive, protective parenting during important developmental periods of their lives. Possibly the most important lesson learned during our years in this work is that children who experience felt-safety can be released from emotions that hold them hostage and become free to learn and grow.11,12

Predictability

Unpredictability and chaos are stressful for a child13 and having a predictable environment is empowering because it reduces anxiety over what is coming next. One way to create predictability is through routines (e.g., for bedtime or for transitioning from one activity to another).

Physiology

Safe Touch

Regular, affectionate touch is an Empowering Principle because it is important for both physiological health and interpersonal relationships.14 Safe, nurturing touch activates pressure receptors under the skin which send messages to the vagus nerve to slow down heart rate and blood pressure, inducing relaxation. Safe touch also curbs stress hormones like cortisol, facilitates food absorption and digestion, and stimulates the release of serotonin, which counteracts pain. Research has shown that safe touch improves both behavior and biochemistry in children with various medical and psychiatric conditions.15

Sensory Input/Physical Activity

Physical activity is an Empowering Principle because it promotes more balanced brain chemistry, which enables children to learn and organize information more effectively. Any repetitive movement, such as walking, riding a bike, bouncing on a trampoline, or swinging has shown to boost calming neurochemicals16 and lower levels of excitatory and stress neurochemicals17. However, reasonable limits

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should be observed, as there is also a link between fatigue and problem behavior. When a child pushes too hard, aerobic activity turns into anaerobic exercise and the child’s neurotransmitters get depleted, causing conduct and behavior to deteriorate. It is important to be attentive to a child’s signals that he or she is tired or has had enough.

**Connecting Principles**

The Connecting Principles address the relational needs of adopted or foster children who often have past experiences that put them at risk for relationship-based disturbances. Typically, children have two responses to trauma: dissociation and hyperarousal. The Connecting Principles address the tendency of a child to withdraw or dissociate as a means of self-protection through methods that engage the child while attending to his feelings of threat or fear.

The TBRIS®M Connecting Principles are grounded in attachment theory as a way to conceptualize the importance of early parent-child relationships for optimal child development. Connecting principles also draw upon the work of Allan Schore, Daniel Siegel, and Louis Cozolino. In terms of intervention, there is overlap between the Connecting Principles and attachment-based interventions such as Theraplay®, the Circle of Security Intervention, and Child-Parent Psychotherapy.

**Awareness**

**Observing**

While most adoptive children are actually safe in their new homes, many continue to engage in maladaptive strategies, which are fear- and anxiety-based. Fear-based reactions of children are often behaviorally masked as anger, willfulness, stubbornness, or defiance. An anxious or afraid child may also have stiff limbs, clenched fists, or dilated pupils. He may freeze, withdraw physically, or act out behaviorally. When interacting with an adopted child, it is essential to have an awareness of his anxiety level, voice intensity, and facial expression.

**Recognizing Behavior**

Many children who manifest externalizing behaviors have inner needs they are unable...

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to verbalize, which continue to go unmet. These children may be deceptively fragile and afraid and are often driven to further externalize behaviors based on the belief that no one understands them or cares about their need. Two questions arise with each incident of misbehavior: What is the child REALLY saying? What does the child REALLY need? Although misbehavior must be addressed directly and quickly, it must also be addressed sensitively and responsively.

**Engagement**

**Nurturing Interaction**

The best pathway to the true child is through building trust in infancy. When attempting to connect with a child, pay attention to the aspects of relationships that may have been missed in infancy. This may include attention to physical needs, attentiveness to emotional needs, responsiveness, interactivity, matching, and a sensory “bath” of human interaction. A child with a history of maltreatment will likely benefit much more from these types of interactions than from cognitively-loaded interactions.

**Playful Engagement**

The primary mode of interaction should be playful engagement. Use a lighthearted attitude and tone of voice, and interject gentle games and jokes whenever possible as this encourages trust and learning on the part of the child.

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**Correcting Principles**

The TBRI™ Correcting Principles are built on the foundation of the Empowering and Connecting Principles to create an environment in which the child can risk abandoning maladaptive behaviors and creating new behaviors through the Correcting Principles. When increasing structure, it is imperative to simultaneously increase nurture. Warm, playful interaction in the context of consistent care is the mode for optimal development and provides a relational pathway to positive behavioral change.

The Correcting Principles are grounded in Cognitive-Behavioral Therapy (CBT), which has been shown to be effective for a wide range of childhood disorders, including depression, aggression, and PTSD. These principles have also been effective in our summer camps, family camps, and home programs for adopted children with behavioral issues.

**Proactive Strategies**

**Emotional Regulation**

In normally developing parent-infant dyads, regulation by the parent offers not only a venue of practical care such as regulation of warmth...
and food, but also becomes the vehicle by which a developing child learns to self-regulate emotions and behavior. Many children with histories of maltreatment or neglect lacked physical regulation by caring parents and consequently fail to develop skills of self-regulation (both physically and emotionally). “How does your engine run” is one tool developed by occupational therapists, which can be used by parents to teach the child awareness of his or her own needs, feelings, and emotions, and in turn, to encourage awareness of how and when he needs to self-regulate. (For a more comprehensive presentation of pragmatics on sensory integration and its efficacy, see The Out of Sync Child [revised ed.], by Carol Kranowitz, 2005.)

**Life Value Terms**
The child who began life without a devoted caregiver learned one simple value: survival. He dealt with difficulty on instinct alone — perhaps by becoming manipulative, avoidant, or physically dominant. Short scripts such as “showing respect” and “being gentle and kind” reflect important core values. These scripts are designed to communicate basic life values simply to the child. Over time and with regular use, these short scripts become meaningful markers for the child to evaluate his own behaviors. See Figure 2 for a list of Life Value Terms as well as some comments on their use.

**Redirective Strategies**

**Choices for Discipline**
During times of misbehavior and challenge to the adult’s authority, giving choices provides an optimal avenue for discipline and redirection. The Levels of Response® addresses these behaviors (see Figure 3 for a further description of Levels of Response®). Challenges are identified in four levels: Level One—mild (attempt to redirect through playful engagement), Level Two—moderate (attempt to redirect through giving choices), Level Three—verbally aggressive (attempt to redirect through “time-in”/think it over), and Level Four—physically aggressive (attempt to redirect through physical interruption of physical aggression).

**Re-Do’s**
Children who have difficulty regulating their behavior need opportunities to practice appropriate responses. Once an opportunity to correct inappropriate behavior is identified, parents should model the appropriate way to complete the action. When the child completes the “Re-Do,” praise her lavishly and sincerely for her efforts. If done in a playful and fun manner, Re-Dos can build self-esteem and shape positive behaviors through success. In contrast to lecturing, scolding, and shaming, this approach has the advantage of providing opportunities for success instead of failure, and for providing parent-child interactions that are positive, encouraging, and practical.

**Conclusion**
For children who have experienced early trauma, abuse, or neglect, the injuries of the past are always present and driving current behaviors. The TBRI Principles outlined here (Empowering, Connecting, Correcting) represent a broad scope of research-based practices for interacting with adopted children with attachment-based disturbances and behavior.

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problems. They are also derived from experience working with adopted children with special needs and are shared here in hopes that they will enrich services for children in other domains. Although these principles have demonstrated efficacy for children with severe relational disorders and behavioral problems in one-on-one and small group settings, they have not yet been empirically researched with a large population of children. Future research will focus on empirical evaluations of these principles both with high-risk adopted children and with other populations of children who display behavior problems. For more information about TBRISM, please visit our website at: http://www.child.tcu.edu

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**Figure 2. Verbal Scripts**

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<td><strong>&quot;Showing Respect&quot;</strong></td>
<td>Teach the child to treat themselves and others with respect. There is no tolerance for disrespect of any kind. Respectful behaviors include respectful voice, respectful facial expressions and attitudes, respecting others’ space, and respecting others’ belongings. If a child is disrespectful, redirect with the short statement, &quot;Try that again with respect.&quot; When the child is respectful, reinforce with, &quot;That was great showing respect!&quot;</td>
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<td><strong>&quot;Use Your Words&quot;</strong></td>
<td>At-risk children often express their feelings with tantrums, running away, or aggression. Although it is important to understand these behaviors in terms of the underlying feelings, it is important to continually prompt the child to &quot;use your words&quot; to express needs and feelings. It is also helpful to model this script yourself. You might tell your child, &quot;Right now I am feeling sad. What are you feeling?&quot; Be sure to praise them with, &quot;That's great using your words!&quot; when they talk.</td>
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<td><strong>&quot;Gentle and Kind&quot;</strong></td>
<td>The purpose of this script is to increase self-awareness in the children by helping them modulate their behavior. It allows them to practice the difference between a rough and soft touch or a mean and soft facial expression. We often practice this script by bringing a puppy or kitten to the classroom and guiding the children in touching and holding them gently. If the child is being aggressive he can be prompted with, &quot;Was that gentle and kind? Try that again.&quot; Praise him with, &quot;That was good being gentle and kind!&quot;</td>
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<td><strong>&quot;Who is the Boss?&quot;</strong></td>
<td>Children who have experienced unpredictable and chaotic experiences early in life often want to have control of others around them. A way to deal with this issue is to calmly tell the child that the adult is in charge. When the child makes demands, ask them, &quot;Who is the boss here? Are you the boss?&quot; Once they acknowledge that they aren't in charge, a response can be, &quot;That's right. Parents (teachers) are the boss. It's not your job to tell others what to do.&quot;</td>
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<td><strong>&quot;Listen and Obey&quot;</strong></td>
<td>The parent or teacher is the authority with the child. When a child is given an instruction, it can be helpful to remind them, especially if they hesitate in following the direction, to &quot;listen and obey.&quot; Always follow with, &quot;Good listening and obeying.&quot; We implement &quot;practice drills&quot; in the form of games that require immediate compliance, such as &quot;Simon Says&quot; so that the child can playfully practice the skill. By using the game &quot;Simon Says&quot;, we will ask the child to mimic our words, voice (tone, loudness) body, and facial expression &quot;matching.&quot;</td>
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<td><strong>&quot;With Permission and Supervision&quot;</strong></td>
<td>&quot;With permission and supervision&quot; is important in acknowledging concepts such as the child is not the &quot;boss&quot; and that there are safe adults who will help them protect them and insure their safety. One way to practice this is to make milkshakes with a blender, which give children the opportunity to ask permission (&quot;May I turn on the blender and put in the strawberries and ice cream?&quot;). Then to practice allowing an adult to supervise and keep them safe from harm.</td>
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<td><strong>&quot;Accepting No&quot;</strong></td>
<td>Although it is important to show the child that we care about her desires, it is necessary that she is also taught to handle occasional disappointment without a behavioral meltdown. The child may ask to do something special, and the teacher responds in a kind but firm voice, &quot;That is really good asking, but this time I'd like for you to practice 'accepting no.'&quot; Then, before the child can begin a meltdown, the teacher quickly responds with the affirming praise: &quot;Wow! That's great, 'accepting no!'&quot; In this manner, a child (almost) painlessly begins to defer getting her own way. By combining this technique with ample positive interactions, the child may begin to develop the ability to comply, and to trust the adult.</td>
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**Figure 3. Levels of Response® example of a situation on the playground in which a little five-year-old girl demands that the teacher pick her up and carry her into the building for snack time**

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<th>Challenge By Child</th>
<th>Response By Adult</th>
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<td>Level One: &quot;Pick me up and carry me in the building!&quot;</td>
<td>Level One (playful engagement): &quot;Are you asking me or telling me?&quot;</td>
<td>This response is playful and is often successful in redirecting a child who may then say, &quot;I was asking&quot; to which the adult may reply (again playfully), &quot;Well then, please try it again, with respect.&quot;</td>
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<td>Level Two: &quot;I was telling you! Pick me up and carry me in!&quot;</td>
<td>Level Two (with a firm voice of authority): &quot;No, you have two choices. You can walk beside me and hold my hand or you can just walk beside me. Which do you choose?&quot;</td>
<td>Implicit in the adult's response is the fact that she is not going to carry the child into the building, but that the child has a second chance to self-regulate. Again, many children will realize that the adult's voice is now more serious and will capitulate to the offering of choices, at which time the adult immediately returns to the mode of playful engagement. The conflict is OVER; and the relationship is restored to playful, respectful interaction.</td>
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<td>Level Three: &quot;You aren't my mother and can't tell me what to do. Your choices are stupid, and I don't have to mind you!&quot;</td>
<td>Level Three (think it over! time-in): &quot;I want you to come over here with me to the park bench. Sit here, breathe quietly, and think about what you did wrong. When you are ready to tell me, say 'Ready!' and I'll be right here waiting for you to tell it over.&quot;</td>
<td>Again, the moment the child says &quot;ready&quot; the adult goes, bends down, matching the child, makes eye contact and leads the child to say what she did wrong and how she could do it right. The conflict is OVER; the adult immediately returns to the mode of playful engagement. There are no sermons, lectures, or rejecting attitudes. The conflict is over and adult and child return to attunement.</td>
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<td>Level Four: The child begins hitting and kicking the teacher or a nearby child. Now she has escalated from verbal aggression to physical aggression.</td>
<td>Level Four: If it is absolutely required for the safety of the child, teacher, or others, the adult may have to hold the child briefly until she can calm herself. An adult should only conduct interrupting physical violence with specialized training such as that provided by the two-day workshop of Crisis Prevention Intervention (<a href="http://www.crisisprevention.com">http://www.crisisprevention.com</a>)</td>
<td>Untrained, angry, or controlling adults have injured many children; only trained adults should carry out this fourth level of response. Immediately when the child is calm and has been talked through what went wrong and how to do it correctly, the event is OVER; the adult returns to the mode of playful, nurturing engagement. It should be clear to the child that the interruption of aggression was not about her value, but simply about her behavior. The child is offered a re-do. For example, in this case, the child asks the adult with respectful voice, face and body language, to carry her into the building for snack time. The interaction ends with a positive re-do, and with reconnection, praise, encouragement, and affirmation of the child's preciousness.</td>
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Evaluation of NCFA's Infant Adoption Awareness Training Program

Joan R. Rycraft and John R. Gallagher

Introduction

With the passage of the Children’s Health Act of 2000, subsequent re-authorizations, and continued funding, competency-based adoption awareness training has been delivered nationwide for almost a decade. The primary objective of adoption awareness trainings is to provide education on adoption to family planning staff, adoption counselors, and other health and human services professionals. An important goal of these trainings is the transfer of training to the practice setting, which will improve services to women and couples who are experiencing unintended pregnancy. The education provided at adoption awareness trainings can assist in reducing the biases and judgments associated with adoption. Training curriculum topics include: types of adoption, legal issues related to adoption and parental rights, appropriate adoption terminology, and informing trainees of the various community adoption-related resources. A safe environment, free from biases and judgment, can increase the level of communication that occurs between professionals and women and couples who are facing unplanned pregnancy. The openness of communication that occurs within this professional relationship is crucial in assuring that a woman or couple facing unintended pregnancy can make an informed choice when it comes to choosing to parent or not to parent the child.

The National Council For Adoption (NCFA) and Training

In 2007, NCFA entered into a five-year cooperative agreement with the Department of Health and Human Services, Administration for Children & Families to provide adoption awareness trainings in federal Region 3 (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia).1 To date, over 1,300 adoption counselors and other human service professionals have received the training. Members of the Inter-University Evaluation Panel led by Dr. Joan Rycraft, University of Texas at Arlington, include: Dr. Jack McKillip, Professor Emeriti, Southern Illinois University; Dr. Michael Patchner, Professor and Dean, Indiana University; and Dr. Stephen Wernet, Professor, St. Louis University.

The Evaluation

A pretest/posttest methodology was used to measure the trainee’s knowledge before the adoption awareness training and the trainee’s knowledge immediately following the training. The Inter-University Evaluation Panel developed both tests based on the curriculum approved by the Department of Health and Human Services.

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1 Prior to 2006, NCFA oversaw adoption awareness training nationwide and since the inception of adoption awareness training, has trained nearly 20,000 individuals.
Prior to the commencement of the evaluation, all evaluative instruments and research methods were presented and approved by the Office of Research and Integrity at the University of Texas at Arlington Institutional Review Board (IRB). An item analysis was completed following both evaluation periods to assure test question validity and reliability. A focus group was also facilitated with the master trainers to determine the fidelity of curricula presentation and training delivery.

Findings

During the first evaluation period, October 1, 2007—September 30, 2008, 50 adoption awareness trainings were facilitated: 41 one-day trainings and nine two-day trainings. Trainers attempted to administer pretests and posttests to all 478 trainees who attended the trainings; however, a few trainees were unable to complete both tests because of external reasons. Out of the 478 individuals that attended an infant adoption awareness training, 446 (93 percent) completed both the pretest and posttest. Of the 446 trainees that completed both the pretest and posttest, 407 trainees received a higher score on their posttest than their pretest, indicating that 91 percent of the trainees experienced an increase in knowledge related to adoption.

Paired t-test procedures were used to compare the significance of the knowledge gained by comparing the trainee’s knowledge prior to the training to the trainee’s knowledge following the training. As highlighted in Table 1, the paired t-test notes that both the one-day trainees and two-day trainees showed a statistically significant increase in knowledge, which indicates that the knowledge gained was not by chance but as a result of the training.

As seen in Table 2, the independent t-test reveals that there is not a statistically significant difference between the posttest mean scores with the one-day trainees and the two-day trainees. Therefore, we can conclude that although both training lengths contribute to a statistically significant increase in knowledge gained for the trainees, there was no difference between the overall posttest scores for the one-day trainings and the two-day trainings.

The most recent evaluation on the effectiveness of the infant adoption awareness trainings was completed on the pretest and posttest data received from trainees who attended a training between October 1, 2008 and September 30, 2009. During this evaluation period, a total of 53 trainings were facilitated, 41 of which were one-day trainings, eight two-day trainings, and four half-day trainings. NCFAR began facilitating half-day trainings in July 2009 to meet the needs of potential participants, and this addition to the curriculum allows for further comparison of the impact that training length has on knowledge gained. There was a substantial increase in the total number of trainees who participated in the infant adoption awareness training during this evaluation period, from 478 trainees in the 2007-08 evaluation period to 824 trainees during this evaluation period. Out of the 824 trainees that participated in a training, 799 (97 percent) were able to complete both the pretest and posttest, and 751 (94 percent) scored higher on the posttest than the pretest.

As with the first evaluation period, t-test procedures were used in the analysis of the pretest and posttest scores. A paired t-test was used to measure the significance of knowledge gained by comparing the mean pretest scores to the mean posttest scores for all three training lengths. As seen in Table 3, the paired t-test results indicate that all three training lengths experienced a statistically significant increase in knowledge, and when all session lengths are analyzed cumulatively, a statistically significant increase in knowledge is also noted.
### Table 1

<table>
<thead>
<tr>
<th>Training</th>
<th>N</th>
<th>Pretest</th>
<th>Posttest</th>
<th>Knowledge Gained</th>
<th>Paired T-Test</th>
</tr>
</thead>
</table>
| 1-day    | 345| 58.24%  | 75.68%   | +17.44%          | \( t = -26.14 \)  \
p < .05         |
| 2-day    | 101| 58.72%  | 76.08%   | +17.36%          | \( t = -15.85 \)  \
p < .05         |
| 1 & 2-day| 446| 58.36%  | 75.76%   | +17.40%          | \( t = -30.45 \)  \
p < .05         |


### Table 2

<table>
<thead>
<tr>
<th>Training</th>
<th>N</th>
<th>Posttest Mean</th>
<th>Independent T-Test</th>
</tr>
</thead>
</table>
| 1-day    | 345| 75.68%        | \( t = -31 \)  \
p = .76         |
| 2-day    | 101| 76.08%        |                    |


### Table 3

<table>
<thead>
<tr>
<th>Training</th>
<th>N</th>
<th>Pretest</th>
<th>Posttest</th>
<th>Knowledge Gained</th>
<th>Paired T-Test</th>
</tr>
</thead>
</table>
| ½-day    | 42 | 59.04%  | 70.00%   | +10.96%          | \( t = -7.07 \)  \
p < .05         |
| 1-day    | 512| 53.68%  | 76.04%   | +22.36%          | \( t = -38.53 \)  \
p < .05         |
| 2-day    | 245| 53.08%  | 70.60%   | +17.52%          | \( t = -24.87 \)  \
p < .05         |
| ½, 1, & 2-day | 799| 53.80%  | 74.04%   | +20.24%          | \( t = -44.97 \)  \
p < .05         |

An independent t-test procedure was used to compare the posttest mean scores between the different training lengths to see if a significant difference in knowledge gained is associated with the length of a training. There are several notable findings related to the data presented in Tables 4, 5, and 6. First, Table 4 indicates that there is a statistically significant difference between the posttest mean scores of the trainees that attended a half-day training and the trainees that attended a one-day training. This data reveals that one-day training participants benefited more from the training, in regards to final posttest scores, as compared to the half-day training participants. Table 5 also reveals a statistically significant difference in posttest mean scores between the one-day training participants and the two-day training participants. Overall, the data indicates that the one-day training participants had a greater increase in knowledge than participants that attended either a half-day or two-day training. The final table, Table 6, reveals no statistically significant difference in posttest mean scores for the half-day participants and the two-day participants, which indicates that these participants had similar gains in knowledge as a result of the adoption awareness training.

The pretest and posttest methodology is used to measure the immediate impact that the infant adoption awareness training had on increasing an individual’s knowledge base on adoption-related issues, such as learning about the different types of adoption, the legal rights of birthmothers and fathers, and adoption-related community resources.

Beginning in April 2008, all trainees who participated in a two-day training were asked to participate in a follow-up survey. The goals of the follow-up survey are threefold: 1) to measure the trainee’s retention of knowledge gained at the training; 2) to assess whether the learning that occurred at the training has been applied to adoption related practices; and 3) to identify the successes and challenges that trainees have experienced in applying the knowledge learned at training to a practice setting. Participants received an e-mail 30-45 days post-training that provided a link to the follow-up survey. The data for the follow-up survey is collected through Survey Monkey.

Response to the follow-up survey has been moderate; approximately half \( n = 140 \) of the participants that attended a two-day training since April 2008 have completed the survey. While the response to the follow-up survey has been moderate, the data received from survey indicates that the trainees have been able to retain the knowledge that was gained from the training. The majority of participants answered correctly on all of the 15 follow-up questions. Additionally, approximately 48 percent of the participants indicated that the infant adoption awareness training had assisted them in changing the way in which they approach their jobs. The participants also reported that they felt more informed about adoption, more aware of adoption as an option, and more comfortable discussing adoption as an option with birthparents, making use of correct adoption terminology, and increased sharing of adoption-related information with colleagues.

The following quotes collected from the follow-up survey reflect the participants’ views:

“I am much more informed about the option of adoption and the best way to raise that issue with a client.”

“I am able to effectively provide adoption as a viable option without feeling like I don’t know what to do next.”

“I have the confidence that I would be able to sit down with expectant parents to discuss their options in an accurate and informed way. I am trying to get more word out (i.e. visual posters, etc.) that I am available to discuss adoption options.”

“Knowing positive adoption language helps reinforce helpful,
**Table 4**

<table>
<thead>
<tr>
<th>Training</th>
<th>N</th>
<th>Posttest Mean</th>
<th>Independent T-Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>½-day</td>
<td>42</td>
<td>70.00%</td>
<td>$t = -3.01$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$p &lt; .05$</td>
</tr>
<tr>
<td>1-day</td>
<td>512</td>
<td>76.04%</td>
<td></td>
</tr>
</tbody>
</table>


**Table 5**

<table>
<thead>
<tr>
<th>Training</th>
<th>N</th>
<th>Posttest Mean</th>
<th>Independent T-Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-day</td>
<td>512</td>
<td>76.04%</td>
<td>$t = 5.65$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$p &lt; .05$</td>
</tr>
<tr>
<td>2-day</td>
<td>245</td>
<td>70.60%</td>
<td></td>
</tr>
</tbody>
</table>


**Table 6**

<table>
<thead>
<tr>
<th>Training</th>
<th>N</th>
<th>Posttest Mean</th>
<th>Independent T-Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>½-day</td>
<td>42</td>
<td>70.00%</td>
<td>$t = -0.29$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$p = .77$</td>
</tr>
<tr>
<td>2-day</td>
<td>245</td>
<td>70.60%</td>
<td></td>
</tr>
</tbody>
</table>

positive communication with clients and their families.”

“I am able to explain adoption in an accurate way using language that helps to dispel myths.”

“When a client of mine finds out she is pregnant I am more prepared to discuss all of her options.”

“More aware of options and appropriate language to share with the people I supervise who work directly with clients.”

“I have a greater understanding of the options and techniques to use when counseling women who are considering adoption.”

Among participants that reported that the infant adoption awareness training has not assisted them in changing the way that they approach their job, the most common barrier mentioned was that they did not work in an agency that frequently dealt with adoption.

Additionally, participants were requested to indicate if they would be willing to participate in a follow-up telephone interview to discuss issues of implementation of the training further. Of the 70 two-day training participants that indicated in their follow-up survey that they would be willing to participate in a telephone interview, 21 percent \((n = 15)\) were interviewed by telephone. Throughout the telephone interviews, a number of major thoughts and ideas were consistently expressed by the participants. All 15 participants reported that they felt the infant adoption awareness training was valuable. In addition, all participants indicated that as a result of the training they felt more informed on adoption topics, more comfortable discussing adoption with their colleagues and within their agencies, and better able to make referrals to adoption-related community resources. Following the training, at least half of the participants interviewed by telephone reported an increase in referrals made to adoption agencies; approximately 22 referrals to an adoption agency were made. These participants also indicated an interest in further training on adoption.

Conclusion

The evaluations completed for Region 3 have provided evidence that adoption awareness trainings are beneficial both to professionals and the clients they serve. Data received from the pretests and posttests have demonstrated that a statistically significant amount of knowledge is being gained through the adoption curriculum. Follow-up data indicates that the education gained at the trainings is being utilized in the practice setting in a variety of ways, including an increase in adoption-related dialogue among colleagues and professionals feeling more equipped to discuss adoption options. NCFA has future plans to continue providing half-day, one-day, and two-day trainings in Region 3, and ongoing evaluations will continue to be completed by the Inter-University Evaluation Panel. By offering these adoption trainings, NCFA has contributed to an increased public awareness of adoption by actively promoting its mission on a regional and national level.
Section 9

Putative Father Registries
States with Putative Father Registries and the Time Frames to Register

- Alabama—within 30 days after birth
- Arizona—within 30 days after birth
- Arkansas—prior to filing of petition for adoption
- Connecticut—within 60 days of notice of TPR
- Delaware—within 30 days after birth
- Florida—prior to filing of TPR*
- Georgia—until the birthmother signs a surrender (usually within a day of birth) and when the court enters an order terminating mother’s parental rights (involuntary), whichever is earlier*
- Hawaii—within 30 days after birth or prior to mother’s relinquishment or to placement of child
- Idaho—before adoption or TPR proceedings
- Illinois—within 30 days after birth
- Indiana—within 30 days after birth or prior to filing of adoption
- Iowa—prior to child’s birth or before filing of adoption or TPR
- Louisiana—prior to TPR hearing*
- Massachusetts—prior to surrender or TPR
- Michigan—before birth
- Minnesota—within 30 days after birth
- Missouri—within 15 days after birth
- Montana—within three days after birth
- Nebraska—within five days after birth
- New Hampshire—before mother’s surrender or involuntary termination
- New Mexico—within 10 days after birth
- New York—prior to the setting of the final hearing, but registering does not necessarily protect a man’s parental rights, which can be terminated if he has not “acted like a father”*

* Updated information provided by AAAA members.

NOTES: This information was compiled by Steven M. Kirsh with the assistance of Prof. Mary Beck, University of MO. Law School, by means of a poll conducted of the American Academy of Adoption Attorneys in October 2010. DISCLAIMER: This map is intended as a general overview. Every effort has been made to assure that it is accurate. However, before relying on the the information depicted on this map with respect to any particular state, a member of the American Academy of Adoption Attorneys should be contacted in that state.
Ohio—within 30 days after birth

Oklahoma—has a putative father registry but the time limits are not clear

Oregon—before placement for adoption

Pennsylvania—prior to TPR hearing but no sooner than 60 days from birth, but there are other grounds to terminate parental rights even if a man registers*

South Carolina—prior to the filing of the petition for adoption, which can be filed anytime after birth*

Tennessee—within 30 days after birth

Texas—not later than the 31st day after birth

Utah—prior to mother’s consent or relinquishment or the first business day after birth of the child, whichever is later*

Vermont—prior to the filing of the petition for adoption, which can be filed anytime after birth*

Virginia—within 10 days after birth*

Wisconsin—within 14 days after birth

Wyoming—prior to filing interlocutory hearing on petition for adoption

* Updated information provided by AAAA members.
Introduction to Putative Father Registries (PFRs)

Putative father registries (a.k.a. responsible father registries) exist in as many as 38 states.1 A fully functional registry serves to protect the parental rights of responsible unwed fathers against adoption and child abuse actions by giving them notice of the proceedings at the addresses they listed with the registries. Armed with such notice, unwed fathers can participate in legal proceedings to advance their interests. Importantly, registries also expedite the stable placement of children and protect the privacy and safety of unwed mothers and fathers.

Paternity registries developed in the wake of wrenching publicity over adoptions contested by the fathers of Baby Jessica, Baby Richard, and Baby Emily.2 In 1983, the U.S. Supreme Court found New York’s putative father registry constitutional in Lehr v. Robertson.3 State decisions on putative father registries generally follow Lehr and continue to support the constitutionality of registries,4 but various exceptions have developed to protect responsible fathers whose efforts are thwarted.5

Legislation

Legislation creating a national registry database is necessary for many reasons. Interstate travel of mothers and the filing of legal actions in states other than the state of conception thwart the protections for unwed fathers provided by individual state putative father registries. As such, Senator Mary Landrieu developed a national father registry bill and introduced it as the Proud Father Act in 2006.6 The bill died, but Senator Landrieu’s dedication to this cause did not. In 2009 Senator Landrieu amended the bill, renamed it “Protecting Adoption and Promoting Responsible Fatherhood Act of 2009,”7 and introduced it as S. 939. This bill has been read and referred to the Senate Finance Committee.8

5 Beck, note 1, at 319 – 328.
7 Protecting Adoption and Promoting Responsible Fatherhood Act of 2009, S. 939, 111th Cong. (2009). Congressional Authority to implement such a national registry is based on spending power.
8 Ibid.
Laura Richardson introduced H.R. 6298, “Protecting Adoption and Promoting Responsible Fatherhood Act of 2010.”

A national registry database is essential to protect unwed fathers’ rights. A responsible unwed father may file his intent to claim paternity with the registry in the state in which the child was conceived, or in the state in which he last saw the mother. However, due to the lack of a national registry database, this act of registration in the first state will not secure notice to the father if the mother has delivered/moved the child to a second state and/or the adoptive petitioners file the adoption in either the second state or in their home state (which might be in a third state court). Neither the second nor third state would have knowledge of the father’s registration in the first state. A national registry would accept putative father filings from all state registries and, upon proper search, transmit such filings to anyone party to any state’s legal proceeding involving the adoption or dependency of children of named mothers.

Senator Landrieu’s S. 939 and Representative Richardson’s H.R. 6298 would amend Title IV of the Social Security Act to implement a national putative father registry. Its features would be designed to protect all parties to adoption.9 Congressional authority to implement a national registry is based on spending power, and states would be provided with grants to assist in covering the costs of compliance. Participation by states would be voluntary, with national and state publicity campaigns mandated in participating states, and the states would determine the substantive parameters of features required by the national bill.10 The specific features of the legislation require participating states to:

1) establish a paternity registry;

2) develop easily accessible registry centers and forms explaining that registration may be used as evidence in child support actions;

3) develop technical pathways for transmission of registration information;

4) define a putative father as a man who has had sexual relations with a woman not his wife and is therefore on notice that she may become pregnant as a result of such relations;

5) amend long arm statutes to assert jurisdiction over fathers whose putative father registry filings are transmitted to the forum state;11

6) guarantee notice of adoption and child protective custody petitions to fathers who register a timely notice to claim paternity;

7) set a time period during which fathers must file with the registry in order to secure notice;

8) protect the privacy and safety of birthmothers and fathers;

9) provide that mothers may (not shall) notify fathers of pregnancy and/or adoption;

10) define consequences for father’s failure to file in a timely manner;

11) define prenatal and postnatal abandonment and allow implied consent to adoption in cases of such abandonment; and

12) set time limits for revocability of adoptions.

Controversial Provisions

The most controversial provisions in the national and state registry statutes are those 1) setting time limits upon fathers to register and establish paternity, and 2) relieving mothers of the requirement to identify fathers and notify them of pregnancy and adoption. The time limits upon fathers to register and/or establish paternity exist in most states with registries. The time limits both guarantee the timely registered or legally

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established father with notice and/or a right to consent to adoption and cut off those rights for non registered or untimely registered father.\textsuperscript{12} Lehr assures the constitutionality of these limits.\textsuperscript{13}

Relieving birthmothers of the duties to disclose their pregnancies and/or adoption plans is a multidimensional strategy grounded in both practicality and public policy. The majority of children relinquished for adoption are born outside of marriage; the mother and father may or may not have an ongoing relationship. Adoption requires the consent of a child’s legal parents. Identifying birthmothers is easy because their names automatically go on their children’s birth certificates, and they are typically the custodians. Identifying unwed fathers and the rights they have to children is more difficult, for a number of reasons. An unwed father’s name or location may not be known; he may wish to avoid disclosure that he has fathered a child out of wedlock; he may wish to evade financial or custodial responsibility for the child; he may have lost contact with the birthmother and not know how to assume responsibility for his child.

It might seem intuitive to charge mothers with the duty to notify fathers of a pregnancy, but closer examination of the facts reveals that unwed mothers may choose to avoid identifying fathers for a number of reasons, and that public policy is well served by relieving mothers of this responsibility. The mother may not know how to contact the father. The father may be abusive (one out of four women in the U.S. are abused, and abuse of children is magnified in a home in which the mother is abused).\textsuperscript{14} The mother may be afraid of the father because of prior abuse (one-third of all female homicides result from domestic violence, and domestic homicide is the leading cause of death to pregnant women in the U.S.).\textsuperscript{15} The child may have been conceived in rape and the mother may be outraged by any requirement to identify the father, notify him of pregnancy, or grant him any legal rights to a child conceived in rape (one out of five college women are raped, often while impaired).\textsuperscript{16} The mother may be fearful that the father will pressure her to abort the pregnancy or to keep the baby. The mother also may not be able to identify the father if she had multiple partners, if she was raped, or if she engaged in a one-night stand either while impaired or with a man whose name she did not learn. Additionally, the mother may wish to protect her privacy and not produce a list of men with whom she had sexual relationships so that courts may contact each of them to determine the father of her child.

Mandating that a woman identify the father of a child puts her and her child at increased risk of physical injury or death at the hands of an abusive man. In addition, mandating identification of the father puts a woman at risk of humiliation and trauma when she has been raped, and puts a man at risk of misidentification, disclosure, and embarrassment. Mothers may lie to protect their ignorance, privacy, or safety and may intentionally or accidentally misidentify men as fathers. This may cause courts to order misidentified men to support and visit children to whom they are not genetically related.

The man who relies upon a woman to notify him of pregnancy and his paternity and to thereby protect his parental rights misplaces his reliance.


\textsuperscript{13} Lehr v. Robertson, 463 U.S. 248 (1983).


Birthmothers have many reasons to intentionally or unintentionally misidentify the father/potential fathers of their children. Public policy for mothers, fathers, and children is better served by reliance upon putative/responsible father registries rather than by charging mothers with duties to inform unwed fathers of pregnancy and adoption or to identify fathers to courts in adoption or dependency actions. Additionally, the law’s granting of rights to certain fathers may provide mothers with an incentive to abort the child.17 Public policy generally does not favor pressuring women to undergo abortion.

**Putative Father Registries**

The safer course to protect men’s parental rights is the putative father registry. Putative father registries legally charge unwed fathers with the responsibility to identify themselves as potential fathers and indicate their willingness to assume financial and custodial responsibility for their children.

Ideally, the father—in an ongoing relationship with the mother—will assist with the prenatal care and planning for his child, attend the birth of his child, and sign an affidavit of paternity at birth, placing his name on the birth certificate in order to legally establish his paternity. If the father does not have an ongoing relationship with the mother, he must ascertain from her whether she became pregnant after their sexual relations and then assume financial and custodial responsibilities during the pregnancy and after the birth—which, again, includes establishing his paternity legally. Establishing paternity does not require the father to maintain a relationship with the mother, but it does require him to establish/maintain a relationship with the child and assume responsibility for the child including during gestation.

If the father cannot locate or communicate with the mother, he must file his intent to claim paternity in the mother’s name with the state’s putative father registry. The putative father registry assures the father of notice if an adoption petition or an action for protective custody due to abuse or neglect is filed.

In this way, no one can thwart an unwed father from asserting his parental rights in a timely fashion, and this is the biggest advantage to fathers. Many states have fraud provisions that extend the father’s time limit in cases in which the mother has intentionally deceived a man by telling him that she aborted the pregnancy, that the baby died, or that she did not conceive.18 Most states also require the father to establish his paternity legally and serve the mother in the manner that the state requires.19

The best interests of children are served with the responsible father registry in that children are assured of fathers or adoptive parents who will promptly assume financial and custodial responsibility for them. In this way, the states achieve prompt permanency for children, which is established as a fundamental right of children.20 Such prompt permanency benefits children because bonding with their parents can begin within the first few days of birth.21

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18 Mo. Rev. Stat. § 192.016(7) (2010). Failure to timely file pursuant to paragraph (b) or (c) of subsection 3 of section 453.030, RSMo, shall waive a man’s right to withhold consent to an adoption proceeding unless:
(1) The person was led to believe through the mother’s misrepresentation or fraud that:
(a) The mother was not pregnant when in fact she was; or
(b) The pregnancy was terminated when in fact the baby was born; or
(c) After the birth, the child died when in fact the child is alive; and
(2) The person upon the discovery of the misrepresentation or fraud satisfied the requirements of paragraph (b) or (c) of subsection 3 of section 453.030, RSMo, within fifteen days of that discovery.


20 In Re Adoption of Doe, 2008 WL 5006172 (Fla. Cir. Ct. Nov. 25, 2008).

Concluding Thoughts

Rule of law exists to eliminate anarchy and chaos. Is judicial activism judge-made law over the will of the people, or is it the defense of the constitution? If fathers do not have a reasonable opportunity to establish their paternity prior to the filing of the adoption petition, then the law violates *Lehr*. But the prenatal period offers an opportunity to establish responsibility for a child. State laws pretermmitting fathers from establishing a relationship with their children are constitutional if the father has failed to assume responsibility during the pregnancy.
Putative Father Registries: Midwestern States’ Review of Recent Case Law

Mary Beck

Kansas

Kansas has no registry.

Illinois

In D.J.A.D., “Illinois waived a father’s right to intervene in an adoption, barred him from filing a paternity action, and waived his right to notice of an adoption where he filed a paternity action timely but did not file with the putative father registry.” Subsequently, the Illinois Supreme Court denied appeal in D.J.A.D., but ordered that the adoption and paternity actions be consolidated and that DNA testing be conducted.

On February 1, 2007, the Illinois Supreme Court held in J.S.A. that the biological father’s filing of a paternity action prior to the filing of a stepparent adoption action, if the child was born during the pendency of the mother’s marriage to her husband, relieved the father of the putative father registry requirement. The child in the case was 3.5 years old when the father filed for paternity; at the time, he had had no part in the child’s life and had not previously filed with the putative father registry. The mother’s husband, the presumed father, had been acting as the child’s father from the time of the child’s birth. The mother and her husband had filed a stepparent adoption petition shortly after father filed for paternity, but paternity had not then been established.

The J.S.A. Supreme Court held that requiring the father to file with the putative father registry within 30 days of birth frustrated the legislative intent of the Illinois Parentage Act, which gave fathers up to 20 years to establish paternity if no adoption action was pending. Because the adoption action was filed after the paternity action, the Court upheld the orders establishing the father’s paternity. The Court cautioned that paternity and paternal rights to custody and visitation were separate and could only be ordered if they were in the child’s best interests.

The policy implications in J.S.A. are complicated. Illinois, of course, supports men establishing paternity at any time before their children reach majority. However, that policy presupposes that the child in question has no lawful father. The rights of men to establish paternity should have some limitations: 1) The filing of an adoption action should cut off the rights of men to establish paternity unless a man has otherwise protected his parental rights through timely filing with the registry and the provision of meaningful prenatal and postnatal support; and 2) The rights of men to establish paternity should also be cut off if the child has a lawful de facto father. J.S.A. provided the unusual situation in which paternity was already “established,” in that the child had a lawful father, a man who had acted as his father for 3.5 years. The Supreme Court’s holding
essentially provided two fathers for the child, and the rule of law established by its decision is not likely to advance the best interests of children.

On March 28, 2007, the Illinois Supreme Court in *In re D.J.A.C.* ordered the Appellate Court to vacate and reconsider its judgment in light of the *J.S.A.* holding.

On July 11, 2008, after the Illinois Supreme Court handed down the *J.S.A.* and *D.J.A.C.* decisions, *J.S.A.* again went up on appeal and the Appellate Court upheld the trial court’s consolidation of the parentage and adoption actions, reversed the trial court’s dismissal of the father as a party to the adoption action, and held that the trial court had no authority to dismiss the parentage action on the grounds that it was not in the child’s best interest. Judge Schmidt strongly dissented, averring that the Supreme Court “got it wrong” and that a best interest of the child hearing should have been held for the then-12-year-old boy who had only known his mother’s husband as his father and whose biological father had never contributed financially for his support nor developed a relationship with the child. The dissent further criticized the Illinois Supreme Court holding because it allowed the biological father to establish paternity after the filing of an adoption petition, in violation of an Illinois law which forecloses a putative father’s option to establish paternity if he “has not established paternity to the child in a court proceeding before the filing of a petition for the adoption of the child.” Judge Schmidt dissented because the father had filed for paternity but had not established paternity prior to the filing of the adoption action.

**Indiana**

In *E.L.*, the Indiana Appellate Court held that a putative father implied his consent to adoption by his failure to timely file with the putative father registry, and barred his paternity action. However, the Court permitted the child to file a paternity action under separate Indiana law, filed by his next friend, the father. The Court called this an “apparent anomaly,” and the significance of any paternity establishment will not change the implied consent of the father.

**Iowa**

Iowa has a registry.

**Missouri**

The Missouri Supreme Court held in *N.L.B.* that a father who had not filed a timely paternity action or filed with the putative father registry was not precluded from challenging an adoption if his paternity was established by acknowledgement after the adoption was filed, and if his abandonment was not supported by the evidence. The court limited its holding to the unusual facts in the case in which a biological mother and father executed an acknowledgement of paternity after the adoption was filed and the mother’s rights were terminated, and the adoptive petitioners did not contest the paternity acknowledgement. The acknowledgment of paternity gave standing to the father to intervene in the adoption if the father had otherwise protected his constitutional rights to paternity by supporting the child. This decision allowed a mother whose parental rights had been irrevocably terminated to identify and establish a man as the father of her child by acknowledgement. This holding does not advance permanency for any parties to the adoption.

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6 Ibid at 696 – 702.
8 Ind. Code Ann. § 31-19-5-12 (West 2007)
10 Ibid at 1282 – 1283.
12 *In Re Adoption of N.L.B. v. Lentz.*, 212 S.W.3d 123 (Mo. 2007).
13 Ibid. at 127 – 128.
14 Ibid at 128.
**Nebraska**

In *Ashby & M.A.*, a biological father filed a negligence action against the State of Nebraska (specifically, the Interstate Compact on the Placement of Children (ICPC) worker who authorized the removal of the child from Nebraska to Alabama), the birthmother, the adoptive parents, and the adoptive parents’ Alabama attorney. The biological father alleged that the state violated his due process rights by allowing the child to leave the state while he could still assert his paternity. The birthmother and birthfather were unmarried; the birthmother notified the father of the pregnancy and adoption plan; the father did not give notice of objection to the adoption plan or file intent to claim paternity prior to birth of the child; the birthmother did not put the father’s name on the birth certificate; the birthfather made a timely filing with the Nebraska putative father registry after birth, but did not file a paternity action. Nebraska ICPC allowed the adoptive parents to leave the state without knowing of the father’s registration. The court held that the state did not have a duty to check the putative father registry prior to authorizing adoptive parents to remove the child from the state, and that the legal risk document signed by the adoptive parents was appropriate. The court dismissed the birthfather’s conspiracy charges against the birthmother, adoptive parents, and their attorney.16

**North Dakota**

North Dakota has no registry.

**Ohio**

In the Ohio case *The Adoption of G.V.*, there was a similar fact pattern and comparable state law to the Nebraska case *Ashby & M.A.*. In this case, the adoptive parents appealed the holding of the Appellate Court to the Ohio Supreme Court. Specifically, the adoptive parents appealed the Appellate Court’s decision because it affirmed the trial court’s dismissal of an adoption action when a father made a timely filing with the putative father registry, filed a paternity action before the adoption action was filed, but obtained a determination of his paternity after the filing of the adoption action.18 Ohio law requires consent to adoption of those fathers who are married to the mother, have adopted the child, have acknowledged paternity pursuant to statutory procedure, or were determined by a court to have a parent/child relationship with the minor child prior to the date the adoption petition was filed.19 Thus, Ohio law waived the father’s consent in cases in which his paternity was not established prior to the filing of the adoption action. The G.V. court held that a determination of paternity or non-paternity had to be resolved before the adoption action could proceed if the father had filed in a timely manner with the putative father registry (on the 17th day in the 30-day period allowed by Ohio law), and filed a paternity action two months after birth but before the adoption action was filed.

The Ohio Supreme Court is now faced with conflicting decisions out of different appellate divisions for a case with facts similar to *G.V.* In *P.A.C.*, a different Appellate Court District reversed a trial court dismissal of an adoption action in which father had neither filed in a timely manner with the putative father registry nor established his paternity prior to the filing of the adoption action.20 The biological father had determined his genetic paternity two months after the child’s birth in July 2005, but did not file a paternity action until 18 months later in January 2007. The birthmother married in April 2007 and her husband filed a stepparent adoption action that same month before the biological father had legally established paternity. The trial

16 Ashby v. State et al., 779 N.W.2d 343, 348, 349 (Neb. 2010).
18 In Re Adoption of G.V., No. L-09-1160, 2009 WL 4447562 (Ohio Ct. App. Nov. 30, 2009), appeal docketed with the Supreme Court No. 09-2355.
19 Ohio Rev. Code Ann. § 3107.06 (West 2010).
court stayed the adoption action and proceeded on the paternity action, in which it established the biological father’s paternity. The stepfather appealed, and the Appellate Court found that the biological father’s consent was not required for the adoption because he had not registered with the putative father registry in a timely manner or otherwise established his paternity or constitutionally protected his parental rights. The Appellate Court discussed the importance placed by the legislature on a child’s first month of life, and cited the state’s interest in facilitating expeditious adoption as justifying rigid application of its laws.21

South Dakota

South Dakota has no registry.

Wisconsin22

In Marquette S., a case not involving its putative father registry, a Wisconsin Court held that an incarcerated father had no fundamental liberty interest protectable by due process and equal protection, because he failed to establish a relationship with a child he did not know had been born.23 The father complained that, by incarcerating him, the state prevented him from determining that a pregnancy had occurred and subsequently establishing a relationship with the child once discovered. The court commented that it was the father’s criminal behavior, not the state’s action, that resulted in incarceration and prevented him from establishing a relationship with his child.24 The court described the father’s obligation to determine a pregnancy as including “look[ing] hard” in a timely manner, using the phone book, the internet, his parole agent, and a public computer at the public library or other location: “A child does not stop growing and wait for a parent to have the time and inclination to find and nurture them.”25

21 Ibid. at paragraphs 26, 27.
23 In Re Termination of Parental Rights to Marquette S., 766 N.W.2d 242 (Wis. Ct. App. 2009).
24 Ibid. at paragraphs 36 – 40.
25 Ibid. at paragraph 40.
Maine

According to the Maine Statutes, Maine has no putative father registry. Putative fathers receive notice by publication.

New Hampshire

The governing statute is **TITLE XII, PUBLIC SAFETY AND WELFARE, CHAPTER 170-B, ADOPTION, Section 170-B: 6 1. (c)**, which provides:

A person who claims to be the father and who has registered his claim of paternity with the office of child support services in what shall be known as the New Hampshire putative father registry or in the putative father registry of the state where the child was born. The registration form filed with the appropriate putative father registry may be filed prior to the birth of the child but shall be filed prior to the birthmother’s parental rights being surrendered pursuant to RSA 170-B:9 or involuntarily terminated. Failure to register with the appropriate putative father registry prior to this time shall bar the alleged father from thereafter bringing an action to establish his paternity of the child, and shall constitute an abandonment of said child and a waiver of any right to a notice of hearing in any adoption proceeding concerning the child.

In accordance with Section 170-B: 7, Person Not Required to Surrender, surrender of parental rights is not required of:

- I. The alleged father who has not met the requirements of RSA 170-B:5, I or RSA 170-B:6;
- II. A parent whose parental rights have been voluntarily or involuntarily terminated by order of a court in another state;
- III. An alleged father who is found not to be the father pursuant to RSA 168-A;
- IV. Any parent of the adoptee, if the adoptee is an adult;
- V. A parent whose parental rights have been terminated pursuant to RSA 170-C;
- V-a. An alleged father who is convicted of an offense under RSA 632-A:2, RSA 632-A:3, RSA 632-A:4, or RSA 639:2 which resulted in conception of the adoptee; or
- VI. Parents whose parental rights have been determined to be voluntarily or involuntarily terminated by the proper authorities in another country, such determination to be evidenced by documentation issued by the United States Department of Justice or the United States Department of State and deemed acceptable by probate court rule.

Vermont

15A V.S.A. § 1-110; Title 15A: Adoption Act Article 1: General Provisions (§§ 1-101 - 1-113)

The governing statute is § 1-110. Notice of intent to retain parental rights:

(a) At any time, a parent or alleged parent of a child born in this state may file in any probate
court in this state a notice of intent to retain parental rights. The notice shall specify the name and address of the person filing it, the name and last known address of the other parent of the minor child, the name of the minor child, if known, and the date or approximate date of the minor’s date of birth.

(b) Each probate court shall forward a notice filed with that court under subsection (a) of this section, of this section to the probate court in the district of Chittenden, which shall serve as a central repository for all such notices.

(c) When a petition to adopt a minor is filed in this state, the register of the probate court in which it is filed shall determine as of the date of the petition whether or not a notice has been filed under this section with respect to the minor to be adopted.

Massachusetts

The governing statute is M.G.L.ch. 210 § 4A, which provides:

Whenever the mother of a child born out of wedlock has surrendered the child in accordance with section two, or whenever the right of such mother to withhold consent for adoption has been terminated in accordance with section three, notice of such surrender or termination and a right to petition for adoption shall be afforded to any person who, prior to such surrender or termination, has filed a declaration seeking to assert the responsibilities of fatherhood, hereinafter called a paternal responsibility claim, or has been adjudicated the father of the child, except when a decree has been issued pursuant to section three dispensing with the need of consent of said father. The paternal responsibility claim shall be filed with the department of children and families, hereinafter called the department, on a form prescribed by the department. The department shall provide the person filing with evidence of the filing within five days and shall at the same time, send notice of the filing to such mother by registered mail at her address as stated on the paternal responsibility claim or to such other address as the department determines to be correct after making every reasonable effort to locate such mother. Such filing shall constitute an acknowledgment and admission of paternity.

Upon request of any person or agency receiving a child for the purpose of adoption, the department shall examine all paternal responsibility claims filed with it and shall within five days provide an affidavit to such person or agency stating whether or not there has been a paternal responsibility claim filed with respect to such child. If such a paternal responsibility claim has been filed, the department shall notify the person claiming paternity by registered mail, at the address stated on said paternal responsibility claim, that the child is in the care of a licensed placement agency which is planning for the adoption of the child. A copy of the notice shall be sent to the person or agency requesting the affidavit. The person claiming paternity may within thirty days from the date of mailing of said notice by the department file a petition for adoption or custody of such child in the probate court of the county where the agency is located. If he fails to do so, he shall not be entitled to notice of any subsequent proceeding concerning custody, guardianship, or adoption of the child. The court shall consider the case as expeditiously as possible, and, without regard to other potential adoptive parents, shall allow the petition of the person claiming paternity if it finds that such adoption or custody is in the child’s best interest and if it finds that such person is the father of the child. The court on its own motion may order the production of any evidence to determine if the petitioner is the father of the child. Any such petition shall be subject to clause (E) of section 2A. Any costs incurred for the temporary care of the child pending the hearing on the petition of the person claiming paternity shall be borne by said person.

1 The general practice is NOT to enforce this statute, but rather to give notice, regardless of compliance. There is presently a case before the Massachusetts Supreme Judicial Court, challenging the enforcement of this statute as one of several grounds to terminate the birthfather’s rights.
No other petition for adoption shall be allowed without proof of compliance with this section.

Connecticut

The governing statute is Chapter 815y Paternity Matters, Sec. 46b-172a, which provides as follows:


(a) Any person claiming to be the father of a child born out of wedlock may at any time, but no later than sixty days after the date of notice under section 45a-716, file a claim for paternity with the court of probate for the district in which either the mother or the child resides, on forms provided by such court. The claim shall contain the claimant’s name and address, the name and last-known address of the mother and the month and year of the birth or expected birth of the child. Not later than five days after the filing of a claim for paternity, the judge of the court of probate shall cause a certified copy of such claim to be served upon the mother or prospective mother of such child by personal service or service at her usual place of abode, and to the Attorney General by first class mail. The Attorney General may file an appearance and shall be and remain a party to the action if the child is receiving or has received aid or care from the state, or if the child is receiving child support enforcement services, as defined in subdivision (2) of subsection (b) of section 46b-231. The claim for paternity shall be admissible in any action for paternity under section 46b-160, and shall stop the claimant from denying his paternity of such child and shall contain language that he acknowledges liability for contribution to the support and education of the child after its birth and for contribution to the pregnancy-related medical expenses of the mother.

(b) If a claim for paternity is filed by the father of any minor child born out of wedlock, the court of probate shall schedule a hearing on such claim, send notice of the hearing to all parties involved and proceed accordingly.

(c) The child shall be made a party to the action. Said child shall be represented by a guardian ad litem appointed by the court in accordance with section 45a-708. Payment shall be made in accordance with such section from funds appropriated to the Judicial Department, however, if funds have not been included in the budget of the Judicial Department for such purposes, such payment shall be made from the Probate Court Administration Fund.

(d) In the event that the mother or the claimant father is a minor, the court shall appoint a guardian ad litem to represent him or her in accordance with the provisions of section 45a-708. Payment shall be made in accordance with said section from funds appropriated to the Judicial Department, however, if funds have not been included in the budget of the Judicial Department for such purposes, such payment shall be made from the Probate Court Administration Fund.

(e) Upon the motion of the putative father, the mother, or his or her counsel, or the judge of probate having jurisdiction over such application, filed not later than three days prior to any hearing scheduled on such claim, the Probate Court Administrator shall appoint a three-judge court from among the several judges of probate to hear such claim. Such three-judge court shall consist of at least one judge who is an attorney-at-law admitted to practice in this state. The judge of the court of probate having jurisdiction over such application under the provisions of this section shall be a member, provided such judge may disqualify himself in which case all three members of such court shall be appointed by the Probate Court Administrator. Such three-judge court when convened shall have all the powers and duties set forth under sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, 17a-495 to
17a-528, inclusive, 17a-540 to 17a-550, inclusive, 17a-560 to 17a-576, inclusive, and 17a-615 to 17a-618, inclusive, and shall be subject to all of the provisions of law as if it were a single-judge court. The judges of such court shall designate a chief judge from among their members. All records for any case before the three-judge court shall be maintained in the court of probate having jurisdiction over the matter as if the three-judge court had not been appointed.

(f) By filing a claim under this section, the putative father submits to the jurisdiction of the court of probate.

(g) Once alleged parental rights of the father have been adjudicated in his favor under subsection (b) of this section, or acknowledged as provided for under section 46b-172, his rights and responsibilities shall be equivalent to those of the mother, including those rights defined under section 45a-606. Thereafter, disputes involving custody, visitation or support shall be transferred to the Superior Court under chapter 815j, except that the probate court may enter a temporary order for custody, visitation or support until an order is entered by the Superior Court.

(h) Failing perfection of parental rights as prescribed by this section, any person claiming to be the father of a child born out of wedlock (1) who has not been adjudicated the father of such child by a court of competent jurisdiction, or (2) who has not acknowledged in writing that he is the father of such child, or (3) who has not contributed regularly to the support of such child or (4) whose name does not appear on the birth certificate shall cease to be a legal party in interest in any proceeding concerning the custody or welfare of the child, including but not limited to guardianship and adoption, unless he has shown a reasonable degree of interest, concern or responsibility for the child’s welfare.

Rhode Island

Rhode Island has no putative father registry.
Putative Father Registries: Taking a Deeper Dive in the Southwestern States

Heidi Cox

Texas

As of January 1, 2008, Texas law regarding the provision of notice to putative fathers in parental rights terminations and adoptions changed. A putative father does not require notice of an adoption plan unless he has filed a paternity suit or his name is listed on the registry. The paternity registry must be checked in all terminations unless there is a legal father who either signs a relinquishment after birth or is served with notice of the termination pleading (Tex. Fam. Code §§ 160.403, 161.002 and 161.109(a)(2007)). Additionally, if a child is conceived in another state, it is mandated that the registry of the conception state also be checked (Tex. Fam. Code § 160.421(2007)). This statute has been affirmed at the appellate level.

In the case of In re C.M.D., 287 S.W.3d 510 (Tex. 2009), a biological mother signed an affidavit stating that she had told the biological father of the planned adoption of the child she was carrying. However, he was not provided legal notice of the termination proceeding. Ruling against the application of the paternity registry statute, the trial court refused to allow the termination without additional protections for the absent father. The Houston appellate court reviewed the lower court’s refusal to comply with the new Texas paternity registry statute, examining several issues including constitutionality, due process, and equal protection. The appellate court, ruling in favor of the new law, found the statute to be constitutional, purposeful, and useful in protecting children, asserting that “[a]n unwed father does not automatically have full constitutional paternal rights by virtue of mere biological relationship… If the father had no intent to assert his parental rights, he could not have suffered a due process or equal protection violation based on a deprivation of those rights…” (Id. at 516). The court added the following in a footnote: “Even with a complaining father, the constitutionality of paternity registry statutes has been overwhelmingly upheld” (Id.).

Arizona

Arizona law requires a diligent effort to provide notice to a putative father. The notice served to the potential father must contain the following information:

1) That adoption is planned
2) The potential father’s right to consent or withhold consent to the adoption
3) The potential father’s responsibility to initiate paternity proceedings (pursuant to the applicable statute) and to serve the mother within thirty days of completion of service
4) The potential father’s responsibility to proceed to judgment in the paternity action
5) The potential father’s right to seek custody
6) The potential father’s responsibility to begin to provide financial support for the child if paternity is established
7) That the potential father’s failure to file a paternity action (pursuant to the applicable statute) and to serve the mother and proceed to judgment in the paternity action as prescribed by this section bars the potential
father from bringing or maintaining any action to assert any interest in the child (ARIZ. REV. STAT. § 8-106(G)(1)-(7)(2010)).

Besides providing legal notice to a potential father, the Arizona paternity registry must also be checked after the child is more than 30 days old (ARIZ. REV. STAT. § 8-106.01(A)-(B)(2010)).

In May 2008, the Arizona Court of Appeals examined Arizona’s paternity registry law in light of a constitutional challenge in an adoption action. In Marco C. v. Sean C. and Colleen C., 218 Ariz. 216, 181 P.3d 1137 (Ariz. App. 2008), the Arizona Court of Appeals sustained the lower court’s determination that the Arizona paternity registry law is constitutional. In Marco, the child’s putative father was aware of the pregnancy and adoption plan at least two months prior to the delivery of the child, but he waited until the child was 31 days old to file with the registry. Although he filed a paternity suit after the birth, Marco failed to serve the biological mother within 30 days of filing his paternity suit.

The Marco court discusses Lehr v. Robertson, 463 U.S. 248, 264 (1983), and concludes as follows: “Thus, we find without merit Marco’s suggestion that, because he demonstrated his desire to assert his rights and establish a relationship…, he should be excused from complying with the terms of the statute or that strict application of its provisions here was unconstitutional” (Id. at 219). In addressing the 30-day time limit imposed by the Arizona statute, the court concedes, “Although the result may be harsh when a father misses this deadline, we do not second-guess the legislature’s policy” (Id.).

**New Mexico**

The New Mexico statute is not nearly as clear-cut with time deadlines as other states’ statutes. New Mexico does require, however, that the putative father come forward early and take affirmative steps toward being a parent. In a ruling which followed Lehr v. Robertson, as well as many other states’ decisions, the New Mexico Supreme Court concluded that neither a late filing with the registry nor a defensive filing of a parentage suit may be used to defeat an adoption once the placement has occurred and the adoption proceeding is pending. The bulk of the discussion addressed the biological father’s failure to act and establish parentage prior to the placement of the child for adoption and the filing of the adoption petition (In the Matter of the Adoption Petition of Bobby Antonio R. and Rosario R. — Helen G. v. Mark J.H. 143 N.M. 246; 175 P. 3d 914 (N. M. 2008)). Under the New Mexico statute, the potential father, Mark, would have had to establish his interest in the child within ten days after the birth or establish himself as being an “otherwise acknowledged father” in order to protect his right to consent to the adoption (Id. at 250). Mark did not register his intent to claim paternity until after the child had been placed with the adoptive parents, at least two months after the birth of the child (Id. at 251).

The New Mexico court addressed the short time frame for the registry: “Finally, it is universally understood that time is of the essence in adoption matters when dealing with infants and very young children…. ‘Placement should occur as early as possible so that the child and the adoptive parents may bond, especially if the child is a newborn’ (Laurence C. Nolan, Preventing Fatherlessness Through Adoption While Protecting the Parental Rights of Unwed Fathers: How Effective Are Paternity Registries?, 4 Whittier Journal of Child & Family Advocacy 289, 296 (Spring 2005)). ‘Time is even more of the essence for very young children….’ (Laura Oren, Thwarted Fathers or Pop-Up Pops?: How to Determine When Putative Fathers Can Block the Adoption of Their Newborn Children, 40 Family Law Quarterly 153, 188-89 (Summer 2006)). This has led many states to impose rather short deadlines…. ” (Id. at 257).

**Arkansas**

Arkansas law does not require a putative father’s consent to an adoption of a minor if the father is listed on the Putative Father Registry but failed
to establish a significant custodial, personal, or financial relationship with the juvenile prior to the time the petition for adoption is filed (ARK. CODE ANN. § 9-9-207(a)(11)). Furthermore, the statute does not mandate that notice of a hearing on a petition for adoption be provided to a person whose consent is not required or to a person whose consent or relinquishment has been filed with the petition, except as provided in §§ 9-9-212 and 9-9-224 (ARK. CODE ANN. § 9-9-207(b)).

In *In re Adoption of Reeves*, 831 S.W.2d 607 (Ark. 1992), the Arkansas Supreme Court confirmed that a putative father did not have a right to receive notice to a stepparent adoption even though the child’s mother misrepresented that the identity of the father was unknown the court held that:

*Because Arkansas’s existing statutory scheme does provide notice to putative fathers who have registered, we affirm the trial court’s decision denying Tom’s request to set aside Andrew’s adoption decree…. Tom failed to comply with Arkansas’s registry law so as to trigger its notice provisions. As a consequence, he was not entitled to notice regardless of the improper actions of Andrew’s mother. By our holding, we certainly do not condone her actions and merely state that sanctions are available when a party or witness offers perjured testimony (Id. at 609).*

In the more recent case of *Escobedo v. Nickita*, 231 S.W.3d 601 (Ark. 2006), a split court issued an opinion in favor of the registry, but for different reasons. The ruling included two concurring opinions and a dissenting opinion. In *Escobedo*, the pregnancy resulted from a brief affair, and the putative father did not know about the pregnancy until after the child’s birth. Although the putative father was not entitled to notice, he was given notice of the adoption. In spite of his having notice of the adoption, the registry received a significant amount of ink in the court’s opinion.

The right to notice and the right to consent are tied together. Because he received notice after the adoption petition had been filed, the putative father’s window of opportunity to sign the registry had passed by the time he received notice. One concurring justice quoted the Vermont Supreme Court in *In re C.L. Juvenile*, 178 Vt. 558, 878 A.2d 207 (2005). “In that case, the Vermont Supreme Court said: To conclude that petitioner acted promptly once he became aware of the child is to fundamentally misconstrue whose timetable is relevant. Promptness is measured in terms of the baby’s life not by the onset of the father’s awareness. The demand for prompt action by the father at the child’s birth is neither arbitrary nor punitive, but instead a logical and necessary outgrowth of the State’s legitimate interest in the child’s need for early permanence and stability.” (*Escobedo* at 609).

**Oklahoma**

Oklahoma requires notice to a father whose rights are being terminated under the following circumstances:

1) Any person adjudicated by a court to be the father of the child;

2) Any person recorded on the child’s birth certificate as the child’s father;

3) Any person openly living with the child and the child’s mother at the time the proceeding is initiated or at the time the child was placed in the care of an authorized agency and who is holding himself out to be the child’s father;

4) Any person who has been identified as the child’s father by the mother in a sworn statement;

5) Any person who was married to the child’s mother within ten (10) months prior to or subsequent to the birth of the child; and

6) Any person who had filed with the paternity registry an instrument acknowledging paternity of the child, pursuant to Section 6 of this Act (Title 10 O.S.1991 §29.1(B)).
This statute was challenged in the 1995 Oklahoma Supreme Court case of Solomon Tarih v. Hannah’s Prayer Adoption Agency, 903 P.2d 304 (Okla 1995). In Tarih, a mother placed her three children for adoption. After the adoption was finalized, the putative father, Tarih, sought to invalidate the adoption. Tarih made the following arguments to support his request:

1) The child’s mother defrauded him and the court by stating that the father of the children was unknown;

2) The publication which theoretically provided him notice was defective as it did not list his name; and

3) The statute that allowed the adoption without notice to the putative father is unconstitutional.

In considering the arguments, the Oklahoma Supreme Court relied on the U.S. Supreme Court case of Lehr v. Robertson 463 U.S. 248, 103 S. Ct. 2985, 77 L.Ed.2d 614 (1983) and the prior Oklahoma Supreme Court case of Matter of Adoption of Baby Boy D, 742 P.2d 1059 (Okla. 1985), cert. denied sub nom., Harjo v. Duello, 484 U.S. 1072, 108 S.Ct. 1042, 98 L.Ed.2d 1005 (1988), and affirmed the trial court’s ruling, which denied the putative father’s attempt to invalidate the adoption. In ruling against the putative father, the Oklahoma court concluded that the applicable statutes did not require that notice be provided to Tarih, and that the statutes did not violate the putative father’s constitutional rights (Id. at 305). Because notice was not required, Tarih’s consent to the adoption was also not required.

The court first reviewed Tarih’s argument that the child’s mother perpetrated a fraud on the court by stating that she did not know the identity of the biological father. At the adoption hearing, the mother had testified that she did not know who was the father of one of the children. The Oklahoma court disregarded Tarih’s contention and put the obligation to assert paternal rights back on Tarih: “Tarih failed to show that he possessed an interest dis deserving of protection within the adoption proceeding, and we need not address his contention as to what Terri did or did not know” (Id. at 306).

Tarih’s second argument was that he had a right to notice, and because the publication notification did not include his name, it was technically defective. The court quickly dismissed this argument by affirming that Tarih was not within the class of persons entitled to notice; therefore, any defect in the publication notice is immaterial (as long as the statutes are constitutional) (Id. at 307).

The more significant part of the case is the discussion about the registry and the statutory scheme which allowed an adoption to occur without notice or consent of the putative father. Referencing the Lehr decision, the Oklahoma court wrote, “Notice is not constitutionally required to a putative father in all circumstances.” The court went on to quote Lehr, “‘The rights of parents, are a counterpart of the responsibilities they have assumed.’” The court also noted that a potential parent-child relationship is deserving of less protection than one already developed. (Id.) Quoting the prior Oklahoma case, Baby Boy D: “We stated that protection is afforded to biological parents who have formed an emotional bond with their children. After Lehr it is clear that in some circumstances the state may constitutionally omit to notify or allow participation by unwed fathers…. The Constitution protects only parent-child relationships of biological parents who have actually committed themselves to their children and have exercised responsibility for rearing their children” (Id. at 308).

The court also identified that the child’s need for permanence and stability, especially in the early years, is a superior obligation than the protection of a putative father’s rights when the putative father did not take on the parental responsibilities which would have lead to permanence and stability.
Putative Father Registries: West Coast States

Larry Jenkins

Status of Putative Father Registries in West Coast States

California

California has no putative father registry.

Colorado

Colorado has no putative father registry.

Hawaii

Hawaii has a form of a putative father registry. Under HAW. REV. STAT. § 578-2(d)(5), a man is presumed to be the father of a child if he acknowledges paternity of the child in writing filed with the Department of Health, and the mother does not dispute the acknowledgment within a reasonable time after being informed. If an acknowledgment is filed by a putative father and is not disputed by the mother, and if another man is not presumed to be the father, a new birth certificate is prepared for the child, listing the father (Id.). A putative father's consent to an adoption is not required unless he makes his filing with the Department of Health “during the first thirty days after such child’s birth; or prior to the execution of a valid consent by the mother of the child; or prior to the placement of the child with adoptive parents whichever period of time is greater” (HAW. REV. STAT. § 578-2(a)(5)).

Idaho

In Idaho, a putative father must first file a paternity proceeding in court, and then register notice of his commencement of proceedings to establish his paternity of a child born out of wedlock with the vital statistics unit of the Idaho Department of Health and Welfare (IDAHO CODE §§ 16-1504(2)(b)(i) and 16-1513(a)). These may be filed before the baby is born, but they must be filed “prior to the placement for adoption of the child in the home of prospective parents or prior to the date of commencement of any proceeding to terminate the parental rights of the birthmother, whichever event occurs first” (Id.). A putative father who fails to meet this deadline “is deemed to have waived and surrendered any right in relation to the child and shall be barred from thereafter bringing or maintaining any action to establish his paternity of the child” (Id. at §§ 16-1504(5) and 16-1513(4)). Furthermore, failure to file a paternity proceeding or to register constitutes an abandonment of the child (Id. at § 16-1513(4)).

Importantly, “[a]n unmarried biological father is presumed to know that the child may be adopted without his consent unless he strictly complies with the provisions of this chapter, manifests a prompt and full commitment to his parental responsibilities, and establishes paternity” (IDAHO CODE § 16-1501A(3)(c)). The Code of Idaho states further that an unmarried biological father who has engaged in a sexual relationship with a woman, is deemed to be on notice that a pregnancy and an adoption proceeding regarding that child may occur (Id. at § 16-1505(2)).

Montana

Montana maintains a putative father registry in the vital statistics bureau (MONT. CODE ANN. § 42-2-202 (2009)). A putative father must register within 72 hours of a child’s birth by providing
certain information required by statute on a form supplied by the vital statistics bureau (Id. at § 206 (2009)). A putative father is presumed to know a woman may be pregnant if he had sexual relations with her (Id. at § 42-2-204(1) (2009)). If a putative father registers, he is entitled to notice of any proceeding to terminate parental rights regarding the child (MONT. CODE ANN. § 42-2-203 (2009)). But he must still appear at any hearing on the termination of parental rights and prove that he has established a substantial relationship with the child according to the requirements set forth in § 42-2-610. The burden is on the putative father to prove that he has a substantial relationship with the child; mere biological connection to the child is not enough (Id. at 42-2-208 (2009)). If he does not meet this burden, his parental rights may be terminated. Furthermore, fraud on the part of the birthmother or any other person is not a defense for the failure to register (Id. at § 42-2-230 (2009)).

**Nevada**

Nevada has no putative father registry.

**Oregon**

Oregon’s registry is similar to Idaho’s and Utah’s. For a putative father to have rights to notice of an adoption proceeding, he must file a filiation proceeding before the child is surrendered for adoption (OR. REV. STAT. § 109.092 (2009)). A putative father “is entitled to reasonable notice in a proceeding for the adoption of the child if notice of the initiation of filiation proceedings as required by § 109.225 was on file with the Center for Health Statistics of the Department of Human Services prior to the child’s being placed in the physical custody of a person or persons for the purpose of adoption by them” (OR. REV. STAT. § 109.096(3) (2009)). However, “[i]f the notice of the initiation of filiation proceedings was not on file at the time of the placement, the putative father is barred from contesting the adoption proceeding” (Id.). If a putative father has provided the required notice to the Center for Health Statistics, and has been served notice of the adoption proceedings, the adoption may still be granted if either the court finds him to be unfit or if he fails to respond to the notice of the adoption proceedings (OR. REV. STAT. § 109.098(2)(c) and (3) (2009)).

**Utah**

For a putative father to have consent rights in an adoption, he must, before the birthmother executes a relinquishment or consent to adoption or one business day after the child is born, whichever is later: (1) file a paternity action in a Utah court, (2) file a sworn affidavit in the paternity action stating he is willing and able to have full custody of the child, setting forth a plan for care of the child, and agreeing to a court order of child support and the payment of the mother’s pregnancy-related and childbirth expenses, (3) file a notice of the commencement of the paternity action with the Utah registrar of vital statistics, and (4) offer to pay a fair and reasonable share of the mother’s pregnancy-related and childbirth expenses, unless (a) he did not have actual knowledge of the pregnancy, (b) he was prevented from paying the expenses by the person or agency having custody of the child, or (c) the mother refused to accept the offer to pay the expenses (UTAH CODE ANN. § 78B-6-121(3) (2009)).

If the putative father does not know, and through the exercise of reasonable diligence could not have known, that (i) the child or the child’s mother resided on a permanent or temporary basis in Utah during the pregnancy, (ii) the mother intended to give birth to the child in Utah, (iii) the child was born in Utah, or (iv) the mother intended to execute a consent or relinquishment in Utah or under the laws of Utah (called “qualifying circumstances”), then different rules apply. Under these circumstances, in order to have consent rights in an adoption, before the mother executes a consent or relinquishment, the putative father is required to fully comply with the requirements to establish paternity and preserve the right to notice of an adoption proceeding regarding the child in the last state in which he knew the mother resided, or in the state in which conception occurred (UTAH CODE ANN. § 78B-6-122(1) (2010)). If the putative father knows, or through
the exercise of reasonable diligence should have known, of a qualifying circumstance, the putative father has twenty days from when he was on notice or when the mother executes a consent or relinquishment for adoption to fully comply with the requirements stated in the previous paragraph, whichever is later (Id.).

Under Utah law, a putative father is on notice that a pregnancy and adoption may result if he has had sex with a woman (UTAH CODE ANN. § 78B-6-110(1) (2010)). The burden to comply with the putative father laws is on the putative father, and he may not rely on the representations or actions of others, even if fraud is involved (Id. at §§ 78B-6-102(6) and 78B-6-106 (2008)).

Washington
Washington has no putative father registry.

Wyoming
Wyoming has a putative father registry that is maintained by the Wyoming Department of Family Services, where a putative father may file a notice of intent to claim paternity either before or after a child is born (WYO. REV. STAT. § 1-22-117). If a putative father files with the registry, his consent to the adoption is required unless he does not respond to notice of the adoption proceeding or the court finds that the best interests of the child require the adoption petition to be granted (Id. at §§ 1-22-108 and 1-22-109). Interestingly, under Wyoming law, if a putative father is known, his consent to the adoption is also required, even if he has not filed with the Wyoming registry (Id. at § 1-22-109(a)(iii)).

Recent Cases Decided During the Last Two Years in West Coast States

The only cases decided during 2008 and 2009 in West coast states have been in Utah.

In In the Matter of the Adoption of I.K., 2009 UT 70, 220 P.3d 464, the Utah Supreme Court held that the birthfather had waived his rights to the child where he had not complied with either Utah or New Mexico law to establish rights regarding the child. New Mexico also has a putative father registry that requires the birthfather to file within 10 days of the child’s birth and/or file a parentage action before an adoption petition is filed regarding the child. The birthfather in I.K. did neither.

O’Dea v. Olea, 2009 UT 46, 217 P.3d 704, involved a birthfather from Wyoming who had gotten his name on the Wyoming Putative Father Registry before the child’s birth. But just before the birth of the child, the birthmother called him from Utah and told him she was in Utah. Under Utah law, if a birthfather has knowledge of certain statutorily defined connections that the birthmother, the child, or the adoption may have to Utah, the birthfather is required to strictly comply with Utah law, including filing a parentage action and registering on the Utah registry, among other things, within twenty days of gaining that knowledge. The birthfather in O’Dea did not comply with Utah law within the time allowed, and the Utah Supreme Court held that he had no rights regarding the child.

In H.U.F. v. W.P.W., 2009 UT 10, 203 P.3d 943, the Arizona birthfather was aware that the birthmother was placing the child for adoption in Utah, yet he did nothing to comply with Utah law. After the placement, the birthfather and the birthmother executed a voluntary acknowledgment of paternity, and had an Arizona court enter an order adjudicating his paternity of the child. The Utah Supreme Court held that even though the Arizona court had found him to be the child’s father, the paternity order was irrelevant because the birthfather had not complied with Utah law to have any rights to the child in the case of an adoption.

In In the matter of the adoption of Baby Boy Doe, 2008 UT App 449, 199 P.3d 368, the Utah Court of Appeals discussed the importance of requirements found in Utah law that are in addition to getting on the Utah registry. Under Utah law, to have any rights to a child placed for
adoption, an unmarried birthfather must (1) file a
parentage action, (2) file with the parentage action
a sworn affidavit stating his willingness to have full
custody of the child, setting forth his plan for care
of the child, and stating his agreement to court
ordered child support and court ordered payment
of pregnancy-related and child birth expenses,
(3) file a notice of the commencement of the
parentage action with the state registrar of vital
records, and (4) offer to pay and pay a reasonable
share of pregnancy-related and childbirth
expenses, unless precluded from doing so. In Baby
Boy Doe, the birthfather filed a timely parentage
action and filed notice of the parentage action with
the state registrar of vital records, but he did not
file a sworn affidavit setting forth his plans for care
of the child. Because he did not file the required
affidavit, the Court of Appeals held that he had
waived his rights to the child.

Case Study of a State Where the Registry
is Working Well

Utah has had some form of a putative father
registry for approximately 30 years. As
demonstrated by the cases above, it is the subject
of frequent appellate court decisions, both in the
Utah Court of Appeals and the Utah Supreme
Court. Utah birthfather laws have been upheld
as constitutional as far back as Wells v. Children's
Aid Society, 681 P.2d 199 (Utah 1984), which
involved a father who had filled out and mailed
in his registry notice before the child was
placed for adoption. The state did not receive
his notice until after the child had been placed
for adoption. Against constitutional due process
arguments, the Utah Supreme Court found that
the registry was not only constitutional, but
necessary to advance the compelling state interest
of quickly ascertaining whether a child of an
unmarried birthmother was available to be placed
for adoption.

The Utah appellate courts have continually
upheld the registry and other requirements
of the law since the Wells decision. The statute
itself has evolved over the years to include not
only a registry, but other requirements intended
to demonstrate an unmarried birthfather’s
commitment to the mother and the child,
as discussed above. The most recent changes
amended the requirements that must be followed
by unmarried birthfathers who are not residents
of Utah. These requirements are discussed above
under the Utah section and under the O'Dea
case summary.
Putative Father Registries in the Southeastern States

James Outman

Alabama

Alabama established a Putative Father Registry in 1996 and amended the statute in 2002. It is found at Alabama Code Section 26-10C-1. The Alabama putative father registry is maintained by the Department of Human Resources and the Department will upon request “provide the names and addresses of persons listed with the registry to any court” (emphasis added). Thus, the registry is not searchable except by court order.

In addition, when the Department receives notice of the pendency of an adoption pursuant to the provisions of Alabama Code Section 26-10A-17 it sends to the Court handling the adoption a copy of the notice of intent to claim paternity and that Court notifies the man who filed with the registry.

Alabama Putative Father Registry Cases


**J.B. v. F.B. and A.B.** 929 So.2d 1023, (Court of Civil Appeals of Alabama, No. 2040448), November 18, 2005.

Florida’s Putative Father Registry is found at Fla. Stat. Ch. 63.054 Actions required by an unmarried biological father to establish parental rights; Florida Putative Father Registry. It states in pertinent part:

In order to preserve the right to notice and consent to an adoption under this chapter, an unmarried biological father must, as the “registrant,” file a notarized claim of paternity form with the Florida Putative Father Registry maintained by the Office of Vital Statistics of the Department of Health which includes confirmation of his willingness and intent to support the child for whom paternity is claimed in accordance with state law. The claim of paternity may be filed at any time before the child’s birth, but may not be filed after the date a petition is filed for termination of parental rights. In each proceeding for termination of parental rights, the petitioner must submit to the Office of Vital Statistics a copy of the petition for termination of parental rights. The Office of Vital Statistics may not record a claim of paternity after the date a petition for termination of parental rights is filed. The failure of an unmarried biological father to file a claim of paternity with the registry before the date a petition for termination of parental rights is filed also bars him from filing a paternity claim under chapter 742.

It was enacted in 2003 and amended in 2006 and 2008.

**Florida Appellate Putative Father Registry Cases**

In 1998 Georgia enacted a requirement that the Putative Father Registry be searched in connection with an adoption in Superior Court or in connection with the involuntary termination of rights to a child by the State in a deprivation situation in Juvenile Court. There already existed a Putative Father Registry that had been established in connection with child support recovery efforts and it was amended to make provision for a male to register the “possibility of paternity without acknowledging paternity,” in
addition to the already existing provision allowing for registration by a male before or after birth of a child acknowledging “paternity in signed writing.” By allowing a male to register indicating the “possibility of paternity” he could preserve his right to receive notice in the event his act of sexual intercourse with the mother of the child resulted in a pregnancy without acknowledging paternity. Then if the child was either being placed for adoption by the mother or if the mother was to have her parental rights involuntarily terminated after the child was declared to be deprived under Georgia’s Juvenile Code the male could be notified of the proceedings such that he could take action to protect his rights through the filing of a Petition for Legitimation.

The Putative Father Registry is established under O.C.G.A. §19-11-9(d). The provisions requiring that it be searched in connection with an adoption are set forth in O.C.G.A. §§19-8-12 and 19-8-13(h). The parallel provision for the search of the Putative Father Registry in connection with termination proceedings in Juvenile Court are set forth at O.C.G.A. §15-11-96(g)-(i).

**Georgia Appellate Putative Father Registry Cases**

The Georgia Putative Father Registry requirements in adoption cases have not been challenged in Georgia’s appellate courts, but the parallel provision in the Juvenile Code has been repeatedly upheld in appellate decisions including the following:

**In the Interest of M.D., a child,** 293 Ga.App. 700, 667 S.E.2d 693 (Ga. App. 2008).


**North Carolina**

North Carolina General Statute 7B-1111(a) (5)a. contains a reference to a “central registry maintained by the Department of Health and Human Services” but there is no other reference to that “central registry” in the North Carolina General Statutes.

Also, a search of the regulations for the Department of Health and Human Services did not disclose any “central registry” related to paternity.

Pursuant to the provisions of North Carolina General Statute 7B-1111(a)(5)a., “the court shall inquire of the Department of Health and Human Services as to whether such an affidavit has been so filed and shall incorporate into the case record the Department’s certified reply” but again
Without further information one does not know how a man would go about establishing paternity by affidavit to be filed on the central registry.

Because a man’s parental rights can be terminated under NCGS 7B-1111(a)(5) by a showing that he has failed to do any of the four acts enumerated, in a., b., c., and d., there are cases holding that the court must make specific findings as to each of those four grounds before termination is supported.


Inquiry would need to be made with the North Carolina Department of Health and Human Services about such registry and how it is to be searched.

North Carolina General Statute 7B-1111(a)(5) reads as follows:

“(a) The court may terminate the parental rights upon a finding of one or more of the following:

“(5) The father of a juvenile born out of wedlock has not, prior to the filing of a petition or motion to terminate parental rights:

““a. Established paternity judicially or by affidavit which has been filed in a central registry maintained by the Department of Health and Human Services; provided, the court shall inquire of the Department of Health and Human Services as to whether such an affidavit has been so filed and shall incorporate into the case record the Department’s certified reply; or

““b. Legitimated the juvenile pursuant to provisions of G.S. 49-10 or filed a petition for this specific purpose; or

““c. Legitimated the juvenile by marriage to the mother of the juvenile; or

““d. Provided substantial financial support or consistent care with respect to the juvenile and mother.”

**South Carolina**

South Carolina’s putative father registry is called the Responsive Father Registry and it was passed in 2009. It can be found at South Carolina Code of Laws Title 63, Chapter 9, Sections 810 and 820.

**South Carolina Appellate Putative Father Registry Cases**

There are no appellate decisions construing the application of the Responsive Father Registry at this time.

**Tennessee**

Tennessee’s Putative Father Registry was enacted in 1997, amended in 2001, and can be found at Tennessee Code Section 36-2-318. It provides that notice will be provided to persons who file with the registry including those who file a “written notice of intent to claim paternity of a child with
the putative father registry either prior to, or within thirty (30) days after, the birth of such child.”

_Tennessee Appellate Putative Father Registry Cases_

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For 30 years, the National Council For Adoption has been a leader in advocating for and promoting adoption as a viable option for permanency for children around the world. The Council has been at the forefront of educating adoptive families and agencies, birth families, policymakers and the general public about adoption policies and research, as well as dispelling the myths about adoption. The National Council For Adoption’s Adoption Factbook is an indispensable resource.
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We at the Congressional Coalition on Adoption Institute consider ourselves the direct beneficiaries of the National Council For Adoption’s 30 years of experience. When it comes to international, federal, or state issues, we know we can turn to NCFA for their expertise. CCAI’s main goal is to reduce the legal and policy barriers that stand in the way of children being adopted, and we could not do that work without partners like NCFA.
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As a person that was adopted, it has been my privilege contributing to the development of Adoption Factbook V.
—Lauren Koch, Director of Development, NCFA