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Hope for the Children: A Community-Based Approach to Supporting Families Who Adopt Children with Special Needs

Laurie Kramer and Doris Houston

This study explored the need for and use of support by preadoptive families of children with special needs in the Hope for the Children program. The families live in a community alongside other foster and adoptive parents, senior citizen volunteers, tutors, therapists, mentors, and family advocates, and receive extensive community supports. Descriptive results from the study provide a basis for recommendations about the use of coordinated service delivery systems to promote adoption success.

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Efforts by the states, combined with federal initiatives such as President Clinton's *Adoption 2000* and the Adoption and Safe Families Act of 1997, are resulting in an increased number of adoptions. Illinois has seen a spectacular increase in adoption during the past year alone as the number of children adopted from out-of-home care almost doubled from 2,229 in fiscal year 1997 to 4,293 in fiscal year 1998 [Illinois Department of Child and Family Services (IDCFS) 1998]. Although this historic increase in adoptions is laudable, it appears that insufficient attention is being devoted to ensuring that adoptions are sustained over time and that the quality of adoptive home environments are suitable to each child's long-term developmental needs [Howard & Smith 1997]. The benefits of placing a record number of children with special needs with families will be undermined if the rate of adoption disruption is high. Thus, it is important to understand the circumstances under which families are best able to sustain their commitment to a child with special needs.

The successful adoption of children who have spent some portion of their lives in out-of-home care generally requires a great deal of planning, preparation, and ongoing support [Eheart & Power 1995; Groze & Gruenewald 1991; Rosenthal & Groze 1992]. Children who are removed from their parents' custody as a result of abuse or neglect typically have complex medical, emotional, developmental, and behavioral needs [Berry 1990; Berry & Barth 1990; Lakin 1992; Partridge et al. 1986; Rosenthal & Groze 1992; Smith & Howard 1994]. When adoptive parents cannot meet these needs, the stability of the adoption may be threatened [Barth & Berry 1988 1991; Eheart & Power 1995]. The situation may be exacerbated if services designed to preserve the family (e.g., in-home services, respite care, parent education, parent support groups) are not initiated until *after* a family crisis has occurred [Smith & Howard 1994]. If services are provided on a preventive basis and as a matter of course, however, the stability of adoptive placements may be enhanced.

The support that families with children with special needs receive is an important factor in the attainment of permanency [Barth & Berry 1988; Groze 1996; Nelson 1985; Partridge et al. 1986]. Winkler and associates [1988] suggest that involvement with supportive resources and mental health services should be considered a normative part of the adoptive family's experience. Given the multitude and diversity of problems that children with special needs and their families may experience, it is important to ascertain which types of supports and resources are most important, who should provide those resources, and how those resources should be provided.

Kramer and Houston [1998] made some progress answering these questions through their study of 40 parents who were in the process of adopting children with special needs through a traditional service system, the Illinois Department of Children and Family Services (IDCFS). Their study revealed that families rely on a variety of formal and informal resources. Families used formal resources such as the adoption agency and professionals to help with health, medical, and educational problems, but they also reported turning to their indigenous support system of family members and friends for assistance with a wide range of adoption-related issues. Although these informal sources of support typically possessed little specific knowledge about the adoption process, parents sought their help with child behavior problems and family adjustment difficulties. In contrast, families tended to underutilize several types of supportive resources that were provided by the adoption agency, such as family resource support specialists and experienced "master" adoptive parents. To some extent, parents were not aware of the availability of these types of services.

Kramer and Houston [1998] also noted that although families preparing to adopt sought assistance from many sources, the support they received was not always coordinated. Children often received services from multiple practitioners based outside of the adoption agency, and few mechanisms existed for practitioners to share information. Service providers were unaware of the treatment services being provided by their counterparts, a situation that led to the duplication of services, the simultaneous pursuit of conflicting treatment goals, or problems "falling through the cracks." Furthermore, members of the families' indigenous support network—who were regularly involved in the care of the adoptive children—were usually not included in the formation or implementation of service delivery plans.

Adoption services that integrate different types of support and draw from both formal agency-linked resources and informal, indigenous resources may be most effective in helping preadoptive families adjust to the critical transitions involved in special needs adoption. One such approach is the Hope for the Children program, developed by Brenda Krause Eheart in 1994. Hope for the Children (HFTC) grew out of a desire to increase support services to families adopting children with special needs by combining professional support services traditionally available to adoptive families with nontraditional, neighborhood-based support networks of foster and adoptive families, senior citizen volunteers, foster grandparents, tutors, mentors, and family advocates in a carefully designed intergenerational neighborhood [Eheart & Zimmerman 1998].

HFTC or "Hope" has charted new territory in child welfare by basing its services to children and families on a community concept in which all families and children in the program reside side-by-side to maximize social support. The HFTC community, Hope Meadows, consists of 65 housing units spread across 22 acres on a former air force base in rural Rantoul, Illinois. The single family homes, which were once military housing units, were purchased from the U.S. government and refurbished as homes for the HFTC families and agency staff. Approximately 50 senior residents, who serve as foster grandparents and volunteers, live on the grounds in reduced rent apartments.

Parents who join HFTC are licensed foster parents who agree to care for one or more children in out-of-home care with the goal of adopting those children who are either legally free for adoption or are likely to become so. At least one parent is required to serve as a full-time caregiver for the family. Each family receives free housing and a monthly stipend.

HFTC's community-centered supports include on-site child care, tutoring programs, respite services, and recreational programs. Family advocates meet weekly with families to provide parent education and training, facilitate problem solving, and make referrals to relevant community agencies for added assistance. Behavioral therapists live in Hope Meadows and are available to respond almost immediately to family crises. On-site training and enrichment activities are provided to families on a weekly basis. The HFTC model also includes a multigenerational component in which senior citizens provide six hours of their time per week to assist families as foster grandparents.

Currently, HFTC's key objective is to increase opportunities for children with special needs to be adopted and to support their families over time. Because the program is relatively new, evaluating its effectiveness in preventing adoption disruption is not yet feasible. At the time of data collection, only one placement had resulted in a legalized adoption. It is possible, however, to assess whether the provision of coordinated supports on a preventive basis are perceived as helpful by HFTC families, the degree to which participating families take advantage of the resources provided by HFTC, and the extent to which HFTC parents identify any unmet needs for support. This study addresses four questions: (1) What problems do HFTC families face as they adopt children with special needs? (2) Who do HFTC preadoptive parents seek out when faced with problems related to their children's special needs? (3) How helpful do HFTC families perceive their available resources to be? and (4) What services and supports do HFTC families perceive that they need but are not receiving?

Method

Participants

All HFTC parents were invited to participate in the study. At the time of data collection, 13 families were enrolled in the program. One family that recently experienced a critical life experience chose not to participate in this study. The final sample ($N = 17$ parents) included at least one parent from each of the remaining 12 HFTC families.

Each HFTC parent was a licensed foster care provider who was caring for one or more children. Each HFTC family was in the preadoption stage: they were committed to adopting at least one child for whom they were caring, but the adoption had not yet taken place. Each of the children studied was identified by the HFTC staff as meeting one or more special needs criteria as defined by IDCFS at the time of data collection: a documented physical, emotional, learning, or developmental disability; a child of color over three years of age; a Caucasian child over six years of age; or a member of a sibling group that was to be adopted together. In addition to meeting state requirements for special needs, preadoptive children included in this study were required to be between the ages of 2 and 17 years old and to have lived with their nonrelative, preadoptive family for at least six months, a requirement designed to ensure sufficient time for the preadoptive parent to know the child and his or her needs. Although these criteria encompass widely different dimensions, the children who were identified shared the experience of a long wait for an adoptive family.

Family characteristics. Twelve of the 17 parents were female. Eleven parents were Caucasian, five were African American, and one parent did not indicate an ethnic identity. HFTC mothers reported a mean age of 40.6 years; the mean age for fathers was 44.0 years. Mothers reported completing 14.6 years of education on average; fathers 13.90 years. Thirteen of the parents were married, two were single (never married), one was widowed, and one was divorced. Median family income was in the $30,000 to $39,999 range.

Characteristics of the preadoptive children. Sixteen preadoptive children were placed with the 12 HFTC families. Parents had plans at the time of study to adopt an average of 1.6 children. Eight of the preadoptive children were female and eight were male. On average, the preadoptive children were 4.6 years of age. Twelve of the preadoptive children were African American, three were Caucasian, and one was biracial. In addition to the target preadoptive children, the families were parenting 16 previously adopted children, seven foster children, and six birth children. The mean number of children per household was 3.75.

At the time of the study, the preadoptive children had been placed with their current families an average of 14.87 months. On average, the children had lived in 2.72 previous family foster homes. Thirteen of the preadoptive children were reported by their preadoptive parents to have experienced child neglect, 11 had experienced emotional abuse, five had experienced physical abuse, and seven had been sexually abused. Eleven of the children had developmental problems, 11 had emotional problems, 11 were exposed to drugs prenatally, eight had educational problems, seven demonstrated behavioral problems, and seven had medical problems. Parents commonly described their preadoptive children as having multiple problems.

Procedure

The project coordinator contacted eligible parents by phone to explain the research procedures and to ask for their participation. Parents were assured that their decision regarding participation would in no way impact their relationship with HFTC. Parents who agreed to participate were mailed a written informed consent form along with the questionnaire packet. To ensure anonymity, each questionnaire was coded with an identification number. A stamped return envelope was included to facilitate the return of the questionnaire and consent form. Parents who agreed to participate but who did not return their questionnaire were called at least twice to encourage them to complete the instrument. Each parent who returned a completed questionnaire was mailed a check for $10 as compensation for their time.

SNAPS questionnaire. The Special Needs Adoption Parent Support Questionnaire (SNAPS) [Kramer & Houston 1998] was used to assess the types of supports currently received by the preadoptive parents, and their satisfaction with these supports with regard to their child's behavior at home, health and medical issues, child development and education, the child's birth family and history, family adjustment during the transition to adoption, concerns about receiving adequate services, and concerns about community acceptance. Three to five items were included to tap each of the seven problem domains, for a total of 25 items.

SNAPS consists of four sections. In Part I, parents indicated whether they had experienced each of the 25 listed problems while parenting their preadoptive child. If they had experienced the problem, they were asked to identify the individuals they normally turned to for help. If they had not experienced the problem, they were asked to identify who they might turn to for help if this problem were to arise. A list of 39 potential resources was provided to parents for these selections. This list included individuals and organizations from the parents' formal, agency-related resource network (e.g., caseworkers, other adoption staff from HFTC, IDCFS staff who monitor each case); the formal, nonagency-related resource network (e.g., medical specialists, therapists, school representatives); the informal, agency-related resource network (e.g., other adoptive parents at HFTC, foster grandparents); and the informal, nonagency-related resource network (e.g., spouses, extended family members, friends, and church affiliates). Parents also could list additional sources of support that were not specified on the questionnaire.

In Part II of SNAPS, parents indicated how often they turned to each potential resource for help (daily, weekly, monthly, twice a year, or once a year or less). In Part III, parents were asked to rate, on a five-point Likert scale, how helpful each potential resource had been in helping them with parenting their adoptive child (5 = extremely helpful, 1 = harmful). Parents also could select a "not applicable" response if they did not have contact with a particular type of helper.

Part IV of SNAPS consisted of two open-ended questions that invited respondents to describe the areas of support they needed but were not currently receiving, and to identify individuals they felt they ought to be able to turn to for help, but could not. These responses were later subject to content analysis. After a list of all responses was generated without information identifying the respondents, the project coordinator created categories that reflected the general themes. Seven categories of needs emerged: access to agency staff and resources (such as the assistance of a caseworker in understanding court procedures); access to nonagency services (such as obtaining a medical referral); background information about the child; counseling or other assistance with child behavior problems; trusting agency personnel to keep confidences; financial assistance; and additional unmet needs. Each parental response was coded using one or more of the above categories with the coding process repeated by an independent research assistant. Interrater reliability was 95%. The reliability of the SNAPS questionnaire also was supported by its internal consistency. Parents' responses about whether they faced a particular problem within each of the seven domains yielded alpha coefficients that ranged from .52 to .88 (median = .71). This suggests that the questions used to assess each of the seven dimensions of parenting problems were interrelated, an indication that SNAPS is a reliable instrument.

Results

Problems Faced by HFTC Parents Adopting a Child with Special Needs

The reports of one parent per family (randomly selected) were used for descriptive analyses of the types of problems experienced by parents during the preadoptive period. This avoided overrepresentation of the characteristics of children whose preadoptive mother and father both responded to the survey.

Parents reported a total of 118 problems related to parenting their preadoptive children. The number and percentage of parents who reported each of the 25 problems assessed in SNAPS are presented in table 1.

As table 1 shows, the preadoptive parents' greatest areas of concern related to their child's development and education, health and medical problems, behavior problems at home, and birth family and history, and to service concerns. Least frequently reported were concerns about family adjustment and acceptance from the community.

HFTC Parents' Preferences for Assistance

Parents' reports of the types of resources they sought for help with each of the above problems were examined next. Table 2 shows parents' choices in relation to helpers from the four categories of formal/informal and agency-related/nonagency-related resources.

Parents were asked to identify specific potential helpers within each of the four categories of resources. Specific information is provided below about the 39 potential helpers cited by parents as resources for assistance with particular problems.

Child development and education. Parents reported seeking help most often from formal, nonagency-related resources when faced with problems related to child development and education (see table 2). They were most likely to seek assistance on issues related to development and learning from their child's teacher

TABLE 1

Parenting Problems Reported by HFTC Preadoptive Parents (*N* = 12)

Type of Problem	***Number of Parents Reporting Problem***	***Percentage of Parents Reporting Problem***
Child Development and Education		
Child is not developing at a normal pace	7	58.33%
Child has learning problems at school	10	83.33%
Child has behavior problems at school	8	66.67%
Health and Medical Issues		
Child was exposed to drugs at birth	7	58.33%
Child has problems with bed-wetting	4	33.33%
Child has attention deficit disorder	10	83.33%
Child's Behavior at Home		
Child threatens other children in the home	6	50.00%
Child destroys property	5	41.60%
Child refuses to follow rules in the home	6	50.00%
Child acts out sexually	4	33.33%
Child's Birth Family and History		
Child misses his/her birth family	6	50.00%
Behavior problems after visiting birth family	5	41.60%
Questions about child's past that I cannot answer	10	83.33%
Agency and Service Concerns		
I can't get needed services from the adoption agency	3	25.00%
I haven't received enough background information	7	58.33%
My child is not getting needed medical care	4	33.33%
My child is not getting needed school services	2	16.67%
My child is not getting needed counseling	2	16.67%
Family Adjustment		
My other children don't get along with child	3	25.00%
I disagree with my spouse about ways to parent	1	8.33%
I can't get over not having a child by birth	0	0.00%
Adoptive parenting is different than I expected	4	33.33%
Acceptance from Community		
My friends and family do not accept my child	1	8.33%
My child is teased about being a foster child	3	25.00%
Our community doesn't respect us as an adoptive family	0	0.00%

TABLE 2
HFTC Parents' Choices for Help (*N* = 12)

	Type of Resource			
Problem Area	***Formal Agency***	***Formal Nonagency***	***Informal Agency***	***Informal Nonagency***
Child Development and Education	15.97%	59.72%	9.03%	15.28%
Health and Medical	30.14%	37.67%	8.22%	23.97%
Behavior at Home	35.05%	9.28%	10.82%	44.85%
Birth Family and History	57.44%	2.84%	22.70%	17.02%
Service Concerns	80.62%	8.37%	1.76%	9.25%
Family Adjustment	28.57%	8.33%	6.55%	56.55%
Acceptance from Community	26.12%	5.22%	14.18%	54.48%

(25%), child development specialist (11.8%), doctor or medical specialist (10.4%), and school counselor (9.7%). To a lesser extent, parents also reported relying on their spouse (7.6%) and HFTC therapist (6.9%) for assistance with child development and education needs.

Health and medical issues. When faced with medical problems in their child, such as attention deficit disorder, bed-wetting, and drug exposure, parents were most likely to turn to members of their formal support system who were not directly linked with HFTC. Although one-quarter of parents stated they would seek help from doctors on health and medical issues, parents also viewed their HFTC therapist (11%), their HFTC caseworker (8.9%), their spouse (10.3%), and their best friend (7.5%) as potential sources of support for health-related problems.

Child's behavior at home. Table 2 shows that HFTC parents were most likely to seek help from informal nonagency-related resources regarding child behavior problems. Parents often selected their spouse (16.3%), best friend (9.8%), and minister (6.7%) as supportive resources. In addition, parents reported drawing upon formal agency supports, with 18.6% percent of parents choosing

HFTC therapists for help with their child's behavior at home. The HFTC family advocate (7.2%), the HFTC caseworker (6.2%), and other foster parents (7.7%) were also endorsed as sources of support, although less frequently.

Child's birth family and history. HFTC parents were most likely to seek formal agency support when confronting problems regarding their child's birth family and history. Parents reported that they would turn to the therapist (22.7%), caseworker (18.4%), and family advocate (9.9%) provided by the HFTC program for assistance with these issues. Parents also reported that they would seek support from their spouse (9.9%). In contrast to other areas of concern, parents indicated they would seek assistance from a birth relative of their child but not the child's birth parent (7.8%) to help them with issues related to their child's origin.

Agency and service concerns. HFTC parents indicated they would turn to formal agency resources when faced with problems accessing services from HFTC and from other formal service providers such as health clinics, counseling centers, and schools. HTFC caseworkers (23%), family advocates (19.5%), and the HFTC director (12.8%) received the highest endorsements in this area. Smaller percentages of HFTC parents named their spouse (8.4%) and their IDCFS caseworker (7.5%) as resources when they needed assistance accessing services.

Family adjustment. Parents appeared to rely heavily on their informal, nonagency-related network of support regarding family adjustment issues. Parents most often endorsed their spouse as the person they would seek out for support in this area (19%), followed by their best friend (15.5%), other foster parents (6.5%), and extended family members (6.0%). When parents stated they would turn to professionals for help with family adjustment issues, they were most likely to identify their HFTC therapist (12.5%) and their HFTC family advocate (11.9%).

Acceptance from the community. Concerns about community acceptance were rarely reported by HFTC parents. Parents indicated that if such concerns did arise, they would most likely seek support from their spouse (18.7%), their HFTC family advocate (11.9%), their HFTC therapist (11.2%), and their best friend (11.2%).

Frequency of Contact with Helpers

Table 3 summarizes parents' reports regarding the frequency with which they had sought help in the past from the specific potential resources that were listed. HFTC parents reported the highest levels of contact with their spouse, their HFTC family advocate, other adoptive and foster parents, HFTC caseworkers and therapists, and their best friend. Resources that were contacted only minimally by parents included the child's court-appointed guardian ad litem, CASA volunteer, attorney, former foster parents and birth relatives, respite care provider, child development specialist, and IDCFS support staff.

Perceptions of Helpfulness

Parents' perceptions of the helpfulness of particular support resources also are presented in table 3. In general, parents reported that members of their informal, nonagency-related resource network, including their spouse, parents, and best friends, were most helpful to them. Parents also considered members of their faith communities, neighbors, and extended family members as quite helpful. Of the informal agency-related resources, parents endorsed HFTC tutors as most helpful, followed by other adoptive and foster parents, grandparents, buddies, and respite providers.

Representatives of formal support agencies received high endorsements of helpfulness. HFTC therapists, family advocates, licensing staff, caseworkers, and the HFTC agency director were all viewed as very helpful. Parents' ratings of nonagency-related formal supports indicated that they found professionals such as their child's and their own (non-HFTC) therapists to be most helpful. They also rated medical specialists, child development specialists, their attorney, school counselors, teachers, physical therapists, and their child's guardian ad litem as helpful.

TABLE 3

Frequency of Contact with Helping Resources and HFTC Parents' Perceptions of Helpfulness (*N* = 12)

	Frequency of Contact		***Helpfulness Rating***	
Resource	***M***	***SD***	***M***	***SD***
Informal, Nonagency Resources				
Spouse	4.14	(1.41)	5.00	(0.00)
Extended family member	2.82	(1.03)	3.94	(0.96)
Parent	2.77	(1.31)	4.55	(0.78)
Best friend	2.92	(1.21)	4.40	(0.71)
Neighbor	2.71	(1.27)	3.93	(0.77)
Minister	2.50	(1.12)	4.15	(0.94)
Church member	2.82	(1.03)	3.88	(0.83)
Employer	1.83	(1.21)	3.29	(0.88)
Day care provider	1.44	(1.26)	3.67	(0.47)
Informal, Agency-Linked Resources				
HFTC grandparent	2.80	(1.56)	3.69	(0.82)
HFTC buddy	2.72	(1.48)	3.67	(0.75)
HFTC tutor	2.60	(1.31)	4.00	(0.63)
Child's former foster parent	2.00	(1.30)	2.73	(1.13)
Other foster parent	3.54	(1.08)	3.73	(0.61)
Other adoptive parent	3.57	(1.12)	3.77	(0.69)
Respite provider	1.50	(0.87)	3.38	(0.99)
Child's birth parent	1.44	(0.68)	2.25	(0.83)
Child's birth relative	1.55	(0.66)	3.33	(0.60)
Formal, Agency-Linked Resources				
HFTC caseworker	3.00	(1.00)	3.43	(0.70)
HFTC family advocate	3.71	(0.75)	3.65	(0.66)
HFTC agency director	2.27	(0.93)	3.29	(0.75)
HFTC licensing staff	1.94	(0.97)	3.53	(0.60)
HFTC therapist	3.00	(1.20)	4.00	(0.61)
IDCFS caseworker	1.40	(0.49)	2.92	(1.25)
IDCFS nurse	1.22	(0.42)	2.29	(1.03)
IDCFS adoption staff	1.60	(0.60)	3.20	(0.98)
IDCFS supervisor	1.00	(0.00)	2.50	(1.32)
IDCFS agency director	1.00	(0.00)	2.13	(0.92)
Formal, Nonagency-Linked Resources				
Child's therapist (non-HFTC)	1.11	(0.31)	4.00	(1.00)
Parent's therapist (non-HFTC)	1.60	(0.92)	4.00	(0.00)
Child's teacher	2.88	(1.22)	3.62	(0.73)
School counselor	2.20	(0.98)	3.67	(0.47)
Doctor/medical specialist	2.33	(1.01)	3.90	(0.56)
Child development specialist	2.00	(1.15)	3.83	(0.37)
Physical therapist	1.55	(0.78)	3.60	(0.48)
Child's guardian ad litem	1.09	(0.29)	3.50	(0.87)
CASA volunteer	1.10	(0.30)	2.00	(0.00)
Attorney	1.08	(0.28)	3.78	(0.63)

In contrast, parents assigned low ratings of helpfulness to their child's CASA volunteer and birth parents, and to the IDCFS support staff members who did not have direct responsibility in adoption services. These low ratings of helpfulness, however, may relate to limited use of these particular resources.

Unmet Needs for Service and Support

Ten of the 17 parents provided written descriptions of their unmet needs for service and support in response to the questionnaire's open-ended questions. Thirty discrete unmet needs were identified through a content analysis of these written comments. The main themes that were expressed in these comments, along with the frequency with which they were endorsed, are presented below. Because parents generated these concerns without reference to a standard list of possible unmet needs, it is likely that the reported frequencies do not represent the full scope of the parents' concerns but, instead, reflect those that are most salient or pressing.

Access to nonagency services through the adoption agency. Seven of the 30 unmet needs reflected a need for help in accessing and paying for nonagency services such as medical care and developmental/educational evaluations and services. In most cases, parents reported that they were aware of, but found it very difficult to obtain services for, a medical, learning disability, or mental health need of their child. For example, one parent requested but could not access, "an *extended* and *excellent* evaluation... of the child's learning disabilities and hyperactivity—not just a one-hour evaluation" [emphasis in original]. Another parent described the outcome when needed services were not forthcoming: "I had a heart-rending experience because I was not able to procure medical treatment for a preadoptive placement in psychological crisis. As a result, the placement disrupted."

Access to agency staff. Six of the 30 comments about unmet needs reflected difficulty in communicating directly with IDCFS adoption staff. Parents reported being frustrated repeatedly in their attempts to gain information and answers to their questions. One parent stated, "It is not that we can't turn to people for help, but it is the supreme effort to get people to react to your request—whether it be a plain 'no' or just some sort of action." The problem was also reflected in comments describing professionals representing other agencies who "do not return your calls or messages without repeated requests."

Inadequate background information. Four of the 30 comments about unmet needs related to the need for adequate background information about a child. As one parent stated, "As a parent, I have had to search for, beg for, and investigate my child's background. That [information] should be provided in a prompt and efficient manner." One parent felt that the problem was associated with difficulties obtaining such information from the agency last involved with the child: "Hope staff so far are saying 'Well, you have all you need' and are too sympathetic to the last agency."

Counseling. Four of the 30 unmet needs reported by parents involved counseling services over an extended period of time. As one parent wrote, "One of my children wanted counseling but it was limited to just three sessions. It wasn't extremely helpful." One parent further stated that the counseling should be independent from HFTC services, explaining that she should not "fear ramifications from Hope staff for 'spilling my guts.'"

Financial issues. Three of the 30 unmet needs involved financial issues. Parents felt they needed help in preparing income tax forms, a complicated process for families receiving a stipend to help support a preadoptive child in state custody. They also needed clearer information regarding reimbursement for items such as textbooks, lunches, and private school. One parent felt that his preadoptive child did not have the benefit of the resources that his other children had because the child could not be included on his insurance policy.

Trust. Three of the 30 unmet needs reflected a concern about the dual role that parents perceive that they play at HFTC: they are both recipients of supportive services and, because they receive stipends, employees. Some parents reported concerns that information shared with HFTC personnel might not be kept confidential or might be used in a less constructive manner. One parent wrote, "I'm careful about sharing with Hope staff about any problems I'm experiencing. Because Hope is my employer, I want to be a 'good parent.' Therefore, I don't share all of my problems."

Additional unmet needs. The remaining unmet needs, each of which was identified by one parent, included respite care, additional training about lifelong adoption issues, and confirmation that policies are applied consistently to all HFTC families.

Discussion

As public support for special needs adoption gains momentum, child welfare practitioners continue to seek ways to maximize formal and informal support for families adopting children who have or who are at risk for medical, educational, and emotional problems. The HFTC model arose from a desire to find new ways to provide comprehensive services to adoptive families. Several hallmark features set it apart from traditional adoption services.

First, the HFTC model regularly provides supportive resources to adoptive families on a proactive basis so that a child or family does not need to exhibit flagrant symptoms and the placement does not have to be in jeopardy before services are offered. Second, HFTC emphasizes coordination of resources. HFTC service-delivery professionals have direct and open communication with participating families and with one another through regular staff meetings that facilitate the exchange of information and updating of service delivery plans. Coordination enhances the likelihood that assistance is targeted where it is most needed and that duplication of services is minimized. Family advocates represent the needs and concerns of HFTC families at the staff meetings.* Third, HFTC recognizes that informal supports are equivalent to formal supports in terms of their importance in promoting adoption success. Informal supports, including mutual support from adoptive families, educational assistance from tutors, child care and respite by foster grandparents, and mentoring by buddies are important resources in the HFTC community. The present research indicates that participating parents believe the HFTC model has been effective in meeting many of their needs.

In comparing the descriptive results of this study with the findings of Kramer and Houston [1998] in their study of families adopting children with special needs through a more traditional program (IDCFS), it is clear that both sets of parents face similar challenges. Both HFTC and IDCFS parents reported problems regarding their child's development and education, health and medical status, behavioral problems at home, birth family and history, and obtaining needed resources and referrals. The families, however, drew upon different facets of their support systems, in different combinations, to meet their diverse needs.

Responses from HFTC parents indicate that direct access to on-site professionals such as mental health care providers, caseworkers, and family advocates was helpful in gaining access to needed resources and referrals, obtaining available information about children's backgrounds, and helping to resolve child behavior problems in the home. HFTC parents also reported being very satisfied with their nonagency formal resources, including doctors, medical specialists, teachers, and child development and educational specialists, whom they contacted for health and medical problems and for child development and educational problems. Informal, agency-based resources were also perceived to

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* Because general programmatic issues that relate to the entire set of participating families are discussed at staff meetings, HFTC parents are not invited to attend. This procedure is intended to preserve confidentiality.

be helpful. With the exception of other foster and adoptive parents, however, HFTC informal resources such as foster grandparents, tutors, and buddies appeared to have been underutilized by parents.

One interesting finding was that although parents appeared to find the informal, agency-based resources beneficial, they continued to turn to indigenous support networks. Not surprisingly, spouses were called upon for support with regard to virtually every problem reported by parents. Other nonagency-related informal resources were often contacted for help with family adjustment issues. Furthermore, parents' ratings of helpfulness for their spouse, family members, and friends were often higher than their ratings for other forms of support. The findings make clear that even when parents were provided with a community replete with supports, they still turned to their friends, family members, and faith community for help. This outcome should not be viewed as a program failure, but as the natural tendency of individuals to seek support from others with whom they have a common history. The pattern of seeking help more often from relatives and friends than from other HFTC parents might change after families have spent more time in residence at HFTC. Given that preadoptive parents regularly turn to natural support networks for help, however, it would be beneficial to include these individuals in adoption education and service planning activities.

The provision of coordinated services in a community-based program does not come without some disadvantages. Although the self-contained environment of HFTC lends itself to the provision of high levels of supports and resources, the close proximity of agency personnel, HFTC parents, and community volunteers was perceived by some parents to be an intrusion upon their family privacy. These concerns were expressed by a small number of HFTC parents, who felt they were under scrutiny by on-site professionals and volunteers. Their dual roles as recipients of services and paid employees led some parents to feel reluctance in acknowledging problems for fear of being viewed as ineffective parents and employees. Programs that offer intensive, on-site supports and services to families must balance open access to resources and respect for families' needs for privacy, autonomy, and affirmation. Future research should expressly examine the factors that foster a climate of trust in community-based programs such as HFTC.

A second concern raised by participants about receiving services from a coordinated, community-based program is that program providers have limited control over needed resources outside of the HFTC community. Similar to non-HFTC families [Kramer & Houston 1998], HFTC parents complained about insufficient access to adoption staff from the state agency that oversees adoptive placements. This lack of direct access left the preadoptive parents with unanswered questions about their children's backgrounds, adoption status, and the level of support they could expect from the state. Furthermore, several parents expressed concerns regarding their children's unmet medical, psychological, and educational needs. Because parents' access to medical and educational services other than tutoring falls outside the purview of HFTC, strong coalitions must be forged among programs; schools; medical care providers; child development, educational, and learning disability specialists; and other professionals serving families with multiple needs to receive optimal support.

Given the strengths of the HFTC model and the national attention it has received, replication of this program in other locations is quite possible. If such replication occurs, program effectiveness in other locations will need to be evaluated. Because it may not be possible to replicate the entire HFTC program in other communities, it is essential to consider whether specific components of the HFTC model can be incorporated into other programs to produce successful outcomes.

One feature of HFTC that may be particularly useful for other programs to consider is the high level of service coordination. If it is not possible to physically locate adoptive families and supportive resources in the same neighborhood as in the HFTC model, an alternate approach might be the creation of "wraparound" teams (see IDCFS [1995]). Although already used as a service approach for children in out-of-home care in Illinois, wraparound services have not been provided regularly to adoptive children and their families. The use of "wraparound" teams to serve adoptive families may offer significant promise.

The concept of wraparound services, initially designed to prevent inappropriate institutionalizations for children [Clark et al. 1996; Maynard-Moody 1994], provides a mechanism for both formal and informal service providers to come together on a regular basis to discuss a child's needs and to identify ways that coordinated support services can be best delivered. Wraparound teams are multidisciplinary and are individualized to meet the needs of a particular child and family. A wide variety of professional and community-based individuals may initiate and serve on a wraparound team, including IDCFS caseworkers, foster and/or adoptive parents, professionals from the child's school, close family friends or relatives who are invested in the child's and family's well-being, child care providers, psychologists, counselors, educational specialists, and medical care providers. Consistent with the principles of a family-centered approach, adoptive parents would have the final determination as to who was selected as a member of the wraparound team.

The opportunity to bring parents, professionals, and informal agents of support together on wraparound teams offers several advantages. First, as the present research demonstrates, many professionals and nonprofessionals play a role in supporting adoptive families, yet may lack full knowledge of the issues affecting families who adopt children with special needs. Open communication among members of a wraparound team would likely enhance the understanding that helpers have about special needs adoption, thereby bolstering their effectiveness. Second, the coordination of supportive services would help ensure that the full range of needs was being met and would minimize the likelihood of service duplication. An integration of wraparound concepts into the HFTC model would help parents feel that they have some control and authority over service provision which may, in turn, lessen their concerns about family privacy issues in the HFTC program.

Conclusion

The present research demonstrates several ways in which the HFTC model has significantly contributed to promoting the adoption of children with special needs. This research was necessarily limited by a small sample size. Although all but one HFTC family participated in the research, only 13 families were a part of the HFTC program when this study was conducted. The small sample precluded the statistical testing of hypotheses and the results that are reported are descriptive in nature. Additional opportunities may arise to replicate this research if HFTC is incorporated in other locations. Child welfare specialists and researchers will learn much about the ways that the provision of comprehensive and integrated supports can contribute to sustained adoptions by following the development of this program over time.◆

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