Evidence to the Children and Young People Committee at the National Assembly for Wales

Topic - the support given to adoptive parents and children post-adoption in Wales.

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A brief outline of the specific mental health and behavioural issues which may affect some adopted children

The range of problems manifested by children placed for adoption from care is likely to be the product of numerous influences: biological, environmental and psychological. Studies of the family backgrounds of such children have recorded the frequent occurrence of major mental illness, personality problems and alcohol and drug problems (Quinton et al, 1998). Genetically inherited problems may therefore play a part in the children's development and they may carry certain vulnerabilities. Pre-natal factors like maternal stress, drug and alcohol exposure and subsequently poor parenting, abuse and neglect, sudden changes of environment and disrupted attachments may all interact with any vulnerability. Given that children might have suffered not one but a range of adversities, it becomes difficult to establish which factors are linked to which effects. It is also striking that not all children suffer to the same extent from similar negative experiences. It is a major research question to discover why this might be the case.

The findings presented here are mostly drawn from two UK investigations (The Maudsley Family Research Studies and the Hadley Centre studies) documenting the problems of late adopted children. Not all childhood problems pose the same level of parenting challenge. It is important to know not just the range of problems a child demonstrates, but which ones are likely seriously to challenge the stability of the placement, or are likely to contribute to continuing family stress and dissatisfaction. The problems of children placed from care can challenge even experienced parents. Research has shown that the presence of conduct, overactivity and relationship problems are the ones most likely to predict poor adoption outcomes (Quinton et al, 1998; Selwyn et al, 2006).

Conduct problems might involve refusal to comply with parental requests, temper tantrums, and more rarely extreme expressions of anger and aggression. They are more likely to threaten a placement than emotional difficulties. This may appear surprising, but is perhaps because the adopters are sympathetic to the child's distress or anxiety and find a way to empathise and to calm the child whereas the oppositional child may strain their tolerance and understanding and leave them at a loss as to how to manage the behaviour successfully. Poor concentration and restlessness have proved to be common problems in children in adoptive placements. Such problems can persist and interfere with learning and with establishing positive social interaction.

Difficulties for the child in forming a satisfactory relationship with new parents can be a central problem. This might show itself as the child maintaining an emotional distance, avoiding closeness, being socially undiscriminating and disinhibited, being unable to trust and expressing feelings in a distorted way. Adopters will expect the child to form a positive attachment to them, even if they have been warned that this might be a slow process. The Maudsley study shows that many children do form satisfactory new attachments, especially in the context of responsive parenting. However if the child continues to withhold affection and to reject the adopters, despite their best efforts, adoption can be an unrewarding experience. The fact that impaired functioning for these

children may appear in many aspects of development – behavioural problems, disorders of attachment, indiscriminate friendliness, emotional dysregulation, cognitive delay and poor executive functioning (i.e. impulsiveness and poor decision making) - will make effective treatment particularly challenging. The problems do not sit within discrete diagnostic categories.

Developmental recovery and persistence of problems

A stable, loving home which replaces neglect with care, inconsistency with consistency, regularity with chaos and neglect with protection will have a beneficial effect. But does this radically improved environment result in the gradual abatement of all problems? The research shows that many children settle after a matter of months with a diminution of problems, or at least a reduction in their intensity, for most in the first year. Problems like distress and anxiety, enuresis, encopresis and temper tantrums are likely to diminish, whereas relationship problems may persist for much longer. However in one of the longer term follow-ups conducted on late placed children (Rushton and Dance, 2006), in 28% of the continuing placements the children had substantial difficulties even after six years living in the adoptive family. These included enduring developmental, behavioural and social difficulties. In the longitudinal non-infant adoption study (Selwyn et al 2006) only two fifths of the children followed up at an average of seven years after placement were found to be free from behavioural problems.

Better devised screening tools to identify those most at risk of socio-emotional problems

In adoption work, comprehensive and reliable assessments of children's current functioning are needed. The benefits of systematic assessment are that problems can be accorded priority and the best links made with available services. Standardised measures, observations, file searches and interviews should be used to create the most reliable history of the children's key pre-adoption experiences and their strengths and vulnerabilities. This information should be conveyed, with appropriate explanation, to the adopters.

Some concern has arisen that standard screening measures fail to do justice to the range of problems in adopted children, especially those associated with very adverse backgrounds and a transition to a new family. Difficulties like insecure identity and confused or conflicted ethnic identification are important to capture, but are hard to measure satisfactorily and tools have yet to be widely used and validated. Tarren-Sweeney (2007) has argued that the use of standard, parent-completed problem check lists has led to under-reporting of, for example, attachment difficulties, dissociative responses to trauma, inappropriate sexual behaviour and self-harm. He has developed a new, comprehensive instrument more geared to this population. – the Assessment Checklist for Children (ACC). A similarly focussed instrument (the Ages and Stages Questionnaire - Socio-emotional) is currently being developed and tested in the US (Jee et al, 2010).

If a well recognised instrument like the Strengths and Difficulties Questionnaire (Goodman, 2001; Whyte, & Campbell, 2008) is used in an assessment, it can be profitably supplemented with other measures like an attachment questionnaire (Minnis, Rabe-Hesketh and Wolkind, 2002) and a self-esteem measure (Coopersmith, 1981). Attention also needs to be paid to possible discrepancies between informants, as teachers, carers and social workers may see the child from different perspectives.

The specific CAMHS and therapeutic interventions which are evidenced to meet such needs

There has been longstanding criticism of CAMHS for failing to adapt its assessment and therapeutic services to the needs of adoptive families. In particular adoptive families whose children have multiple problems often fail to receive prompt, relevant, effective services. Struggling adopters can have a sense of failure when approaching services and often report feeling blamed for the child's problems or treated like a dysfunctional family. Clearly the approach has to be 'adoption aware' and sensitively managed. However some child mental health services have improved and we have reports of excellent service (Monck and Rushton, 2009).

Adoption support needs to be available for different purposes and levels of intensity. This can extend from generalised services like group support for adopters, adopted people and birth parents, to telephone help lines, social events, fact sheets and newsletters. At the more intensive end are major therapeutic and educational services by specialist professionals, for example, longer term family based interventions, direct psychotherapeutic work with a child and efforts to resolve sibling group conflicts. Service evaluation can be undertaken at several levels, from surveys of user satisfaction to simple 'before and after assessments' to experimental trials. Although there is evidence of the benefits of behavioural programmes and family therapy with non-adoptive families, empirical support is thin when interventions are applied specifically to the adoption of maltreated children. Evaluations in the adoption field are mostly at the softer end of investigations and few studies are sufficiently rigorous to demonstrate effectiveness. More controlled evaluations have been conducted in the field of foster care. One US adoption academic has stated boldly that there is no good evidence on what works in adoption support!

Voluntary adoption support agencies can provide a range of innovative services employing experienced professionals. The link with local authorities will be improved when clearer specification is made of what the LA requires and what services the ASAs are providing.

The Adoption Passport idea, as discussed in An Action Plan for Adoption: Tackling delay (DfE) is worth pursuing as a way of guaranteeing a measure of post adoption support – but depends on the provision of services of sufficient capacity, expertise and availability to meet any entitlement. Resources should be allocated on the basis of need not as a fixed amount.

Parenting support programmes for adopters

Parenting programmes specially tailored for adopters are strongly to be recommended. The benefits are that they are easy to commission, not too costly, do not need extensive training for parent advisers are easily accessible and should provide a practical response to pressing challenges for adopters and lessen the likelihood of disruption or other poor outcome. Some agencies make claims to have evidence-based programmes but this may simply be a survey of user feedback – usually favourable. A stricter test of effectiveness is needed namely the Randomised Controlled Trial (RCT) whereby cases are allocated on a random basis to either the intervention group or a comparison group. Having equalized the groups in this way allows the outcomes to be fairly compared. This is the only way to demonstrate that it is the intervention that has caused the outcomes and not some other confounding factors.

The 'Enhancing Adoptive Parenting' programme was tested with an RCT design (Rushton and Monck, 2009 & 2010). This individualised, structured programme combined child behaviour management techniques with help in understanding the possible origins and meaning of the children's disturbed behaviour. The trial showed that parenting confidence and satisfaction improved significantly more so for those receiving the ten week programme than for the control group when followed up six months beyond the end of the intervention. The children however sustained a high level of problems in both groups over this relatively short period of time. The parenting manual has now been amended and expanded in the light of the study findings and has been published by the British Association of Adoption and Fostering (Rushton and Upright, 2012). The Post Adoption Centre in London is now offering the programme to adopters and is training professionals to be parent advisers.

Different parenting programmes emphasise different aspects of adoptive parenting, use different theoretical models and formats (individual versus group sessions) . 'Safebase', for example, offered by After Adoption, is an attachment focussed parenting programme

which uses Theraplay (structured play therapy for children and their adopters). This programme has yet to be subjected to a controlled trial.

I should like to see an evidence-based adopter parenting programme offered to all new adopters of challenging children. At the end of the programme, with the aid of 'before and after' measures to assess change, I should like to see a review to identify any persistent problems followed by a focussed therapeutic plan.

Some brief responses to other questions

- Specialist professional university based adoption work courses are needed with academic accreditation to improve skills and gain up-to-date knowledge, giving practitioners greater opportunity to read and critique relevant research. These would be of benefit to teachers and other school staff, to psychologists, medical professionals and social workers.

- Research funds are needed to conduct a longitudinal study of all adoptions in Wales. This will require contact with adoptive families to learn about the quality of placements, not just disruptions, and the effectiveness of support services.

- A national adoption service would be best placed to deliver a recruitment campaign to address the shortage of adopters and to provide easily accessible information about the adoption process and the nature of the children waiting for placement. A national service would maximize the best chance of a good match between adopters and children. A national service could have a research function.

- The preparation of adopters can often be lengthy and not always be relevant for a particular family. Scarce resources are better deployed when the child has been placed and where the parent/ child interactions can be observed and assessed. All these processes should have the children's timescale firmly in mind (Rushton and Monck, 2009).

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