PUBLIC ADOPTION IN ONTARIO

Available Children and the Decision-Making Processes of

Applicants Considering Children with and without Disabilities

by

PHILIP GERARD BURGE

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ABSTRACT

In much of Canada, the number of children in child welfare care has been increasing significantly in recent years. In Ontario, Canada's most populous province, the permanent ward population doubled in size over the decade ending in 2005, according to the Ontario Association of Children's Aid Societies (Gail Vandermeulen, personal communication, January 6, 2006). Ontario law asserts that it is preferable for children who are permanent wards with no access to their biological parents to leave care via domestic adoption rather than remain in fostering arrangements (Ontario Ministry of Community and Social Services, 2000). Nevertheless, rates of adoption for these children in Ontario actually declined over the past ten years according to the former government minister of the Ministry of Community and Social Services (Marie Bountrogianni, personal communication, February 23, 2004).

The purpose of these investigations was two-fold: to profile the population of children who were legally available for domestic public adoptions while developing a theory about the decision-making processes of adoption applicants as they consider available children with and without disabilities. In the first study a representative sample of over 20% of the files of children who were permanent wards of the state on December 31, 2003 and legally available for domestic public adoption in Ontario was reviewed. Results indicated that 57.8% of children had at least one type of disability. Children with disabilities were more likely to enter care at older ages, were significantly less likely to be residing in adoption probationary homes, and have an official permanency plan of adoption than were the child wards who had no disabilities. Multivariate logistic regression analyses demonstrated that the variables most predictive of permanency plans included the age at which a child entered care.

The second study included interviewing 15 adoption applicants. Using a grounded theory approach the data regarding participants' decision-making processes were analyzed and a substantive level theory generated. A core category resulted and was labeled, gaining balance. Key categories

included commitment, persistence, and evaluation. The findings were member checked by a select

group of participants and were found to have considerable explanatory power.

CO-AUTHORSHIP

Philip Burge (i.e., Burge, P.) is the PhD candidate. The study protocols were developed with guidance from his academic supervisor Margaret Jamieson (i.e., Jamieson, M). Manuscripts A and D were co-authored by Margaret Jamieson. Philip Burge conducted or supervised the abstraction of data from children's case files and conducted all interviews and all initial coding and analyses. In manuscript A and D, all literature searches and reviews were conducted by Burge and both authors contributed to the development of the chapters. In manuscript D, both authors contributed to the analysis, interpretation of results and writing. Overall, Philip Burge was responsible for >95% of the material in this thesis.

ACKNOWLEDGEMENTS

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Highly appreciated was the support received from agency executive directors, the lead managers and directors, quality assurance personnel, and administrative staff at all 18 participating child welfare agencies which were engaged in aspects of the project. The executive directors at the following agencies have permitted to have their agency's involvement specifically acknowledged: Catholic Children's Aid Society of Hamilton, Catholic Children's Aid Society of Toronto, Children's

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LIST OF ABBREVIATIONS

ADHD   Attention-Deficit/Hyperactivity Disorder

ART   Artificial reproductive technology

CAS   Children's Aid Society

CWWA   Crown wards without access

DPA   Domestic public adoption

FASD   Fetal Alcohol Spectrum Disorder

HIV/AIDS   Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome

IEP   Individual Education Plan

LTFC   Long-term foster care

OCWS   Ontario Crown Ward Survey

ODD   Oppositional Defiance Disorder

OMCFCS   Ontario Ministry of Community, Family and Children's Services

OPR   Outside Paid Resource

PDD   Pervasive Developmental Disorders

TPB   Theory of planned behaviour

CHAPTER 1: GENERAL INTRODUCTION

The intersection of the fields of child welfare and disability is an area often neglected by

researchers (Hanley, 2002). Important research is lacking at a time when many Canadian

jurisdictions, especially Ontario, are experiencing a crisis in child welfare. This crisis is exemplified

in Ontario by increasing numbers of children with and without disabilities entering the care of the

state and remaining there for longer periods. In 2003, an additional 1093 Ontarian Crown wards, an

increase of 30% over the previous year, surpassed a two-year mark in care (Ontario Ministry of

Community, Family, and Children's Services, 2003). The crisis is also perpetuated by the significant

reduction in the numbers of children leaving care via domestic adoption or guardianship arrangements

during the past five years (Ontario Ministry of Community, Family, and Children's Services, 2002).

Disability rights and adoption advocates, such as Judy Grove, the former president of the Adoption

Council of Canada and Canada's Waiting Children program, believe that there is a high prevalence of

Ontarian children with disabilities or medical conditions who are available for adoption who have

remained unmatched for lengthy periods. They contend that this crisis disproportionately impacts

children with disabilities or medical conditions (Judy Grove, personal communication, August, 15,

2002).

Without passing judgment on the policies and mechanisms that have led to this bourgeoning

population of children in care who have subsequently become available for adoption, important and

timely questions arise about why they remain in care for extended periods. While the adoption system

regulations and procedures clearly influence the achieved rates of permanency outcomes for children,

the decisions of adoption applicants also have a major impact on the rates of adoption among these

children. What are the decision-making processes of adoption applicants who consider adopting

children with and without disabilities? An enhanced theoretical understanding of the decision-making

processes would have particular relevance to both adoption practitioners interested in recruiting

adoptive parents for children with disabilities and for those government planners revising related

social policy.

The major focus of this thesis is the decision-making processes of adoption applicants when considering the adoption of children with disabilities. Surprisingly, little research to date has focused on uncovering the decision-making journey through which adoption applicants proceed before arriving at their final decision regarding which child they will adopt. Most research addressing the adoption of children with disabilities has utilized a retrospective design (i.e., has been conducted many years after the adoption had been finalized) and focused on rates of adoption disruptions or on family adjustment.

Findings from the field of decision-making research suggest that retrospective designs may be problematic in exploring people's decision-making processes (Holyoak & Simon, 1999; Simon, Pham, Le & Holyoak, 2001). Even when study participants were asked to recall their decision-making processes immediately after making a decision, they expressed little confidence in their ability to do so accurately (Holyoak & Simon, 1999; Simon et al., 2001). Despite this, adoption researchers have drawn many conclusions about the characteristics and past motivations of those who adopt children with disabilities, based largely on interviews conducted, on average, several years after the decision was made (Coyne, 1997; Deiner, Wilson, & Unger, 1988; Franklin & Massarik, 1969a; Glidden, 1985, 1986; Macaskill, 1988). The adoptive parents' decision-making process for considering these children during the application and pre-placement period has seldom been studied or studied only partially via an examination of motives of adopters. Furthermore, the available research that has focused on the characteristics of those parents who adopted children with disabilities has limited use for gaining a theoretical understanding of the decisions to adopt these children. This is due to the exclusion from these studies of adopters who considered but ultimately decided against pursuing the adoption of children with disabilities. Therefore, these studies leave many unaddressed questions and have not contributed to the generation of a comprehensive theory of adoption applicants' decision-making processes.

Historically, the Canadian adoption process was administratively and legally formalized in most provinces by the 1920s. Adoptions up until the late 1960s were primarily of newborn infants who had been voluntarily placed under the care of child welfare authorities by their biological parent(s). Up until this time, many parents of children with disabilities were encouraged to and ultimately chose to send their children to be raised in regional residential institutions (Hamilton, 1949). Few formal community supports were available to parents of children with disabilities and considerable stigma was commonly experienced by parents who had given birth to a child with differences from the majority (Miall, 1987). Adoption of these children was almost unheard of and indeed they were considered and formally labeled unadoptable by the child welfare system. Many were placed for the remainder of their lives in large regional institutions for ongoing care.

In the last 30 years, there has been a marked movement toward the goal of community integration, that is, to keep these children with disabilities out of institutions and in their families or in the community. Yet when these children enter the care of child welfare authorities and cannot return to the home of their parents, they appear to be placed for adoption at much lower rates than are wards without disabilities (Ontario Ministry of Community and Social Services, 2000). The senior policy analyst for the relevant Ontario provincial ministry, Nancy Francis, estimated that in year 2003, a total of approximately 2,000 Ontario children were Crown wards without access (CWWA) and therefore legally available for adoption (Nancy Francis, personal communication, November 13, 2003). Well over 50% of these children may have a disability and are expected to face a reduced likelihood of being adopted, which is the preferred goal for CWWA according to Ontario's child and family legislation (Ontario Child and Family Services Act, 2000).

To better address concerns about disproportionately low rates of CWWA with various special needs entering care and leaving care via adoption, some international jurisdictions regularly gather detailed aggregate information on these children (Coyne, 1997). Many studies have concluded that children's disabilities and other special needs should be considered when recruiting and preparing adoptive parents (Brown, 1988; Chambers, 1973; Cole & Donley, 1990). The presence of disabilities

affecting a child available for adoption may have a significant influence on adoption applicants'

decision making as well as the adoption workers' views on the requisite parenting skills and other

supports of prospective adopters. Such studies have spawned pilot projects to increase adoptions of

children with disabilities or informed policy changes (Feuz, 1991; Lahti, 1982; Macaskill, 1988).

According to George Lech, the financial officer for the provincial association of child welfare

agencies, and Nancy Francis, the senior policy analyst for the relevant government ministry, in

Ontario little is known about the wards' aggregate disability characteristics and histories before or

during their state care (George Lech, personal communication, October 5, 2002; Nancy Francis,

personal communication, October 5, 2002). Likewise, there is a need for a coherent theory regarding

the decision-making processes of applicants who may be contemplating the adoption of children with

disabilities. Knowledge about both the profiles of adoptable children and the development of a theory

about adoption applicants' decision-making processes may help facilitate recruitment of adoptive

parents for these children.

1.1 Purpose

The purpose of this study is to gain a theoretical understanding of the decision-making

processes of adoption applicants when considering children with disabilities from among the pool of

Ontarian children available for adoption. Since it is assumed that children with disabilities represent a

sizable proportion of the children available for adoption it is important to study applicants' decision-

making processes when they consider the children they learn about whether they have disabilities or

not. An understanding of the prevalence of disabilities among Ontario's permanent wards without

access complements this purpose. In order to address these purposes two complementary

methodologies were employed.

First, an epidemiological approach, identifying the characteristics of the population of

children currently available for adoption, is required to fill important knowledge gaps concerning the

current context for adoption applicants. This current context is thought to influence the agency

adoption workers and the applicants. The agency adoption workers share their knowledge of the characteristics of available children with applicants during the lengthy adoption qualification and eventual matching process. This portion of the study aimed to compare children with and without disabilities who were available for adoption and investigate any significant differences in demographics, reasons for entering and remaining in care, time in care, placement details, and adoption placement efforts. Second, a grounded theory approach to adoption applicants' decision-making processes in considering children with and without disabilities offered the possibility of developing a conceptual framework to enhance our knowledge, influence changes in child welfare recruitment practices, and motivate further research. This portion included applicants who were at significant temporal and procedural points within the adoption process. The participants represented the continuum of views: from those applicants who had decided at the outset against closely considering children with disabilities to those who entered the process with such an adoption in mind, and those applicants whose views were in between. A few research questions guided the investigations.

1.2 Research Questions

The central research questions addressed were:

1 (a). What is the prevalence of a variety of disabilities among children currently available for adoption by applicants in Ontario?

1 (b). What significant associations exist among these children's disability status and demographic variables, reasons for entering and remaining in care, time in care and placement details, and the nature of permanency plans established on their behalf by their agency?

2. What decision-making processes do adoption applicants employ in considering children with disabilities available for adoption?

1.3 Organization of the Thesis and Overview of the Manuscripts

The remainder of this manuscript-form thesis is organized into two main sections. The first

section - Chapters 2, 3, 4, and 5 - is comprised of manuscripts. All manuscript chapters were

submitted to peer-review journals with a few minor modifications or were published by such journals

with minor revisions from the versions included in this thesis. Beginning with Manuscript A, an

overview of the professional literature on decision-making research generally and literature on

adoption decision making specifically is presented. Manuscript A also concludes with a brief

argument for future investigations of applicants' decision-making processes to be clearly grounded

within accurate knowledge of the profiles of available children within the jurisdiction from which

applicant participants are drawn. This manuscript is in review with the UK-based journal *Social Work*

and Social Sciences Review. The three remaining manuscripts (B, C, D) focus on the quantitative and

qualitative studies. The first of these chapters begins with a focus on profiling adoptable children. It

sets the context for the later focus on the generated theory about the decision-making processes of

adoption applicants who encounter profiles of adoptable children. Manuscript B provides the context

and an overview of the child welfare field pertaining to permanent wards without access in Ontario.

The chapter also provides a comprehensive profile of 429 permanent wards in Ontario on an

extensive range of demographic, family, and service variables. The permanent wards whose files

were reviewed for this paper were all legally available for adoption at the time of the study. The paper

provides a considerable contribution to the literature as it is the first cohesive examination of

Ontario's adoptable children available. The manuscript was published in October 2007 by the journal

Canadian Social Work (Burge, 2007b).

Manuscript C deepens the examination of profiles of permanent wards without access in

Ontario. The chapter presents literature on the determinants of mental health among foster children

and permanent wards. The findings centred on exploring variables associated with permanency plans

developed by staff in the child welfare sector. In particular, variables which relate to the two key

permanency plans (i.e., adoption or remaining in long-term care) were closely analyzed using multiple logistic regressions to shed light on key variables in predicting plans developed for the children. This paper represents the first careful analysis found in the professional literature of the mental health status of a province-wide representative sample of permanent wards in Canada. The manuscript was published by the *Canadian Journal of Psychiatry* in May 2007 (Burge, 2007a).

Manuscript D presents the theory of decision-making processes of adoption applicants derived from the grounded theory approach. The qualitative study included interviews with fifteen adoption applicants. An extensive search of the international professional literature did not uncover a similar approach to examining decision-making processes of adoption applicants. This manuscript has been submitted to the journal *The Qualitative Report*.

The final chapter of the thesis includes a general discussion of findings, their relation to the current professional literature and to the greater societal context for adoption. This section integrates the findings from the quantitative and qualitative methodological approaches. As well, this final chapter details a number of recommendations for further research, implications for professional practice and conclusions.

Appendices offer information about terms used in the thesis (Appendix I), and detailed sampling and data gathering information (Appendices II, III, IV) for readers.

CHAPTER 2

MANUSCRIPT A:

Understanding Applicants' Decision-Making Processes in Child Welfare Adoptions

Reference:

Burge, P., & Jamieson, M. (2008b). *Understanding applicants' decision-making processes in child welfare adoptions*. Manuscript submitted for publication.

2.1 Introduction

A successful adoption is widely considered to be a best practice outcome for children for whom a return to their biological parents has been legally ruled out (Barth, 1997). Yet, in recent years, many international jurisdictions including the US and Canada, have reported periods where increasing numbers of children became available for domestic adoption while the actual adoption placement rates decreased. For instance, the US state of Pennsylvania witnessed an 80% rise in available children from 1987-1997 alongside a declining adoption rate (Jones, 1999) while, in Canada's most populous province, the number of children available for adoption doubled during the decade ending in 2005 while the number of annual adoptions remained relatively unchanged (Burge, 2007a). In response, researchers and social service departments or ministries addressed such situations by commencing studies designed to identify perceived systemic obstacles at the agency or policy level and by introducing measures aimed at removing agency barriers to adoption (Coyne & Russel, 1990). Seldom has attention been directed at uncovering adoption applicant related factors such as understanding how applicants for domestic public adoption engage in the adoption process and make the numerous decisions required of them before finally arriving at the point where they have accepted a child into their homes. Understanding applicants' decision-making processes when considering children with special needs such as disabilities is especially important as reports from the US and Canada note that up to half of all children available for domestic public adoptions have special needs (Burge, 2007b; National Adoption Information Clearinghouse, 1997). Here, children's 'special needs' refers to care needs of children related to their disabilities or medical conditions.

In adoption, applicants' decision making is comprised of much more than a simple selection made from a few available children. The adoption process in many jurisdictions can span over 24 months between the date of application and the formal placement of a child in the home for a mandatory minimum period of adoption probationary status. During this lengthy period, applicants' decision-making processes include both decisions on how to portray themselves on formal applications and how to conduct themselves during multiple contacts with the agency staff members.

As well, initially and at different points throughout the process, applicants are questioned about their preferences for characteristics of hypothetical children they wish to adopt. Later they are required to make decisions about whether to be short-listed for in-depth consideration of a specific child, and, finally, they are asked to decide whether to accept a specific child into their home. Table 2.1 lists some of the common adoption decisions required of applicants at various time phases.

Table 2.1

Common decisions required of applicants during the adoption process

Time Phase	Description of commonly required decisions: Whether …?
Early	To gather information about adoption
	To make a formal application to an agency
	To accept the anticipated or actual waiting period and remain in the process
	To hire a private home study social worker or await for assignment from an agency
	To attend the mandatory education sessions
	To accept the timing of the agency's sessions or seek alternatives
	To complete the required paperwork (preferences form, personal statements, criminal check etc.)
	To inform family members and friends about the adoption application
	To select personal character references from among friends or acquaintances
	To verbalize to workers or partners their motivations and child characteristic preferences
Middle	To accept or challenge the assignment of the specific home study social worker
	To accept the anticipated or actual waiting period and remain in the process
	To provide all needed information to the home study worker
	To ask question about eligibility or chances of succeeding at adoption
	To ask about the likely time frame for adoption and receiving any child profiles
	To verbalize their child characteristic preferences / to change any preferences already communicated
Late	To accept the anticipated or actual waiting period and remain in the process
	To change any child preferences already communicated
	To specify the preferred mode of communication of child profile materials
	To be short listed for a given child profiled
	To moderate the degree of their emotional investment regarding specific children profiled
	To see a photo or not; to see the photo while considering other information or to only see a photo after a decision to meet the child has been made
	To visit with an available child
	To ask questions about a child's characteristics to the worker, foster parent or child's doctor
	To involve family members in discussions about a specific child's profile
	To contact the worker to request information about the meaning / impacts of delays or histories
	To contact the worker and advocate for more profiles or a briefer wait for subsequent profiles
	To determine if a child fits into the existing family arrangement
	To decide if the child's assumed potential or characteristics fit into the applicant's or family's expected life pursuits
	To determine if the known or assumed accommodation needs of the child are acceptable
	To continue with subsequent visits with a child
	To request to have time alone with the child
	To plan specific activities to do with the child
	To have the child on an overnight visit
	To accept the child on adoption probation

This paper is concerned only with domestic child welfare adoptions and adoption seeking, specifically, adoptions by approved applicants who did not previously know the child and who wish to adopt from a child welfare agency within their own country. Adoption can be defined as the official legal transfer of all parental rights and responsibilities that a biological parent has to a child to the adoptive parent(s). The children in these instances usually become available when their biological parents lose custody due to confirmed maltreatment of the child or following the parents' voluntary relinquishment to the child welfare agency and the subsequent agency and legal determination that the child's best interest is to be adopted.

If social scientists are to lead the way in informing practice in the adoption field, then research concerning adoption applicants' decision-making processes is necessary. This paper aims to first review the research on decision making focusing on theories and concepts which are deemed by the authors to be relevant to the area of adoption decision-making processes of applicants. Next, a review of adoption research related to decision making is presented. The paper concludes with a synthesis of these topics and recommendations for further study aimed at enhancing our understanding of adoption applicants' decision-making processes.

2.2 Decision-making Research

Decision making as an area of research inquiry has been pursued for many decades by researchers from diverse disciplines (e.g., commerce, mathematics, medicine, philosophy, psychology, sociology) resulting in multiple definitions, concepts, and theories. In psychology, decision making usually focused on the individual and was primarily studied in two separate fields each using different methodologies (Betch & Haberstroh, 2005). Classic judgment and decision-making research has been rooted, since the fall of behaviourism in the 1950s, in utility theory. In utility theory researchers study deliberative decisions by typically employing the gambling paradigm. Laboratory participants are confronted with novel or one-shot tightly-structured decision problems with pre-determined alternatives leading to a limited number of outcomes. In the 1990s another group of researchers (i.e., Naturalistic Decision Making researchers) began focusing on the study of routine

or recurrent decisions. They used fieldwork versus laboratories and often included professionals as participants (e.g., surgeons, aircraft pilots) who, as part of their jobs, confronted making 'numerous high-stakes decisions under severe contextual constraints' (Betch & Haberstroh, 2005, p. xii). Attempts to integrate isolated theories and concepts which were developed in these separate fields have become more widespread only recently (Betch & Haberstroh, 2005)

For the purposes of this paper we use Tallman and Gray's (1990) definition of a decision as a consciously chosen outcome, which flows from a decision-making process. Essentially, an individual's decision is an outcome of facing a non-routine situation, with a degree of uncertainty and risk, where several alternative courses of action are possible (Tallman & Gray, 1990). Hastie (2001) further contextualizes decisions by defining decision making as, '…the entire process of choosing a course of action' (p. 4). Decision-making processes encompass all of the factors that motivate the decision maker to consider a course of action, sustain the idea, and select next steps based in part on expectations of the outcome.

Indeed, motivation is the key theoretical construct underpinning many theories of human decision making because 'motivation is the process whereby goal-directed activity [such as decision-making] is instigated and sustained' (Pintrich & Schunk, 1996, p. 4). Further, Geen (1995) notes that motivation refers to the initiation, direction, intensity, and persistence of human behaviour.

To date, the main focus of research on decision-making processes has been on understanding how people weigh their various goals and expectations in choosing among alternate courses of action (Hastie, 2001); the utility approach. As well, a number of macro level sociological contributions to the study of decision making have pointed to the ways in which decisions are shaped and influenced by a particular phase of an individual's personal development, trends in his/her society, and other historical events. The moment of decision by an individual, 'may be considered the microcosm which brings together all of the social forces that propel and channel social action' (Tallman & Gray, 1990, p. 429) and therefore no decision, 'can take place free of constraints of historical events, situational demands, and individual capacity' (Tallman & Gray, 1990, p. 418).

Numerous theories of decision making or closely related theories (e.g., theory of reasoned action, theory of planned behaviour [TPB], goal pursuits) may be applicable to the decision-making processes of adoption applicants and some of these, including goal pursuits, self-completion theory, and TPB, are briefly described below.

2.2.1 Theories

Goal Pursuits and Self-Completion Theory.   The work by Gollwitzer and colleagues (Brandstatter et al., 2001; Gollwitzer & Brandstatter, 1997) on goal pursuits highlights the importance of developing self-regulatory strategies (i.e., approaches to attempt to achieve one's goals) that they refer to as implementation intentions. They envision the pursuit of a goal as encompassing four phases: pre-decisional, pre-actional, actional, and post-actional. The development of implementation intentions is postulated to be a key bridge between a person moving from a pre-decisional to a pre-actional phase. They found that research participants relied on habit and routines in achieving easy to implement decisions toward achieving goals. Pursuit of difficult to implement goals was more likely if the participant had developed specific implementation intentions (i.e., a plan to act). Implementation intentions, such as conscious specific plans, worked to prime participants for recognizing situations which might allow acting on goals to which they had already committed (i.e., the immediacy effect; Brandstatter et al., 2001).

Self-completion theory research finds that people usually hold a few major self-defining goals and valued identities (e.g., being a parent). The theory builds on the notions from motivational theories which posit that human behaviour is often driven by the goal of satisfying needs. In experimental laboratory conditions, when participants encountered challenges to their self-defining goals, they expressed feeling incomplete and were seen to engage in compensatory actions to restore their sense of identity, such as trying immediately and arduously to prove their abilities or seek reassurance from others (Gollwitzer & Kirchhof, 1998).

The Theory of Planned Behaviour.   TPB is the most validated and extensively researched of the psychology models seeking to predict behaviour according to Bandawe who conducted an

extensive literature review (as cited in Townsend & Dawes, 2007). Ajzen and Fishbein (1980) developed the theory to assist with the prediction of the probability of people performing behaviours in circumstances in which they did not have complete volitional control. TPB posits that intentions are a key ingredient in motivation toward engaging in a particular behaviour. Their framework outlines three independent conceptual determinants of intentions to perform a behaviour: attitudes toward the behaviour, social norms regarding the behaviour, and the person's perceptions about the degree of personal control over performing the goal (Ajzen, 1991). In Ajzen's (1991) overview of numerous TPB studies by researchers worldwide, he found support for two of the determinants in his model. Predicting intentions was indeed significantly influenced by participants' attitudes toward achieving the specific goal and by their perceived degree of control over actually achieving it, whereas the impacts of social norms were not a significant predictor. It should be highlighted that TPB studies do not link degrees of intentions to perform a behaviour with actual outcomes of embarking on the behaviour under study.

A few of the decision-making concepts found in the decision literature have potential relevance for adoption decision-making processes and for enriching our understanding of this area.

2.2.2 Related Concepts

Coherence and Confidence. Holyoak and Simon (1999), studied participants' integration of multiple inferences (i.e., propositions or statements) during numerous experiments on decision making related to a complex legal case. Their key finding was that as a decision maker progressed toward a final decision, his or her assessments of inferences increasingly spread further apart and only those assessments supporting the chosen decision strengthened, whereas the strength of those supporting the alternative waned. Simon et al. (2001) proposed that this process seemed to be bi-directional. Specifically, decision maker's consideration of information provided to them resulted in progression toward a decision (i.e., one direction) while they almost simultaneously and necessarily looped back (i.e., the second direction) to re-consider and ultimately alter earlier assessments in order to build coherence toward the chosen decision (Simon et al., 2001). This process is similar to

cognitive dissonance theory in its concept of post-decision dissonance (Aronson et al., 2001). Perhaps as a related phenomena, other researchers have noted the tendency for decision makers to stop processing new information from their past experiences or current dilemma once their preference for a decision alternative has surpassed a threshold and, in effect, been chosen (Johnson & Busemeyer, 2005). Simon et al. (2001) found that 'once a decision was made, participants had difficulty recalling the assessments that they made prior to making their decision' and suggested that reaching the point of making a final decision tended to 'render earlier states inaccessible' (p. 1250). Furthermore, participants in their studies expressed a high degree of confidence in the correctness of their decision regardless of which of the two alternatives they selected. The researchers suggested that, as an inherent mechanism of decision making, participants had attempted to differentiate their decision from the other alternative to consolidate their decision and to develop a high degree of confidence in their selected response. Simon et al. concluded that decision-making processes could be driven by many personal goals and, in their experiments, primarily by the goal to be accurate.

Goal Gradients. The concept of goal gradients holds that as commitment to a final decision draws closer, attention to the expected consequences of the decision heightens (Busemeyer et al., 2000). Busemeyer et al.'s laboratory experiments demonstrated that subjects were more likely to readily enter into the preliminary phases of entertaining or considering a decision when the final decision was not required immediately and when consequences were not imminent. As the point of a final decision grew near, potential negative consequences held more weight than positive consequences and the approach to the decision slowed. This finding has been used to explain the common observation that decision makers often make last minute reversals from their earlier stated intentions (Busemeyer et al., 2000).

Values. Verplanken and Holland (2002) examined the motivational properties of personal values and their relationship to behaviour. They defined values as, 'conceptions of desirable ways of behaving or desirable end states' (p. 434). The authors noted that values may form important ingredients of a person's sense of identity and self-concept. They suggested that an individual may

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hold many values to varying degrees and that a small subset of a person's values may be strongly held and form the basis for moral and ethical rules of conduct. After conducting numerous laboratory studies, Verplanken and Holland (2002) concluded that when subjects strongly held a value, and the value was activated or primed in some way, his or her decision-making process was measurably influenced toward expressing that value behaviourally. This was not the case when a value was not central to the person or was not activated. These findings seem to support those from self-completion theory research noted above.

Decision Rules Among Couples. In attempting to determine how competing values of each member of a couple influence the couple's decision-making processes, marital researchers have observed patterns which impact decision making; a phenomena often noted in various areas of decision research and often referred to as decision rules (Corijn et al., 1996; Thomson, 1990). Thomson (1990) described three rules identified by a number of marital researchers which were found to commonly influence which member of a heterosexual couple was ceded the dominant role in decision making for the couple; sphere of interest rule, patriarchal rule, and the power rule. These rules related to spouses' views on gender roles. As one example, the sphere of interest rule suggested that if a decision category, such as whether to plan a pregnancy, is agreed to fall within the sphere of control of the female partner then her wishes would more likely dominate. While the concept of decision rules was supported by Corijn et al., (1996) they found that many subtle factors affected decision rules. For instance, these authors noted that determining the timing of the birth of a first child was heavily influenced by two key variables which were largely unrelated to gender roles, education levels and religions of spouses, and these variables were mediated further by various socio-demographic factors (Corijn et al., 1996).

While literature on decision making is not always linked to an overarching theory, the adoption literature related to decision-making processes has focused primarily on aspects of motivation, the influence of emotions, and TPB, and these are discussed below.

2.3 Adoption and Decision-making Research

To date, the field of adoption has garnered significant research attention with perhaps the most heavily researched areas focusing on the motivations that bring applicants to select the route of adoption generally (Daly, 1989; Daly, 1990; Hoffmann-Riem, 1990), post-adoption adjustment for adopters and their family members (Franklin & Massarik, 1969b; Glidden & Johnson, 1999; Groze, 1996b; Hoffmann-Riem, 1990; Kadushin, 1967, 1970; Levy-Shiff et al, 1990, Rosenthal & Groze, 1994; Rosenthal et al, 1988) and a variety of systemic variables which have been found to affect adoption placement decisions of agency staff including agencies' suitability criteria regarding applications of adoption applicants (Barth, 1992; Hamilton, 1949; Westhues & Cohen, 1990; Sachdev, 1984; Speirs & Baker, 1994), views about the benefits of placing children with ethnically or racially similar applicants (McRoy, 1994), and the effects of negative attitudes held by adoption workers towards the adoption of children with disabilities, and other related procedural obstacles (Coyne & Russel, 1990; Russel & Coyne, 1989). However, following extensive searches of the professional literature using multiple search engines and key words, the authors uncovered very little research directly concerning the decision-making processes of adoption applicants. This topic has only been studied indirectly and retrospectively from either a macro level perspective, or with the objective of creating profiles of recent adopters of children with various characteristics. Only a few studies actually involved applicants and addressed their decision-making processes. These studies are included in some of the following sections.

Adoption Motivation

Macrolevel / Sociological influences. Historical and social forces on adopters' motivations have been studied and focus attention on macro level influences posited to have influenced applicants in their motivations and decision making generally. Hoksbergen (1998) examined generations of adopters from western countries over the past century. The current generation, encompassing adopters from 1985 to the present day, was labeled the materialistic and realistic generation. According to Hoksbergen, a key influence on the current generation is the increasing degree and availability of

professional and scientific information about the apparent psychological challenges to families' and

adoptees' long-term adjustment to adoption, as well as a recognition that nurture cannot necessarily

predominate over nature. Hoksbergen argues that idealism gave way to adopters and adoption

professionals holding more realistic expectations for adjustment and outcomes in both domestic and

international adoption. Casler (1995) posits that, in recent decades, an intrinsic view of the value of

children defined by children being appreciated for merely existing, and being conferred various rights

or entitlements has been dominant, displacing a sentimental view. Casler suggests this makes

completely obsolete in western society the earliest notions described as an economic view of the

value of children (e.g., the gains which can be realized from a child's labour).

Categorizing motives to parent or adopt.   In the late 1960s and early 1970s, Rabin and

Greene (1968) and Hoffman and Hoffman (1973) gathered data and proposed categories for parenting

motives. Rabin and Greene (1968) postulated the existence of four distinct motivation categories for

parenting children - altruism, fatalism, narcissism, and instrumentalism - while in an unrelated paper,

Hoffman and Hoffman proposed nine categories (including economic utility; expansion of self; adult

status and social identity; primary group ties). In the 1970s, two articles reported on the development

of a survey instrument to test applicants' motives to adopt (Lindholm & Touliatos, 1976a, 1976b) but

no subsequent evidence could be found indicating that it had ever been used with applicants.

Motives or reasons for dropping out of the adoption process have seldom been studied. A

Canadian pilot project aimed at improving the rates of adoption of children with special needs

reported that many applicants subsequently dropped out of the adoption process (Feuz, 1991). One

study was found focusing on potential applicants who had contacted agencies enquiring about

adoption (Wallis, 2006). While 46% of the 245 enquirers in this English study went on to begin the

adoption process, respondents who did not noted dominant concerns including the lack of timely

agency response to their inquiries, their disinterest in adopting from the pool of available children

whose needs they had learned about, and their own perceptions that their resources (e.g., income and

housing) were deficient and that supports from agencies would be inadequate (Wallis, 2006).

Profiling adopters of children with disabilities to uncover motivations. Perhaps because of the abundance of children with special needs available for adoption in the past few decades, a number of US and UK studies have focused on shedding light on the profiles of applicants who decided to adopt such children. Franklin and Massarik (1969a) retrospectively studied adoption adjustment of families of 314 children with disabilities adopted between 1950 and 1960. Adopters of these children appeared to be less well-educated and of lower socio-economic status than adopters of control group children who had no disabilities. Macaskill (1988) reported on her UK follow-up study conducted six years after an original 20 families had adopted a total of 23 children with disabilities. Several families, at follow-up, were seeking a second or third child with disabilities often with a greater degree of accommodation needs. After studying approximately 42 adopters who had adopted on average 25 months previous, Glidden (1985, 1986, 1992) suggested two provisional profiles for groups of typical adopters of children with intellectual disabilities. The first group was comprised of couples who already had two or more biological children and were hoping to expand their family. These adopters were: "1) usually familiar with handicap; 2) not as highly educated as other adopters; 3) experienced child rearers; and 4) frequently motivated to adopt a handicapped child specifically" (Glidden, 1986, p.135). The second group was comprised of couples who had experienced infertility and, in many cases, had undergone trials of unsuccessful fertility treatments. These infertility experiences were associated with a sense of urgency to adopt. This group also had greatly widened their views of acceptable characteristics of children during the adoption process. This second profile is consistent with findings from a subsequent study by van Balen et al. (as cited in van den Akker, 2001) of 131 infertile couples who overwhelmingly opted to explore fertility treatments and some of whom only much later considered adoption. These researchers noted that the motivations of fertile adopters tended to be altruistic, whereas those of infertile adopters tended to be more instrumental, focusing on their need for a child.

Casler (1995) studied 104 applicants or recent adopters of children with special needs, which were not exclusively defined as disabilities, using a battery of rating scales including scales of

personality, scales of value statements about children, and questions about characteristics of preferred children. Casler (1995) found that the overwhelming majority of respondents ranked child characteristics in the following descending order of preference: same race babies or infants; slightly older but healthy children; healthy children of sibling groups or ethnicities different from the adopters; and lastly, children with disabilities. Similar findings on preferences were reported by Brooks (1992). Casler (1995) found that the most commonly endorsed motivation statements regarding motivations to adopt related to the intrinsic (i.e., inherent) value of children. As hypothesized, the author found a slightly higher tendency among adopters of special needs children to endorse these intrinsic items over sentimental value items (i.e., items measuring adopters' needs which the child was expected to fulfill).

It should be noted that two recent studies' titles suggest they concern ratings of adoption applicants' preferences for children. Instead, the studies were devised to test the hypothesis that facial cues indicative of poor health in photographs of infants and children negatively influence responses toward them of study participants; none of whom are reported to be adoption applicants (Volk, Lukjanczuk & Quinsey, 2005; Waller, Volk & Quinsey, 2004).

Adoption Decision-making Processes and Emotions

Using a sociology of emotions perspective and the grounded theory qualitative approach, Daly's work highlighted the role of power differentials and emotion in decision-making processes of applicants (Daly, 1989). He studied anger experienced by prospective adoptive parents by interviewing 74 couples recruited from a fertility clinic and from two adoption departments of child welfare agencies. He contended that a structural power imbalance existed for adoption applicants, many of whom had already undergone a similar experience with infertility services. This imbalance was exemplified by 1) the adoption agencies' control of the timing of the multistep process, 2) the agencies' authority to determine the applicants' suitability to adopt based on highly personal evaluations and 3) the resultant dependency of applicants on these staff members. In order to regain control of their parenthood goal, these applicants were first required to relinquish control to fertility

experts and later to adoption experts. Dependency relationships were postulated to be perfect

breeding grounds for anger and resentment, and Daly (1989) argued that these pervaded applicants'

relationships with agency staff.

The Theory of Planned Behaviour (TPB) and Care-giving Intentions

One study was found which directly applied TPB to intentions to adopt or foster children.

Townsend and Dawes (2007) employed the TPB to examine aspects of the decision-making processes

of potential substitute caregivers of children orphaned by HIV/AIDs in South Africa. The

investigators followed recommended steps for survey instrument design proposed by the TPB

creators. This involved conducting a pilot study with 14 participants, to determine the key variables

related to each of the three TPB concepts (i.e., attitudes toward the behaviour, subjective norms, and

perceived behavioural control). Each of these was studied as a determinant of intentions to care for

such a child. The final survey instrument included 14 questions. All questions related to the three

proposed determinants, as is consistent with TPB research; attitudes toward caring for such a child,

the influence of respected others (i.e., subjective views of social norms), and the effects of their

perceived control over decisions to proceed to care for such a child. Participants indicated their

response to most items on a 5-point scale indicating very negative to very positive endorsements of

items. A single *Yes-No* question about their actual intention to care for the child (e.g., 'I would be

willing to care for the child described in the scenario…') was also included. The full study included

completed postal surveys from 166 existing adoptive and foster parents (70 and 96 respectively) who

were involved with child welfare agencies or were subscribers to a newsletter. These numbers

represented a response rate of 19%. Approximately half of the participants received a version of the

survey assessing their willingness to care for a hypothetical child orphan who was HIV-negative and

the other half concerning a child orphan who was HIV-positive.

The authors concluded that their results confirmed the potential of the TPB model in limited

respects. Overall the three model components appeared to significantly predict intentions to care for

the hypothetical children. However, when results for each group of the children (HIV-positive and

HIV-negative) were separated, no component contributed significantly to intentions to care for the HIV-positive child. Furthermore, contributions of each determinant in the combined sample were difficult to clarify and the only significant contributor to the overall intention to care for the HIV-negative child was perceived behavioural control (Townsend & Dawes, 2007). A post-hoc factor analysis revealed a lack of discriminant validity for the postulated three TPB components because attitudes items and social norms items loaded onto the same factor while perceived personal control loaded onto a second factor irrespective of the child's HIV status. Analysis also showed that respondents holding positive views toward caring for the HIV-negative child seemed to be altruistically motivated and highly child-centred whereas respondents' favourable views toward the HIV-positive child were negatively correlated with beliefs about the potential to incur financial costs and placing themselves and their families at risk of acquiring the infection. The authors recommended that, in future research, participants own beliefs about caring for the child could be measured separately and not combined with other variables. Simplifying the scoring formula in this way would help to refine studies of TPB in this population.

2.4 Discussion

2.4.1 Challenges in Decision-making Research

Numerous challenges to the development of decision-making theory have been identified and described by the proponents of decision research and can inform the future study of decision-making processes in adoption. Some of the challenges relate to the lack of research attention paid to certain areas and to limitations in; study designs, measurements used, data analysis, and to the generalization of findings. For example there has been a lack of focus on the effects of a decision maker's emotional states on his or her decision-making processes (Betsch, 2005; Busemeyer et al., 2000). As well, there has been an over emphasis on researching the final decision versus the process in arriving at a decision (Godwin & Scanzoni, 1989). Though TPB has been widely studied for its ability to predict behaviours the model uses intentions to act versus actual actions as its main outcome. This

focus in TPB leaves the link between self-reported decisions to act and actual actions largely unexamined.

Measurement challenges include difficulties in measuring a decision maker's internal weightings of costs, benefits, and personal values related to their goals in given situations since these have relative and not absolute value (Emerson, 1987, as cited in Tallman & Gray, 1990; Hastie, 2001). It is assumed that these measurement and study design challenges are amplified when there are sequences of linked decisions and outcomes and when the realisation of goals for decision makers is distal (Hastie, 2001; Tallman & Gray, 1990). For instance, Simon et al. (2001) have found that research participants in laboratory decision-making studies have reported difficulties in accurately recalling their decision-making processes even just moments after making the decision. Finally, regarding research on couple decision making, Thomson (1990) noted that attempting to access a couples' usual decision rules required observation as well as self-report and that the endeavour was fraught with design and measurement challenges. Furthermore, as noted, there were the encountered problems with survey design and data analysis in the care giver intention TPB study.

These numerous challenges affect the external validity of the findings of several studies. Many investigators have noted the dominant tendency of decision-making research to be concerned only with and be applicable only to simple decisions between two or, at most, three relatively simple alternatives (Hastie, 2001; Roe et al., 2001; Tallman & Gray, 1990). Not surprisingly, the generalizability of laboratory-based studies' results is limited and only 'potentially applicable' to real life decisions (Roe et al., 2001, p. 371). Given all these challenges cited by decision research experts it is notable that after years of conducting research aimed at the development of decision theory Busemeyer et al. (2000) notes, 'very little is known about the principles of multistage decision making' (p. 530).

2.4.2 Limitations in Related Adoption Research

A thorough review of the literature reveals that the decision-making processes of adoption applicants have garnered little direct research attention to date. Limitations in the existing research

literature are widespread and relate to problems with samples drawn, measures used, procedural and design inadequacies and statistical analysis shortcomings. By far the greatest body of related literature has examined the past decisions of adopters, noted the characteristics of children selected, and described profiles of the adopters and their postulated or reported motivations. The contribution of these retrospective studies is restricted by involving only post-adoption participants, by failing to focus on decision-making processes directly and, by related obstacles in designs wherein significant temporal lags in gathering information occurred. To date there also has been almost no concerted attention directed at applicants who withdraw at different stages of the adoption process though it is an area of high interest to social workers in the field (author's unpublished raw data), and could shed considerable light on decision-making processes. Even Wallis's (2006) study of adoption enquirers failed to gather detailed information about enquirers' decision-making processes. Concerns regarding the use of specific measures and statistical analyses problems were also noted. For instance, contributions to our knowledge base from Casler's (1995) study of applicants and recent adopters was restricted by the use of non-validated measures, that did not control for 'social desirability' biases in scales, and having low statistical power. Also, when Townsend and Dawes (2007) carried out their pilot study surveying 14 female adopters and foster parents, the pilot questionnaire was tightly designed to solicit only information that would assist with the selection of the key sub-categories of the three components of the TPB model. The pilot study did not encourage participants' to identify other potentially important factors which interviewees might have deemed influential to their intentions (Loraine Townsend, personal communication, October 18, 2007). By casting their lens narrowly on items related to their selected model components an opportunity to have potential adopters identify other factors, possibly ones of greater influence, for potential study was missed by the researchers. Finally, approaches such as TPB, which measure and aim to predict intent but do not track subsequent actions of potential applicants, will likely prove of limited value in informing child welfare adoption practice or policy.

In summary, the research to date, with few exceptions, has been at best descriptive and therefore has not significantly contributed toward building explanatory theories of applicants' decision-making processes.

2.4.3 Synthesizing Decision Making and Adoption Research

Existing studies on the motives of adopters of children from macro and sociological perspectives suggest that perhaps the adopters who eventually adopt a child with special needs form an extremely committed subpopulation of adopters. The notion of a committed subpopulation appears to be supported by the consistent US and UK research findings of low rates of disruptions in adoptions of children with special needs and overwhelming benefits and positive outcomes in the adoptions of such children (Franklin & Massarik, 1969b, 1969c; Glidden, 1985, 2000; Glidden & Johnson, 1999, Groze, 1996a, 1996b; Macaskill, 1988; Mason et al, 1999) when compared to other children. Even so, a considerable percentage of children with special needs typically remain unmatched for adoption (Burge, 2007b), and, along with the recent increase in popularity of international adoptions, the vast majority of adoption applicants appear to have at least ultimately decided, if not from the outset, against accepting domestic children with special needs.

Daly's (1989) Canadian work highlighting the role of emotions such as anger in the decision-making processes of applicants was the only study found that employed a qualitative approach. The generalizability of these findings (i.e., explanatory power - in grounded theory terms) may be primarily limited to the specific adoption context found in Canada in the late 1980s. This period was especially characterized by a post-WWII over abundance of baby boom-aged adoption applicants at a time when there was a lack of adoptable babies in society and a hegemony of control of the adoption process by child welfare agencies as evidenced by both a relative inaccessibility to privately contracting social workers to conduct home studies and the unavailability of the international adoption route. As societal attitudes were relatively negative toward accommodating children with disabilities in community settings it is not startling to read reports of widespread disinterest in the adoption of available older children and children with special needs. Accordingly, these factors

resulted in many adoption applicants waiting on child welfare agency wait lists for several years (e.g., 4-6 years (Daly, 1989)). Nevertheless, Daly's findings suggest that wherever similar high degrees of dependency of applicants on adoption workers or agencies are found, applicants' feelings of frustration and anger, whether expressed directly or indirectly, are likely to be common ingredients impacting adoption decision making. Indeed Daly's findings concerning expressed frustrations as a partial consequence of applicants' dependency experiences meshes well with the emphasis in TPB on perceived behavioural control as one of three key components. In theory, a low sense of perceived control over the ability to intend to successfully adopt may act as a constraint on applicants' perseverance within the lengthy adoption process.

Applications from goal pursuit and self-completion theory research may be relevant to the range of decisions made by applicants throughout the adoption process. When adoption applicants hold strong implementation intentions their determination to persevere and their compensatory efforts may be bolstered when they encounter perceived barriers. When applicants' implementation intentions are primed, as may be the case as they make extensive and lengthy preparations for addressing the matching period in the adoption process, they may respond quickly when an expected situation arises requiring one specific decision amongst a few anticipated alternatives.

If Simon et al's. (2001) research on coherence and confidence, which postulated not only the decision maker's experience of bi-directional considerations, tendency toward one coherent decision on a given question and development of confidence in that selection, is applicable to decision-making processes of applicants then one may predict various related findings in future research. For example, studies on applicants' decision-making processes that include participants only after an adoption has occurred will be unlikely to uncover accurate reports of the process prior to adoption. Adopters will be unlikely to mentally access, recall, and express their bi-directional steps once they have finalized their decisions. Even if research is conducted during the process with active applicants, the adoption researchers should expect to encounter high degrees of confidence expressed by applicants on

individual decisions taken. This will likely also apply to applicants who have recently accepted a child into their home for the purposes of adoption.

Further research into couple decision-making processes may find that one member of an adoption applicant couple may carry more influence in decision making based on any number of conscious or unconscious rules (i.e., the sphere of interest) but researchers will have to be aware of the many subtle factors intersecting the notion of decision rules as noted by Corijn et al. (1996). Researchers of this concept may need to sample many couples who are similar on key variables (e.g., education levels, religiosity of spouses, and other socio-demographic factors) and remain highly cautious regarding conclusions about the generalizability of findings to other groups of couple applicants.

An interconnection between the concepts of values and goal gradients seems of potential relevance to many applicants' decision making. While the relation between strong motives and positive values toward adopting certain children initially seems supported by research aimed at profiling adopters and their motives (Franklin & Massarik, 1969; Glidden, 1986, 1992), all of this research was conducted retrospectively. Furthermore, the concept of goal gradients may best explain why many applicants withdraw from the process of adoption before its conclusion. As commitment to a final decision draws closer, attention to the expected consequences of the decision heightens (Busemeyer et al., 2000). Adults may be relatively quick to apply to adopt in part due to their values and the distal ultimate decision point. They may only later realize the major life commitment required and its likely impact on their daily lives; with the potential negative consequences holding more weight than positive consequences. It can be hypothesized that the detailed orientation provided by agency staff concerning the characteristics of the children available, including the high proportion who have special needs, simply affords applicants opportunities to learn and become more realistic about their abilities and interests. With regard to perseverance in the adoption process, perhaps it is a lack of control over the adoption process, as highlighted as a key variable in TPB and described in adoption by Daly (1989), which is unacceptable to many of those who inquire or are initially

applicants, including those who initially spent years unsuccessfully engaged in fertility treatments.

Furthermore, perhaps it is holding and attempting to satisfy a strong central value, even a self-identity

as noted by Gollwitzer and Kirchhof (1998), to adopt or altruistically, to save a certain child, which

offsets any perceived negative impacts and which propels some applicants forward in the adoption

process. Nevertheless, it remains untested whether values alone will provide measurable clues to

uncovering that which sustains applicants within the lengthy adoption process.

  Finally, Hoksbergen's (1998) sociological theory identifying the current applicants as part of

the materialistic and realistic generation suggests that accessing information about available

children's special needs (e.g., disabilities) and related attitudes toward disabilities may influence the

decision-making process of adopters. It further suggests that today's applicants may tend to recognize

the intrinsic worth of a child (as argued by Casler, 1995), seek out specific information on the nature

of a considered child's condition and level of any required special care, and hold realistic

expectations about the likelihood that conditions may persist.

2.4.4 Directions for the Future Study of Decision-Making Processes in Adoption

  While it is surprising that the study of applicants' decision-making processes has been largely

ignored to date, the field of adoption remains in great need of theories to help guide future child

welfare practice and policy in support of recruitment and facilitation of adoptions. It will not likely be

useful to study adoption applicants in laboratory settings using the narrowness of the gambling

paradigm. Our theories must recognize and explain the complexities of the numerous real-life

experiences of applicants who are regularly faced with multiple decisions (e.g., see Table 2.1) with

each decision having many potential outcomes and the process occurring over a multiyear timeframe.

Given the existence of the numerous theoretical knowledge gaps and methodological challenges in

decision-making research in general, and the lack of specific attention paid to the decision-making

processes of adoption applicants to date, support is lent to examine these processes using novel

approaches. Furthering our understanding of decision-making processes in adoption will require

investigations along multiple pathways. Both qualitative and quantitative studies, and mixed

methodologies, can contribute to emerging theory. Both prospective and cross-sectional research will be needed but a key goal must be to develop explanatory models for decision making observed to occur among participants who are actually adoption applicants while within the adoption process. The grounded theory approach is one such systematic approach which appears to offer high potential to discover theory related to applicants' decision-making processes (Creswell, 1998; Julie Corbin, personal communication, August 26, 2003).

A key question in adoption recruitment concerns the impact of applicants' knowledge and beliefs about available children on their decision-making processes. For years agency staff have wondered how best to present information about the characteristics of their available children. In order to address this area it is imperative that any future study of applicants' decision-making processes include ample description and profiles of the actual characteristics of the population of adoptable children within the jurisdiction from which applicant study participants are drawn. Awareness of these population characteristics will allow readers to better assess the external validity of findings to multiple jurisdictions. This approach of describing the population of available children is also consistent with utility theory where enhanced knowledge about the potential goals, expectations and outcomes available in decision making aids in theorizing. Finally, a focus on decision-making processes should also be complemented with knowledge gleaned from applicants who withdraw at different stages of the process. These applicants can likely inform us of several motivations, values and obstacles, whether personal or systemic, which influenced them.

Conclusion

Our examination of the adoption and decision-making research literature demonstrates the significant gaps in the combined literature and suggests a variety of potential directions for further research by social scientists. The ongoing social policy crisis in many jurisdictions related to the joint challenges caused by increasing numbers of children becoming and remaining available for adoption and inadequacies in recruitment in adoption contribute to the urgency to addressing this knowledge void.

CHAPTER 3

MANUSCRIPT B:

The Ontario Crown Wards Survey: Profiles of adoptable children

Reference:

Burge, P. (2007b). The Ontario Crown Wards Survey: Profiles of adoptable children. *Canadian Social Work, 9*, 8-25.

3.1 Introduction

In most Canadian provinces and territories, the number of children in child welfare care has been increasing significantly in recent years (Human Resources and Social Development Canada, 2006). In Ontario, Canada's most populous province, the permanent ward population doubled in size (i.e., from 4619 to 9301 children) over the decade ending in 2005, according to statistical tracking conducted by the Ontario Association of Children's Aid Societies (OACAS), (Suzanne Piers, January 6, 2006, personal communication). Children who are permanent wards of the state and have no legal access to biological parents as per their wardship orders and are therefore free for adoption are referred to as Crown wards without access in Ontario. Government law and policy for such children asserts that it is preferable that they leave care via domestic adoption rather than live out the remainder of their childhoods in fostering arrangements (Groze, Haines-Simeon, Barth, 1994). Nevertheless, rates of adoption for these children in Ontario actually declined over the past ten years according to the former government minister (Marie Bountrogianni, February 23, 2004, personal communication).

Internationally, clinicians in the child welfare sector regularly make complex decisions affecting placement and long-term permanency planning activities. As child welfare practice became infused with values of the permanency movement of the 1980s, a prominent concern for clinicians and policy makers became an ongoing close consideration of what was referred to as the best interests of the children in care. While the concept of best interests was only vaguely defined in law (Ontario Child and Family Services Act, 2000, p. 21), it is not surprising that for decades researchers in child welfare and treatment providers have argued that the emotional and physical health needs of children in the care of the state must be identified and addressed (American Academy of Child and Adolescent Psychiatry, 2002; Franklin & Massarik, 1969c). Indeed, earlier Ontario government reports and international research from other jurisdictions consistently concluded that high proportions of permanent wards or children in care were identified as having disabilities, often referred to within the sectors as 'special needs', which were "related to or caused by a developmental disability or a

behavioural, emotional, physical, mental, or other disability" (Ontario Child and Family Services Act, 1990, section 26) (Coyne & Russel, 1990; Cowan, 2004; National Adoption Information Clearinghouse, 1997). Since the concept of special needs is defined very differently across jurisdictions, for instance in some locales a child may be considered to have a special need based solely on his or her age (e.g., being over age 10 years old), it is replaced here with the term disability or disabling conditions.

The rates of disability among children who are permanent wards and legally free for adoption has been reported in the USA to range from 36% to 50% (Coyne & Russel, 1990; National Adoption Information Clearinghouse, 1997). In some jurisdictions, regularly measuring and analyzing the rates of disabling conditions and other practice variables impacting the permanent wards has eventually lead to improvements in care provided to wards. In British Columbia, concerns about inadequate rates of adoptions for children with disabilities in the 1980s lead to a pilot project and ultimately an annually funded program which improved adoption outcomes for children with certain disabilities (Feuz, 1991).

While Ontario law extols the importance of agencies being aware of children's disabilities and using this information when planning in childrens' best interests (Ontario Child and Family Services Act, 2000, p. 21), few sources of aggregate information are available regarding the profiles of permanent wards without access as a whole. Many Canadian provinces and territories perform significant and costly monitoring activities primarily to ensure child welfare services provided to children comply with government regulations and standards. In Manitoba, recognition of previous gaps in aggregate information recently lead to a comprehensive government supported effort to closely study children in care (Fuchs, Burnside, Marchenski & Mudry, 2005). However, these quality assurance activities seldom result in comprehensive profiles specifically of permanent wards who are legally available for adoption. In Ontario, the Ministry of Children and Youth Services' annual reviews exclude substantial portions of the permanent ward without access population and report on only four broad categories of disabilities amongst all foster children (i.e., behavioural, emotional,

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ADHD, developmental delay) (Ministry of Children and Youth Services, 2004; Ministry of

Community and Social Services, 2000). Problematically, when government auditors record children's

disabling conditions, they rely on impressions formed by file reviews rather than from noting the

actual diagnoses by qualified professionals on the file. Since annual review reports offer no detailed

aggregate profile nor analysis of in-care experiences of child permanent wards without access, they

are of limited use in forecasting the future needs of this population, or influencing policy formation.

The Ontario Crown Wards Survey (OCWS) was designed to fill many significant information

gaps about permanent wards without access at a time when Canada's most populace province

continues to experience increasing pressures to child welfare service capacity and long-term planning,

and a decreasing rate of these wards leaving care via domestic adoption. The OCWS was aimed at

creating an aggregate profile of a representative province-wide sample of this population on a broad

number of variables. This paper focuses on identifying the mental and physical disorders among

children who are permanent wards and legally free for adoption in Ontario. It also explores and

compares the relationships between these wards' experiences of maltreatment, family history, in care

experiences, residential settings, and permanency planning efforts made on their behalf, by their

disability status. Information about the demographic, clinical and service variables associated with

permanency planning activities will be presented in a subsequent paper.

3.2 Methodology

A cross-sectional survey design was employed for the purpose of describing a profile of

Ontario permanent wards who have no access to family or whose court orders were silent on access.

A key focus of the study was to identify the proportion of wards with disabling conditions.

3.2.1 Sample

According to the Ministry of Children and Youth Services, just over 8,000 children were

permanent wards in Ontario and cared for by one of the province's 52 child welfare agencies in 2003.

Approximately 2,000 of these children were permanent wards without access or silent on access in

the fall of 2003 according to the senior policy analyst (Nancy Francis, personal communication,

November 13, 2003). As no centralized list of these child permanent wards existed, a stratified cluster sampling approach was employed. Each of Ontario's 52 Children's Aid Society transfer payment agencies were stratified by two characteristics: their OACAS geographical administrative zone and their budget size. In this approach, each agency's previous year budget size was used to artificially divide large agencies or group small agencies with neighbouring same-zone agencies. This approach yielded a relatively uniform cluster size based on achieving a budget mean of approximately $22 million. Next, power estimates determined the number of clusters to be randomly selected per zone to ensure generalizability of findings. Finally, a conservative sampling procedure described by Satin and Shastry (1993) was employed requiring an over sampling (i.e., selection of double the number of clusters to obtain double the number of case files) to avoid threats of homogeneity among clusters. All case files selected were for children under 18 as of December 31, 2003.

3.2.2 Survey Instrument

Data were abstracted from children's case files onto a four-page data form with 2 major sections (see Appendix II). Information from the first section is reported here and identifies the child's demographics and descriptive information (e.g., gender, type of permanent ward, visible minority majority status, primary language spoken, admission to care route), special needs (i.e., disabling conditions), six family history items (e.g., exposure to substances prenatally, parent with serious criminal history), maltreatment experiences, age or time variables (e.g., age at admission to care, age at permanent wardship), and current residential placement type. Disabling conditions were considered present if a diagnosis was made by a qualified healthcare practitioner, such as a physician or psychologist, and if the diagnosis was deemed current.

3.2.3 Procedure

In December 2003, five child welfare professionals agreed to act as study advisors and commented on the draft study design, procedures, and data collection form. The anonymity of children and confidentiality of information from children's case files were key ethical considerations underlying the procedures. In January 2004 executive directors (EDs) at 18 randomly selected

agencies were mailed information about the study and an invitation to participate. All EDs were offered either onsite assistance for abstracting data from files or money to offset the costs of releasing their staff to perform the data collection. Participating agencies identified a lead worker who oversaw the completion of a brief agency questionnaire concerning numbers of permanent wards served and the compilation of a study list of all active cases of permanent wards without access or those with permanent ward orders silent on access (including children on adoption probation). Data abstraction from case files occurred province-wide over an eleven-week period from February–April 2004. It entailed a manual review by the author, his research assistants, or agency staff members, for every selected child's case file and the abstraction of the required data. In some instances the reviewer found it necessary to contact the child's social worker or the unit supervisor to confirm a detail that was unclear or not recorded on file. The author and two key research assistants directly collected information from 85% of files (See Appendix III for further details). Following the analysis of all aggregated data, the advisors commented on a draft report of results.

3.2.4 Data Analysis

All statistical analyses were carried out using the SPSS 12 software for Windows (SPSS, 2003). A minimum significance level of .05 was used for all analyses conducted. Descriptive analyses (e.g., frequency distributions, percentages etc.) were performed for each of the variables. Chi-square (χ^2) tests were computed along with odds ratios and confidence intervals to determine if results on key variables were significantly associated with children's disability status.

<div align="center">3.3 Results</div>

Of the 18 agencies invited, 16 agencies (89%) participated with representation from every selected cluster. Information on 429 children was reviewed and analyzed, representing approximately 21% of all children who were permanent wards without access on December 31, 2003.

3.3.1 Profiles

Most children were male (56.9%), without access (86.7%, vs. silent on access), had a disabling condition (57.8%), were Caucasian (74.9%, vs. visible minority 14.3% or Aboriginal

10.8%), and had entered care via apprehension (84.8% vs. voluntary relinquishment). For the 383

children who were over 18 months of age and had the ability to use language, most spoke English

(98.2%). Finally, for children attending school and over age 5 (*n*=296) 42.2% had an Individual

Education Plan (IEP).

The number of discrete disabilities found among children ranged between 1 and 8 (*M*=2). In

total, 39% of children had one disability, 31% had two, 13% had three, and the remainder had more.

In Table 3.1 the frequency of key categories of conditions among children are noted.

Table 3.1

Disabling Conditions among Children (N=429)

Disabling condition	*n*	*%*
Attention deficit disorder with or without hyperactivity	88	20.5
Speech and language disorders or delays	47	11.0
Developmental delay	46	10.7
Physical disability	46	10.7
Mental illnesses	36	8.4
Learning disabilities	33	7.7
Developmental disability	32	7.5
Behavioural disorders	31	7.2
Seizures / epilepsy (included Tourette's[a])	16	3.7
Fetal alcohol spectrum disorders	14	3.3

Note. Children could have multiple conditions present.

[a]While Tourette's syndrome is not a seizure disorder, it is more broadly considered a neurological disorder.

Approximately one in five children had a diagnosis of ADHD and of these 88 children, 13

(15%) had only that one diagnosis. Speech and language disorders or delays were most commonly

found among children who were younger than 6 years old. Physical disabilities were most often very

rare conditions or syndromes that impacted mobility or dexterity. Developmental delays affected

more than one in ten children. Diagnosed developmental disabilities were less common and as a

diagnostic label, professionals usually only apply it to older children (e.g., over age seven) whose

disability is predicted to last a lifetime. The three most frequently diagnosed categories of mental

disorders (i.e., among mental illnesses and behaviour disorders combined) were anxiety disorders (*n*=19), oppositional defiant disorders (*n*=15), and attachment disorders (*n*=14).

Almost 28% of children (*n*=118) had been prescribed a psychotropic medication. Information about the purpose of prescribed psychotropic medications was not collected. Nevertheless, the most commonly prescribed class of medications appeared to be stimulants prescribed for symptoms of ADHD.

3.3.2 Family History

Information on six family history items was collected because each item was relevant in child welfare literature and related to either why children entered care, remained in care, or had impacted permanency planning. For 19% of children (*n*=81), none of the six items were applicable. For the remaining children the items were applicable to varying degrees: a parent had alcohol or drug dependency (54.8%), a parent had serious criminal history (33.1%), the child was exposed to substances prenatally (27.0%), a birth parent or siblings had a significant mental illness (25.6%), and a parent had a developmental disability (11.0%). A chi-square analysis of all family history items for children with and without disabling conditions was computed. Children who were disabled were significantly more likely to have been exposed to substances prenatally (*p*=.048).

3.3.3 Experiences of Maltreatment

Files were reviewed for evidence that children experienced maltreatment before entering care or during their time in care[1]. This variable was not intended to shed light on the nature of the relationship between child survivors and their abuser. In many instances, during care experiences of abuse were perpetrated by someone other than the foster parents or other resource care providers. To be considered 'verified', there would usually have been a CAS and/or police investigation and evidence of substantiation, although laid criminal charges or convictions were not necessary to code this response. A 'suspected' response indicated a lesser degree of certainty evident from file material; it included where allegations were made and the CAS believed them but where the allegation

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[1] The time in care period related only to the continuous period prior to and leading up to December 31, 2003

nevertheless remained documented as officially unsubstantiated. Table 3.2 summarizes findings on

these variables.

Table 3.2

Abuse Experiences of Children Before and During Care (N=429)

Time period and abuse type	None		Suspected		Verified	
	n	(%)	*n*	(%)	*n*	(%)
Before care (*n*=360)[a]						
Sexually abused	298	(82.7)	37	(10.3)	25	(7.0)
Physically abused	254	(70.6)	29	(8.1)	77	(21.4)
Neglected	80	(22.2)	16	(4.4)	264	(73.3)
Abandoned	299	(83.1)	3	(.8)	58	(16.1)
Witnessed abuse[b] of family member	224	(68.3)	37	(8.6)	99	(23.1)
During care (*n*=429)						
Sexually abused	416	(97.0)	7	(1.6)	6	(1.4)
Physically abused	406	(94.6)	7	(1.6)	16	(3.7)
Neglected	424	(98.8)	0	(0)	5	(1.2)
Witnessed abuse of in-care family member	423	(98.6)	1	(.2)	5	(1.2)

Note. Categories of abuse experiences were not mutually exclusive.

[a]Many children (n=69) entered care directly from hospital, almost immediately following birth, and therefore were excluded from the analyses of before care abuse experiences. [b]'Witnessed abuse' indicates that the child had witnessed, emotional, sexual or physical abuse, including wife assault.

In total, 338 children (78.8%) were suspected of or verified of ever experiencing at least one

type of abuse. Sixty-nine (16% of the sample) of the remaining 91 children entered care directly from

hospital, almost immediately following birth, and therefore were excluded from the analyses of before

care abuse experiences, however, none subsequently experienced abuse while in care. A total of 336

children (78.3%) were suspected of or verified of experiencing abuse that was perpetrated before

entering care and 38 (8.9%) children were suspected or verified of experiencing abuse that was

perpetrated during their time in care. Thirty-six of these 38 children had also experienced abuse (or

been suspected of experiencing abuse) prior to being placed in resource settings; the remaining two

only experienced abuse after entering care.

Subsequent chi-square analyses determined that significantly more children with disabling conditions experienced physical abuse (*p*=.001) before entering care and sexual abuse (*p*=.004) and physical abuse (*p*<.025) while in care than did children without disabling conditions.

3.3.4 Age Variables

Age at Admission to Care   Age at admission to care was based on the date on which the child entered care for the most recent continuous period. While many children had multiple admissions into care, a significant portion entered care for a continuous period at a very young age (*Mean* =3 years, 5 months). Figure 3.1 shows the proportion of children with and without disabling conditions who entered care at each age in years.

Figure 3.1

Children's Age at Admission to Care by Percentage of Sample (*n*=423)
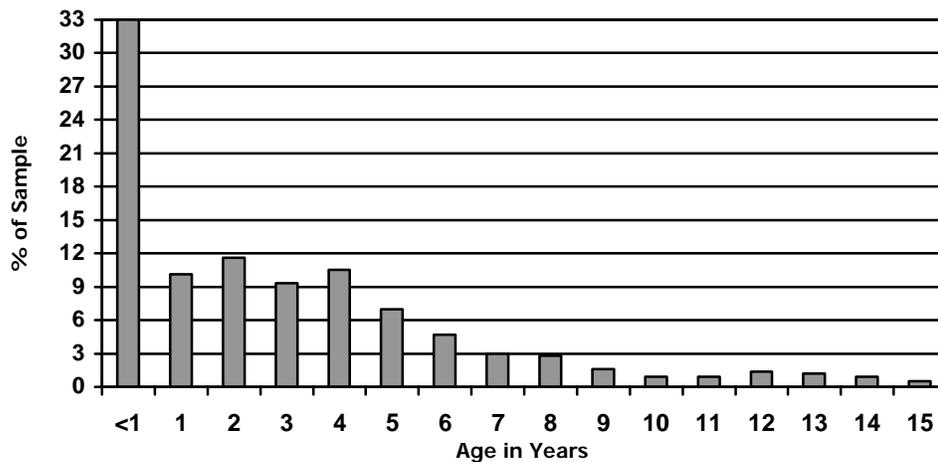
Figure 3.1 shows that approximately 43% of the combined sample entered care for the continuous period before turning two years of age. A total of 16% (69 children) of the sample entered care directly from hospital usually within 1-3 days of birth and often according to a planned apprehension. By age three, 64% of the total sample of children was already admitted to care. Less than 5% (21 children) of the sample entered continuous care when 11 years of age or older.

Analysis by disability status indicated that the mean age of admission for children without disabling conditions was 2 years and 11 months while children with disabilities were 3 years and 9 months old on average. Further, children without disabling conditions were far more likely than those with these conditions to be admitted to care by age 1 (42.1% vs. 26.2%; p=.001, df=1).

Study Age   The 429 children ranged in age from 3 months old as of December 31, 2003 to just younger than 18 years old. The mean age of the sample was seven years and four months[2]. Forty-six percent of the study children were seven years old or older, while 19% were 11 or older. Analysis by disability status found that children without disabling conditions were on average significantly younger (i.e., 5 years, 9 months) than those with disabilities (i.e., 8 years, 6 months).

Age at Permanent Wardship   The average age for wards to become permanent wards without access or silent on access was 4 years and 8 months. Since the mean age at permanent wardship for children with disabling conditions was 5 years and 1 month while children without disabilities were 4 years and 2 months old on average, a chi-square analysis was computed to determine if, when ages were sorted by four age bands (i.e., <1, 1-3, 4-7, 8+), significant differences would be found. Chi-square analysis indicated that children with disabling conditions were significantly less likely to be under one year old ($p < 0.01$, df=3) at the time they were granted permanent wardship without access status. Differences found at other age bands were not significant.

Time Between Admission to Care and Permanent Wardship Order   The average time between entering care for the recent continuous period and being declared a permanent ward without access or silent on access for the total sample was 1 year and 3 months. Children with disabilities were on average one month older than those without disabling conditions. This difference was not significant.

3.3.5 Residential Placement

Analyses were made to examine frequency of various residential placements for children and secondly to uncover any association with disability status. Table 3.3 reports on the number of

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[2] All mean ages reported are rounded to the nearest month.

permanent wards without access residing in each of several types of placements as of December 31, 2003.

Table 3.3

Number and Rate of Children in Types of Residential Placements (*N*=429)

			Category Total	
Type of residential placement	*n*	*%*	*n*	*%*
Total CAS direct care			237	(55.3)
CAS regular foster care	86	20.0		
Specialized foster care	72	16.8		
Treatment foster care	33	7.7		
Provisional foster home	12	2.8		
Emergency receiving home	1	0 .2		
Pre-adoptive foster care	33	7.7		
Adoption probationary home [a]			142	(33.1)
Outside paid resources (OPR) [b]			47	(10.9)
OPR group home	25	5.8		
OPR foster home	22	5.1		
Youth custody facility	1	0 .2	1	(0.2)
Independent living [c]	2	0 .5	2	(0.5)

[a]Children in these homes had been placed with approved adoption applicants for adoption. [b]OPR refers to the purchase of services by a CAS from either a public agency, a private group-home operator, or private company which manages and supports a cadre of foster families. [c]Independent living refers to older permanent wards residing on their own with both financial supports and intermittent staff supports usually provided by the CAS.

Chi-square analysis revealed that children's disability status was significantly associated with specific categories of residential placements. In Table 3.4 children in CAS direct care and outside paid resources were compared to those in adoption probationary homes by computing odds ratios and confidence intervals to determine if significantly different proportions of children lived in each.

Table 3.4

Children's Disability Status by Main Residential Placement Categories (*n*=426)

Type of residential placement	Disability		Total	Odds	Confidence	*p* value
	With (*n*=247) *n* (%)	Without (*n*=179) *n* (%)	*n* (%)	ratio	interval 95%	
Adoption probationary home	46 (32.4)	96 (67.6)	142	1	-	-
CAS direct care	161 (67.9)	76 (32.1)	237	4.42	2.83-6.89	<.0001
Outside paid resources	40 (85.1)	7 (14.9)	47	11.90	4.96-28.60	<.0001

Children with disabling conditions were over four times more likely to be in CAS direct care and almost 12 times more likely to reside in outside paid resources (OPR)[3] than were children without disabilities; who were predominantly in adoption probationary homes (67.6%).

3.4 Discussion

Many factors must be considered when determining the needs of any child who is a permanent ward. For decades researchers in child welfare have emphasized that the particular needs of children with disabling conditions must be identified and addressed; including the potential needs for special assessments, treatment, and adaptive technologies or altered built environments (Brown, 1988; Chambers, 1973; Franklin & Massarik, 1969a, 1969b; Hamilton, 1949). The OCWS is perhaps the first independent study to clearly focus attention on the profile of Ontario permanent wards without access, shed light on their disabling conditions, and use an advanced sampling methodology to attempt to ensure proportional representation from across the province. A few limitations were encountered during the study and are noted here. File information on visible majority / minority status was gathered (i.e., following Statistics Canada's simplest, three category, breakdown) but was cumbersome to code in the sizable minority of cases where a child had apparent mixed race ancestry. Findings related to this status should be cautiously interpreted. A small portion of agencies from the province's Northern and Eastern administrative zones declined involvement resulting in children in these areas being slightly underrepresented; in particular Aboriginal children from agencies funded to

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[3] OPR refers to the purchase of services by a CAS from either an agency or private group-home operator.

serve Aboriginals may be underrepresented[4]. Nevertheless, the high participation rate among

agencies, the conservative participation rule used by the researcher, which required each cluster to

have at least one agency participate, and the over sampling enhanced the generalizability of findings

to the Ontario population of children who are permanent wards without access as a whole.

The OCWS focused on counting disabling conditions, many of which may have been well

treated and had negligible impacts on participation of children on a day-to-day basis. Nevertheless,

the disability rate of 57.8% was more than 16 times higher than that found among the general

population of children in Ontario, which was approximately 3.5% (Statistics Canada, 2002). Overall,

it remains unclear exactly why the permanent ward without access population has such high

proportions of children with various disabilities compared to the general population of children. The

identification of disabilities often occurs when children reach school age as delayed milestones

become increasingly obvious and when teachers and other professionals become involved with the

child. Perhaps the level of supports available via the Ontario service delivery system is significantly

lacking and a combination of limited parental means and staff attitudes make the route into care more

likely. Further research into this question is needed.

Children with disabilities among the permanent wards without access were a demographically

heterogeneous group. The most prevalent diagnosis category was ADHD, which impacted one-fifth

of the sample. In the general population this category of diagnosis has been estimated to apply to only

6.1% of children in Ontario and 4.8% internationally (Waddell, 2002). The OCWS proportion of

children with a diagnosis of fetal alcohol spectrum disorders (FASD) (3.3%) was much lower than

some clinicians in the field might have suspected. It seems that this diagnosis is particularly difficult

to accurately make or that medical experts are reluctant to apply it, especially when reliable histories

of alcohol intake during pregnancies are often lacking (Abel, 1998; Chudley et al., 2005). It is also

conceivable that some proportion of the children diagnosed with ADHD may also qualify for an

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[4] These agencies tend to have a much lower proportion of permanent wards without access than do non-Aboriginal agencies.

FASD diagnosis. Nevertheless, the only family history item to be significantly associated with disabling conditions was a history of being exposed to substances prenatally. Conversely, since the rate of FASD was low given the high rate of substance use amongst children's parents, perhaps exposure to substances prenatally is generally associated with numerous other pregnancy risks factors of disability such as poor or no prenatal care, or is often indicative of limited parenting abilities and higher instances of neglect. Further research is needed to better understand the nature of this association.

Children with disabilities were significantly more likely to experience certain abuses which may relate more directly to their older ages when they entered care than to the disability itself. Regardless of disability status children tended to be admitted to care at relatively young ages; 16% within days of birth and a total of 43% before turning two. The low rate of children admitted to care at older ages may simply reflect a tendency for older children to retain access provisions upon becoming permanent wards and therefore making them ineligible for the study. Children's average time between entering care for the recent continuous period and being declared a permanent ward without access or silent on access was similar regardless of disability status except in the 0-6 month category. The meaning of this finding is not immediately obvious though it may relate to the fact that children with disabling conditions were older when first entering care. Perhaps the shorter time frame for becoming a permanent ward was most common for infants entering care. Since these were more frequently children without disabling conditions perhaps they were viewed as readily adoptable and therefore agencies' were prompted to obtain quick court dates for arriving at the permanent ward status en route to an adoption placement.

Children with disabilities were significantly more likely to be apprehended into care than voluntarily placed. This finding challenges the notion of struggling parents unable to cope and voluntarily placing their medically fragile child into care. While such a pattern was observed it was far out numbered by children with less extreme support needs who were apprehended from their parents at older ages.

As expected, children with disabling conditions had significantly higher rates of prescribed psychotropic medications and IEPs in school. It is widely known that ADHD is usually treated, at least in part, with psychotropic medication. It is likely that the strong association generally found between having a disabling condition and having psychotropic medications prescribed was heavily influenced by this one common co-occurrence; especially since ADHD was the most prevalent category of disabling conditions.

3.4.1 Residential Placements

A successful adoption is widely seen as the best permanency plan in child welfare, even a best practice outcome for children who are permanent wards without access (Barth, 1997)[5]: that is, wards for whom a return to their biological parents has been legally ruled out. In fact, an extremely common goal of the legal process which extinguishes biological parents' access rights is the agency's stated desire to place the permanent ward for adoption. In Ontario, a child must be placed on adoption probation for a minimum of six months before finalization can occur. While 33.1% of the children (*n*=142) were on adoption probation at the time of the study, viewed from a pro-adoption perspective, it appears that with most of the children residing in fostering placements, that adoptions will not occur in the near future for the vast majority.

Children residing and receiving supports from OPRs had usually arrived there after periods of time living in more traditional foster or treatment foster care arrangements. A review of the findings raises the question of whether sufficient flexibility exists for agencies to keep funding children in individualized fostering arrangements instead of moving them. Some file information reviewed seemed indicative of agencies adopting rigidity in their funding formulas for 'in-house' fostering residential services. For example, it appeared that children had been moved from typical fostering arrangements because the income needs of the foster parents (i.e., to support the special needs,

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[5] It is important to note however, that the promotion of the adoption option is not a universally preferred goal for permanent wards without access among child welfare agencies in Ontario. Aboriginal agencies in particular have long preferred and advocated a form of guardianship known as customary care for Aboriginal children who become permanent wards. The key aim is to provide real permanency for children which includes retaining or strengthening the child's access to his or her culture through supporting direct contact with band members (George Simard, personal communication, April, 2004).

including behavioural, of the foster child) rose above the usual allowable per diem maximum, while the subsequently selected staff model OPR options often charged much more than the per diem rate. Were foster parents offered an increased or similar level of funding support (i.e., to fund respite or enhanced staffing) first before the extreme decision to move the child was taken? Further study is needed to determine if this observed lack of flexibility commonly exists across agencies and if reliance on such preset funding formulas results in more costly arrangements and, with the resultant moves and changes in care providers, detracts from the children's best interests being served.

In conclusion, the OCWS findings on the profile of Ontario's permanent wards without access population has many implications for service delivery and policy; it also contributes more broadly to research in the fields of child welfare, and disability. Major policy reviews with stated goals of transformative change are underway at two Ontario government ministries, the Ministry of Children and Youth Services and the Ministry of Community and Social Services. Findings from this study can inform these reform efforts in the child welfare, children's mental health, and developmental services sectors. While the interpretations of many findings may be open for discussion it is clear that more research in this area is necessary to support improved planning, provision of services, and policy development for this population.

CHAPTER 4

MANUSCRIPT C:

Prevalence of mental disorders and associated service variables among Ontario children who are permanent wards

Reference:

Burge, P. (2007a). Prevalence of mental disorders and associated service variables among Ontario's children who are permanent wards. *Canadian Journal of Psychiatry, 52*, 305-314.

4.1 Introduction

Staff members in the child welfare sector are required to promote the safety and health of the foster children they supervise. According to the executive director of the Child Welfare League of Canada, provincial ministries commonly direct these staff to identify and address the particular emotional and behavioural needs of children in care but cannot necessarily provide the professional involvements needed (Peter Dudding, personal communication, May 12, 2006). For decades, researchers and practitioners in children's mental health and child welfare have argued that the mental health needs of children in care must be identified and addressed, (American Academy of Child and Adolescent Psychiatry, 2001, 2002; Coyne, 1997; Franklin & Massarik, 1969; Shin, 2005) yet these needs are still not uniformly assessed. Uniformity could be achieved if psychiatric evaluations or psychological assessments were mandatory, as has been proposed elsewhere (American Academy of Child and Adolescent Psychiatry, 2002). Further, documenting the actual rates of psychiatric diagnoses among samples of foster children is an important building block toward understanding determinants of mental health in this population and may assist future efforts to estimate ongoing contacts with psychiatry and other mental health service providers.

Numerous US studies have profiled wards in care and their mental health status and service use (Halfron, Berkowitz & Klee, 1992; Klee & Halfron 1987; Leslie, Landsverk, Ezzet-Lofstrom R, et al., 2000; Shin, 2005; Takayama, Wolfe & Coulter, 1998), but many of these have been fraught with methodological challenges. Study findings have been criticized for a perceived lack of generalizability in that samples have been drawn from small or homogenous catchment areas (Clausen, Landsverk, Ganger, et al., 1998; Horan, Kang, Levine, et al. 1993), for reporting on only a very limited number of mental disorders (Clausen, Landsverk, Ganger, et al., 1998; Spady, Schopflocher, Svenson, et al., 2005; Waddell, Offord, Shepherd, et al., 2002; Zoutis, 1999), or, as noted by Waddell and colleagues (2002), for difficulties in reconciling conflicting reports of symptomatology among multiple informants. Notwithstanding these limitations, international research has yielded valuable information that can inform child welfare practices. Perhaps the key

finding reported is that prevalence rates of psychopathology and developmental delay are higher among children in foster care than among children in the general population (Cowan, 2004; National Adoption Information Clearinghouse, 1997; Sullivan & Knutson, 1998), even when compared with rates for children from similar sociodemographic backgrounds (dosReis, Magno Zito, Safer, et al., 2001; Garland, Landsverk, Hough, et al., 1996; Pilowsky, 1995). Some studies, using rating scales of psychopathology to estimate prevalence of mental disorders among foster children, have reported that over 40% (Leslie, Landsverk, Ezzet-Lofstrom, et al., 2000) of these children have these disorders, other studies have reported a higher estimate of 80% (American Academy of Child and Adolescent Psychiatry, 2001). These rates contrast sharply with lower estimates among samples from the general population of children, which are closer to 14% on average (Waddell, Offord, Shepherd, et al., 2002).

Multiple reasons have been suggested for these elevated rates. Many foster children, including those who are permanent wards (that is, who cannot legally return to their former parents' care), originally entered care when very young and when neurological development was acute (Leslie, Gordon, Lambros, et al., 2005). Perhaps related to this basic vulnerability, various factors are noted in the professional literature as being associated with foster children's mental health. In particular, three significant influences appear: the biological parents' own mental health from genetic or environmental perspectives (Kadushin,1967), the mental health sequelae of maltreatment that precedes the original involvement of many children with child protective services (Milan & Pinderhughes, 2000; Zoutis, 1999), and the negative effects on children of being separated from their families of origin at young ages (Clausen, Landsverk, Ganger, et al., 1998; Lipman, Offord, Boyle, et al., 1993). Research has also recognized the potential compounding mental health impacts of various factors to which foster children might have been exposed after entering care, such as further abuse (Jaudes & Shapiro, 1999; Sullivan & Knutson, 1998) and unstable placement settings that result in multiple moves (Barber & Delfabbro 2005; Barth, 1997; Rosenberg & Robinson, 2004).

Therefore, it is not surprising that international research has reported that children with mental disorders are less likely to be reunited with parents than are other foster children (Rosenberg

and Robinson, 2004) and that they have been significantly and disproportionately represented in clinical populations receiving psychiatric services (dosReis, Magno Zito, Safer, et al., 2001; Garland, Landsverk, Hough, et al., 1996; Takayama, Bergman & Connell, 1994). No comparable Canadian research on a large sample could be found.

While the number of children in foster care has been increasing significantly in many Canadian provinces, the permanent ward population in Ontario doubled during the decade ending in 2005, according to the OACAS (Gail Vandermeulen, personal communication, December 12, 2006). This growth in the permanent ward population has resulted in increasing pressure on child welfare service capacity and long-term planning at a time when the rate at which these children have been leaving care via adoption has been decreasing, according to the government minister at the time (Marie Bountrogianni, personal communication, February 23, 2004). Therefore, the rate of mental disorders among permanent wards without access to their biological parents is especially important to understand because these children can only leave care via adoption or must otherwise spend the remainder of their childhood in fostering arrangements before embarking on independent living or being transferred to adult service sectors (such as mental health or developmental services).

The OCWS (Burge, 2005) was designed to fill many significant information gaps about permanent wards who have no access to their biological parents by creating an aggregate profile of a representative province-wide sample on a broad range of variables. Information about diagnosed mental disorders and relevant data from other variables were analyzed separately for presentation here.

4.2 Methodology

A cross-sectional survey design was used to describe a profile of permanent wards in Ontario.

4.2.1 Sample

All the estimated 2,000 children in Ontario who were both permanent wards without access (or whose court orders were silent on access) and aged under 18 years on December 31, 2003, were eligible for inclusion in the study. In practice, according to study advisors who recommended their

inclusion, a minority of children with permanent ward orders that fail to specify access provisions are referred to as being "silent on access" and are overwhelmingly treated as if the access to parents were denied. A stratified cluster sampling approach (Satin & Shastry, 1993) was used to ensure a representative provincial sample. The 52 CASs in Ontario were stratified by the 5 OACAS regions, and agencies within each region were stratified by their annual budget size. Within regions, large agencies were artificially divided and small agencies were grouped with neighbouring agencies to create uniformly sized clusters (with a budget mean of approximately $22 million). Next, a weighting was assigned to each region, based on the proportion it received of the previous year's total provincial annual budget; as a result, each region had 6, 7, or 14 clusters. Power estimates were then calculated to guide decisions regarding the number of clusters to be randomly selected per region to arrive at the appropriate sample size for generalizability of findings. Finally, oversampling was used (selection of double the number of clusters to obtain double the number of case files) to avoid threats of homogeneity among clusters.

4.2.2 Survey Instrument

The data abstracted from children's case files included children's descriptive information (that is, age, sex, type of permanent ward, visible minority or majority status, primary language spoken, and admission-to-care route), all disorders (mental and other current medical diagnoses), 6 family-history items (for example, significant mental illness among family members), time (including age at admission to care), current residential placement type, other characteristics (such as existence of a formal IEP), service and historical information, and permanency plan details. Diagnosed mental disorders were recorded as written on case files if the diagnosis was made by a psychiatrist, another physician, or a psychologist and if it was deemed current (that is, if there was no mention on the file of a cure or change in diagnosis). Files were also reviewed to determine whether children experienced maltreatment before entering care or during their time in care. The period of time in care related only to the continuous period leading up to December 31, 2003. Abuse experiences were coded as "verified" when there had been a CAS and (or) police investigation and evidence of substantiation. A

coding of "suspected" indicated a lesser degree of certainty according to file material—for example, where allegations were made, and the CAS believed them, but where they were nevertheless documented as officially unsubstantiated.

4.2.3 Procedure

Five current or former child welfare staff members acted as advisors for the study. In early 2004, executive directors at 22 randomly selected agencies were invited to participate. All were offered either onsite assistance for abstracting data or compensation if their staff performed the data collection. Participating agencies identified a lead worker to liaise with the investigator, to arrange for the compilation of the list of eligible children, to coordinate the site visits, to ensure the selected files were made available, and at a few agencies, to oversee the compilation of file data. Just over one-half of the data were collected directly by the author and another 35% by 2 key research assistants. Data abstraction from children's case files occurred over an 11-week period ending in April 2004. Procedures were approved by the Queen's University Health Sciences Research Ethics Board.

4.2.4 Data Analysis

Descriptive analyses (such as frequency distributions and percentages) were performed for each variable. Proportions, chi-square statistics, ORs, and 95% CIs were computed to determine whether results on certain variables were significantly associated with children's mental disorder status. The DSM-IV (American Psychiatric Association, 2000) nomenclature was used to categorize mental disorders. A multivariate logistic regression analysis was computed to determine which variables were predictive of the 2 key permanency plans. A significance level of 0.05 was set a priori for all analyses conducted. All statistical analyses were carried out with SPSS Base 12.0 for Windows (SPSS Inc, Chicago, IL, 2003).

<div align="center">4.3 Results</div>

A total of 16 agencies participated, with representation from every selected cluster and region. Information on 429 children was reviewed and analyzed, this represented about 21% of all eligible permanent wards as of December 31, 2003. A majority of the children were male (56.9%),

86.7% were designated as permanent wards without access (rather than silent on access), 74.9% were

white (compared with 14.3% visible minority or 10.8% Aboriginal), and 84.8% had entered care via

apprehension (as opposed to voluntary relinquishment). Of the children aged over 18 months, 95.2%

spoke English, 3% were unable to speak, and 1.8% spoke other languages; 44% of the school-aged

children had an IEP.

Among the 429 permanent wards, the prevalence rate of mental disorders was 31.7% (136

children). The number of separate mental disorder labels given to children ranged from 1 to 5, with

most children (65.7%) having 1 diagnostic label, 26.3% having 2, and the remainder having 3 or

more. Table 4.1 shows the frequencies and percentages of various mental disorders.

Table 4.1

Frequency of Specific Mental Disorders (N=429)

Mental disorders	Total Sample		Among those with
	n	%	mental disorders %
No mental disorder	293	68.3	-
ADHD	89	20.7	65.4
Mental retardation and pervasive developmental disorders[a]	32	7.5	23.5
Anxiety disorders[b]	19	4.4	14.0
Oppositional defiant disorders	15	3.5	11.0
Attachment disorders	14	3.3	10.3
Disruptive behaviour disorders	10	2.3	7.3
Mood disorders	9	2.1	6.6
Conduct disorders	7	1.6	5.1
Adjustment disorders	2	.4	1.5
Self-injurious behavior	1	.2	0.7
Tic disorders	1	.2	0.7

Note. Children could have multiple disorders from within or across categories.

[a]Only one of the five children with a PDD did not also have significant intellectual deficits.

[b]Eleven of these children had Post Traumatic Stress Disorder.

Of the 89 (about 1 in 5) children with ADHD, 76 (85%) had at least 1 other mental disorder.

Further analysis was conducted to determine whether children's sex or the region of the province in

which the CAS operated related to rates of mental disorders. Chi-square analysis revealed that the rate

for boys (40.6%), compared with girls (20.0%), showed that boys were twice as likely to have a

mental disorder (95%CI, 1.46 to 2.81; $P < 0.01$, df 1). As well, children supervised by participating

agencies from one Ontario region were twice as likely as children from the other 4 regions to have a

mental disorder (95%CI, 1.10 to 3.76; $P < 0.05$, df 4).

Psychotropic medications had been prescribed for almost 28% of the children ($n = 118$); 83%

of these children ($n = 98$) had mental disorders, and chi-square analysis revealed that children with

mental disorders were significantly more likely to have been prescribed psychotropic medications

($P < 0.001$, df 1) than were children without these disorders.

Of children with mental disorders, 49% ($n = 67$) also had comorbid conditions from another

category of disability, the most common of which were learning disabilities ($n = 24$), physical

disabilities ($n = 20$), and FASD ($n = 10$). Four children without mental disorders also had FASD.

Chi-square analyses were computed to compare whether children with and without mental

disorders would be more or less likely to have the 6 following family characteristics or histories: a

biological parent or sibling with a significant mental illness, exposure while in utero to substance use

by mother, a parent with a substance use problem, a parent with a developmental disability, a parent

with HIV or AIDS, and a parent with a serious criminal history. For the first family characteristic

(significant mental illness), Axis I disorders were always coded as significant, whereas other

disorders were considered significant if they affected the child's wardship deliberations. General file

references to "mental" or "behavioural" problems or "stress" were not coded if unsupported by

further evidence. Findings indicated that the proportions were similar for children with and without

mental disorders for all but the first family-history item. Although 25.6% of the 429 children had a

biological parent or sibling with a significant mental illness, the children with mental disorders were

less likely to have such a family member ($P = 0.037$).

4.3.1 Maltreatment

Chi-square analysis showed that, in total, 338 children (78.8%) were suspected of

experiencing, or had verified experience of, at least one type of maltreatment: 336 children (78.3%)

before entering care and 38 children (8.9%) during their time in care. Of these 38 children, 36 had

also experienced abuse (or been suspected of experiencing abuse) prior to being placed in resource settings; the remaining 2 experienced abuse only after entering care.

Overall, a significantly higher proportion ($P < 0.001$) of children with a mental disorder (91.2%) than children without mental disorders (72.4%) experienced maltreatment before entering care. A significantly higher proportion ($P < 0.001$) of children with a mental disorder also experienced maltreatment during their time in care (16.2%), compared with children without these disorders (5.5%). Table 4.2 highlights significant differences between the proportions of children with mental disorders and those without such disorders in terms of maltreatment before care (suspected sexual abuse and suspected and verified physical abuse) and abuse during care (verified sexual abuse, verified physical abuse, and verified neglect).

Table 4.2

Mental Disorder Status and Maltreatment of Children (N=429)

Time period and abuse type	No Abuse (%) MD		Suspected Abuse (%) MD		Verified Abuse (%) MD		*p* value
	Yes	No	Yes	No	Yes	No	
Before care (n=360)[a]							
Sexually abused (n=359)	75.8	86.8	14.4	7.9	9.8	5.3	0.029
Physically abused	58.3	77.6	11.4	6.1	30.3	16.2	0.001
Neglected	22.0	22.4	2.3	5.7	75.8	71.9	0.304
Abandoned	81.8	83.8	.0	1.3	18.2	14.9	0.312
Witnessed abuse[b]	60.6	63.2	9.8	10.5	29.5	26.3	0.802
During care (n=429)							
Sexually abused	93.4	98.6	2.9	1.0	3.7	.3	0.008
Physically abused	90.4	96.6	.7	2.0	8.8	1.4	<0.001
Neglected	97.1	99.7	.0	.0	2.9	.3	0.037
Witnessed abuse	97.8	99.0	.0	.3	2.2	.7	0.312

Note. Categories of abuse experiences were not mutually exclusive. Fisher's exact tests were utilized for analyses when data cell counts were too small for Pearson chi-square.

[a]Many children (n=69) entered care directly from hospital, almost immediately following birth, and therefore were excluded from the analyses of before care abuse experiences. [b]'Witnessed abuse' indicated that the child had witnessed, emotional, sexual or physical abuse, including wife assault of a family member.

4.3.2 Age Variables

Age at Admission to Care. Since many children entered care and left care more than once before becoming permanent wards, age at admission to care was based on their age in days on the date they entered care and permanently remained in care. The mean age at which all children were admitted to care was 3 years and 5 months (all mean ages reported are rounded to the nearest month). Children with mental disorders were, on average, significantly older when admitted to care than those without these disorders (mean 4 years, 7 months, compared with mean 2 years, 10 months; $t_{421} = -4.87$, $P < 0.001$). Further analyses indicated that significant differences existed in the proportions of

children with and without mental disorders admitted to care at each age in years for the 2 youngest

categories (< 1 year and 1 year): children without mental disorders were much more frequently

admitted ($P < 0.001$).

     Age at Study.   Children's study age was their actual age in days on December 31, 2003—the

date used to select the sample. Ages ranged from about 3 months to just under 18 years, with an

average age of 7 years and 4 months. On average, children with mental disorders were significantly

older than those without these disorders (mean 10 years, 7 months, compared with mean 5 years, 9

months; $t_{427} = -11.28$, $P < 0.001$). Figure 4.1 shows the proportion of children with and without

mental disorders at each age in years by their percentage in each subsample.

Figure 4.1

Age on December 31, 2003, by Mental Disorder (MD) Status and Percentage of Each Sample (N=429)
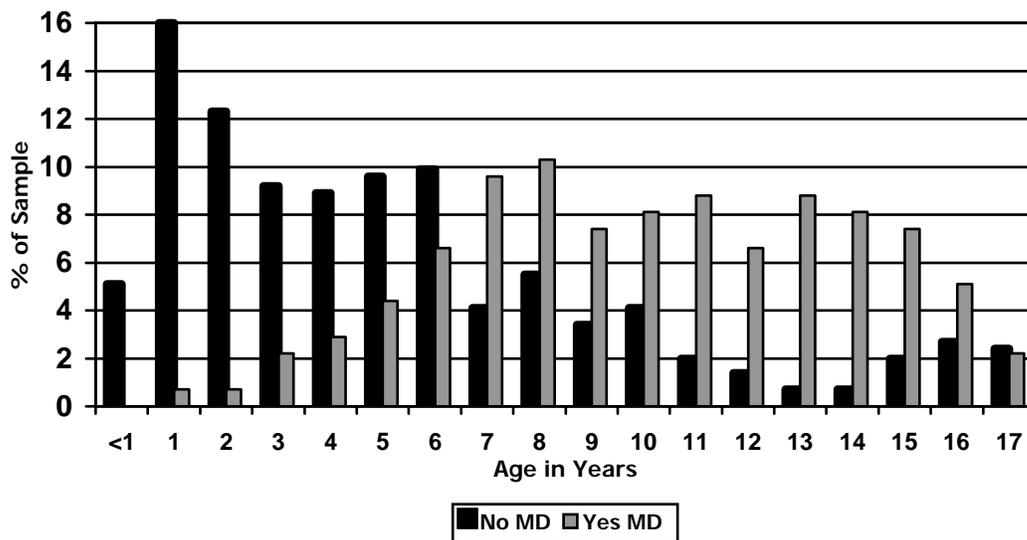
*p<.001

     Age at Permanent Wardship.   Children's age when they became permanent wards was their

actual age in days when the judge made the court order. The average age at permanent wardship was

4 years and 8 months. Children with mental disorders were, on average, significantly older than those

without these disorders (mean 6 years, 1 month, compared with mean 4 years; $t_{427} = -5.94$, $P < 0.001$).

4.3.3 Residential Placement and Permanency Plans

Just over 55% of all the children resided in CAS direct care placements, such as regular or treatment foster homes; 33% were living in adoption probationary homes; and 11% resided in private foster homes or privately operated resources, such as group homes. Three children lived independently or in a youth custody facility. Chi-square analysis revealed that children with mental disorders were almost 3 times more likely to be residing in privately operated resource settings (OR 2.89; 95%CI, 1.50 to 5.58; P< 0.01) and about 10 times less likely to be in probationary adoption settings (OR 9.88; 95%CI 4.79 to 20.37; P< 0.001), as opposed to CAS direct foster care, than were children without these disorders.

Official permanency plans were known for 423 children, and the most common were adoption (*n*= 272, 64%) and LTFC (*n*= 124, 29%). The plans for the remaining 27 children (6%) were to live independently (*n*= 13), live with relatives (*n*= 10), or directly transfer to developmental services and adult mental health residential services.

Chi-square analyses were computed to determine whether the 2 key permanency plans (adoption and LTFC) varied by children's mental disorder status and other variables of interest, including demographics (such as sex and visible majority or minority status), physical disability (when no mental disorder existed), permanent ward type (that is, without access or silent on access), admission route (either voluntary or apprehension), age (age at admission to care, age at permanent wardship, and age on December 31, 2003), the 6 family-history items, and all categories of experiences of maltreatment (both before and during time in care). Table 4.3 shows only the significant results.

Table 4.3

Variables Associated with Key Permanency Plans (N=396)

	Variable	Adopt. *n*	LTFC *N*	Total *n*	Odds ratio	Confidence interval 95%
Mental disorder	No	225	50	275	1	-
	Yes	47	74	121	7.09	1.67-2.65**
Gender	Male	146	80	226	1	-
	Female	126	44	170	1.57	1.01-2.43*
Ward access type	Silent	21	23	44	1	-
	Without access	251	101	352	2.72	1.44-5.14**
Admission route	Voluntary	33	27	60	1	-
	Apprehension	239	97	336	2.02	1.15-3.53*
Before care sexual abuse (n=395)						
	None	249	93	342	1	-
	Verified/Suspected	22	31	53	2.38	1.23-4.54**
Before care physical abuse						
	None	227	76	303	1	-
	Verified/Suspected	45	48	93	2.14	1.26-3.57**
Age at admission	8 yrs +	12	24	36	1	-
	4-7 yrs	58	38	96	3.05	1.36-6.82**
	1-3 yrs	89	37	126	4.81	2.17-10.62**
	< 1 yr	113	25	138	9.04	3.99-20.40**
Age at permanent wardship	8yrs +	21	28	49	1	-
	4-7 yrs	89	60	149	1.97	1.03-3.80**
	1-3 yrs	108	31	139	4.64	2.32-9.28**
	< 1 yr	54	5	59	14.4	4.90-42.23**
Age at study	8 yrs +	54	92	146	1	-
	4-7 yrs	95	26	121	6.22	3.59-10.78**
	1-3 yrs	109	5	114	37.1	14.25-96.74**
	< 1 yr	14	1	15	23.8	3.05-186.46**

*$p < .05$, **$p < .01$

The following variables were significantly associated with greater odds of children having an adoption plan: having no mental disorders; being female; having a permanent ward order with no access to biological parents[6]; having been admitted into care via an apprehension; having no history of being abused sexually or physically before care; and being younger at admission, at the date of permanent wardship, and on December 31, 2003. To determine the predictive strength of the variables associated with the key permanency plans, a multivariate logistic regression analysis was computed

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[6] This finding does not necessarily indicate that children whose orders are silent on access are indeed treated differently when it comes to permanency planning but is likely related to the influence of some other variable. For instance, children with silent orders may be on average older and/ or retain regular contacts with extended family to whom, they may wish return at age 18.

with variables first entered in a conditional forward stepwise fashion and then a backwards one ($n =$ 395). The 3 age variables were entered as continuous variables. Only 2 variables were significant predictors of children's permanency plans: children's age on becoming a permanent ward ($P < 0.001$) and their age on December 31, 2003 ($P < 0.001$). Younger age at permanent ward status and younger age on December 31, 2003, were associated with higher likelihood of a child having an adoption plan. These 2 variables alone were responsible for predicting 41% of the variance in the key permanency plans.

4.4 Discussion

The OCWS is the first independent study in over a decade to clearly focus attention on mental disorders among Ontario's permanent wards, to shed light on their comorbid conditions and permanency plans, and to use an advanced sampling methodology to attempt to ensure proportional provincial representation. The use of diagnosed mental disorders allowed for the inclusion of all selected eligible permanent wards and for reporting on all mental disorders, unlike most studies that use standardized rating scales of psychopathology and behaviour, which are usually not "normed" on children who have significant developmental delay or intellectual disability—a sizable subgroup among children who are wards. The high agency participation rate, the oversampling built into the methodology, and the conservative participation rule (which required each cluster to have at least one agency participate) should minimize any concerns about regional variability in participation.

4.4.1 Mental Disorders

Given that the literature repeatedly reports that foster children have higher rates of mental health concerns than community samples, it was not unexpected that the OCWS rate of 31.7% among permanent wards was a 1½ times higher than the 18.1% previously found among the general population of children in Ontario (Stein, Rae-Grant, Ackland, et al., 1994) or the average of 14.3% found across 6 international studies (Waddell, Offord, Shepherd, et al., 2002). The OCWS rate appears particularly high comparatively because, in another study, Offord and colleagues (1987) relied only on participants' scores on the Achenbach scales to determine whether a child qualified for

a diagnosis, which likely produced a lower threshold than did the OCWS methodology. It is also not surprising that the OCWS rate of mental disorders is much lower than the range of between 41% and 63% reported by Stein and associates (Stein, Rae-Grant, Ackland, et al., 1994) in a sample of foster children from one Ontario CAS. These researchers not only used a measurement tool of psychopathology that likely produced a lower threshold, they also included children who were temporary wards. Temporary wards are more likely to exhibit challenging behaviours caused in part by their having entered care more recently, by having yet to be treated for pre-existing emotional disturbances related to maltreatment or separation from biological family, and by experiencing emotional impacts from uncertainty related to wardship legal deliberations and their futures (Shin, 2005).

The rate for certain diagnostic categories, such as ADHD and mental retardation or pervasive developmental disorder, seemed especially high. The most prevalent diagnostic category was ADHD, with a 20.7% prevalence rate, which was much higher than the 4% (American Psychiatric Association, 2000) or the 6.1% (Offord, Boyle, Szatmari, et al., 1987) rate estimated to apply to children in the general population. This finding may merely reflect the difference between a child welfare sample and a community sample. The high rate of ADHD and comorbid mental disorders (85%) in the OCWS study mirrors findings from other studies (MTA Cooperative Group, 1999). The rate of children with mental retardation (7.5%, hereafter referred to as "intellectual disability") or pervasive developmental disorder was much higher than the 1% to 3% range usually reported among the general population of children. Researchers have concluded that the high proportion of children with intellectual disability in foster care is partly a result of a general increased vulnerability to abuse and neglect among children with pre-existing disabilities and partly a developmental consequence of maltreatment of children who initially had no disabling conditions (Brown & Fudge Schormans, 2003; Fudge Schormans & Brown, 2002; Jaudes & Shapiro, 1999; Sullivan & Knutson, 1998). It is especially important for clinicians and policy-makers to know the childhood rates of intellectual disability because, at any given time, about 37% of adults with an intellectual disability can be

expected to have another mental disorder (Yu & Atkinson, 1993) and since this group is represented at high rates in acute care psychiatric settings and in the province's psychiatric hospitals (Burge, Ouellette-Kuntz, Saeed, et al., 2002; Lunsky, Bradley, Durbin, et al., 2003; Saeed, Ouellette-Kuntz, Stuart, et al., 2003). There is an ongoing need to plan for adequate mental health and social supports for this population as individuals leave the child welfare sector.

It remains unclear why the rate of conduct disorders was lower than expected. Not surprisingly, no children were diagnosed with a psychosis, which is likely owing to the usual age of onset for such illnesses (late adolescence at the earliest) coupled with the sample's very small proportion of older children.

4.4.2 Permanency Plans

Although the OCWS found that many variables were associated with higher instances of mental disorders and with permanency plans, controlling for these factors using logistic regression, revealed that age variables were the only significant predictors of permanency plans. Similarly, US research has consistently found that age is a strong predictor for children remaining in long-term care, with those who are older remaining longer (Barth, 1997; Finch, Fanshel & Grundy, 1986). According to CAS adoption staff, there is a preference among Ontario's adoption applicants for babies or very young children, compared with older children and those with mental disorders or developmental delays (author's unpublished raw data); therefore, it is not unexpected that a high proportion of older permanent wards have mental disorders and permanency plans of LTFC.

4.4.3 Further Research

A recent focus in US research on mental health and child welfare has been on patterns of mental health service use by foster children (Hurlburt, Leslie, Landsverk, et al., 2004). There should be a similar focus on Canadian populations to determine predictors of psychiatric and other mental health service use among children who are permanent wards as a first step toward identifying and addressing any inequities that may be exposed for various subpopulations.

In the 1990s, considerable policy attention and significant legislative changes in Ontario were aimed at streamlining legal timeframes to enhance the protection of children from abuse, to give assistance to families at risk of having a child made a permanent ward, and arrive at earlier final wardship decisions. Many factors impeded the realization of those goals and resulted in the doubling of the permanent ward population in a single decade. If we are to improve the mental health of children, then renewed and enhanced efforts are needed in numerous areas.

To bolster a sense of permanency and stability for vulnerable children, efforts are needed to effectively identify families at risk early, to enhance the range of social services and mental health resources available to these families in a timely fashion, and to further tighten legal timelines for wardship decisions. Further research is also needed to help us better understand the relation between foster children's mental health and permanency planning. Open adoption, where biological parents retain some forms of contact with their offspring who are adopted by others (as opposed to a legal right to access), has been promoted as one solution to conflictual and drawn-out wardship deliberations that often thwart CAS desires to place children for adoption while they are still young and viewed as adoptable (Aitken, 1995). This option has only recently become legally available in Ontario, and research attention to the mental health effects for children involved in these arrangements is strongly encouraged.

In conclusion, the study's prevalence information on mental disorders alone should be important to the CAS administrators, who may not recognize how the aggregate rate of their permanent wards without access who also have a mental disorder compares with the province-wide rate. This information may also be relevant to administrators and clinicians at the transfer payment agencies in various other sectors, including children's mental health, adult mental health, and developmental services. If the 31.7% of permanent wards without access do not have their mental health needs addressed adequately, then many potentially negative long-term effects may be experienced by these individuals well into adulthood and also by the society in which they live (Bueller, Orme, Post, et al., 2000; Quinton, Rutter & Liddle, 1984).

Recently, it has been argued that a comprehensive public health strategy is grossly overdue to improve the mental health of all Canadian children (Waddell, McEwan, Shepherd, et al., 2005). Clearly, government planners and public policy analysts, who may benefit from forecasting the needs of the permanent ward population or the demands on the mental health system, should take note of the need for better tracking of the mental health status of children who are permanent wards.

CHAPTER 5

MANUSCRIPT D:

Gaining Balance: Toward a Grounded Theory of the Decision-Making Processes of Applicants for Adoption of Children with and without Disabilities

5.1 Introduction

Adopting a child from a domestic child welfare agency is a complicated and time consuming venture with many steps requiring decisions and actions. In Ontario Canada, the entire process commonly spans 24 months, between the date of application to the formal placement of a child in the home for a mandatory minimum term of adoption probationary status. In the early phase of this complex process, adoption applicants must formalize their interest in adoption by completing a lengthy and multifaceted application which usually includes a requirement for applicants to complete a preferences form to indicate their willingness to potentially accept children with a range of specific disabilities. In the middle phase, they are required to attend a series of educational sessions and engage in a several session home study conducted by an adoption worker, and if they are subsequently officially approved to adopt in the jurisdiction, they are assigned an adoption worker. In Ontario the late phase can be viewed as commencing after applicants are contacted by their assigned adoption worker to begin actively working to explore further their abilities and child characteristic preferences to facilitate a match between the needs of available children and the wishes of the applicants for the purposes of the pre-adoption placement. There is often a considerable waiting period (i.e., 3-9 months) for applicants between the middle and late phases (authors' unpublished raw data). Throughout these phases, applicants must constantly evaluate whether to remain in the process or resign from it, decide how to conduct themselves during multiple contacts with the agency staff, and express which characteristics or histories of children they would prefer. See Burge and Jamieson (2008b, manuscript submitted for publication) for a detailed list of the common decisions required of or encountered by adoption applicants during various application time phases.

Since various studies and sources have reported that over half of all children who are legally adoptable in North America have special needs such as disabilities (Burge, 2007b; National Adoption Information Clearinghouse, 1997), and since such children may require additional services, resources and supports to maximize their development, the decision-making processes of applicants is likely influenced when considering these children for adoption. Indeed, for many decades researchers have

reported that children with disabilities were often overlooked by workers and applicants for the purposes of adoption and investigators have conducted retrospective studies to shed light on the motivations of adopters' who ultimately chose these children (Coyne, 1997; Deiner, Wilson, & Unger, 1988; Franklin, 1969a; Glidden, 1985, 1986; Macaskill, 1988).

There has also been significant research attention in related fields to decision making in adoption such as in understanding the motivations that bring applicants to the route of adoption generally (Daly, 1989; Daly, 1990; Hoffmann-Riem, 1990; Hoksbergen, 1998), the placement criteria employed by agency staff toward different sectors of the population of available children (McRoy, 1994), the systematic barriers to adoption (Russel & Coyne, 1989), and post-adoption familial factors which decrease the likelihood of adoption disruptions (Westhues & Cohen, 1990). However, only very minimal research attention has been cast on adoption applicants' decision-making processes when considering the characteristics of segments of the population of available children (e.g., those with disabilities) while the applicants are within the adoption process.

For our purposes, adoption is defined as the official legal transfer of all parental rights and duties to a child, which the state has previously assumed from the biological parent(s), to the adoptive parent(s). The child in these instances usually becomes available for adoption when his/her biological parents lose custody to the state due to confirmed maltreatment of the child or following the parents' voluntary relinquishment to the child welfare agency, acting on behalf of the state, and the subsequent agency and legal determination that the child's best interest is to be adopted. The term disability is defined as a professionally diagnosed condition which results in limitations in a child's functioning. Special needs is a commonly used term in adoption practice and research to indicate child circumstances or characteristics considered to require specific atypical accommodations and to distinguish 'the child with special needs' as being atypical from the historical norm of desirable and adoptable characteristics. Special needs of the child are viewed variously in different jurisdictions but they imply any of the following characteristics or experiences, being: disabled, older than a specified

age (e.g., typically age 5), a member of a sibling group which must be placed together in one adoptive home, or from a visible minority population.

Decision making, as an area of research inquiry, has been pursued for many decades by researchers from many disciplines (e.g., commerce, mathematics, medicine, psychology, sociology) resulting in multiple definitions, concepts and theories, each with their own definitions and foci. In this paper, we use Hastie's (2001) definition of decision making and Tallman and Gray's (1990) definition of decision. These definitions were selected as they both reflect the multistage process and inter-related decisions which must be taken throughout the process before applicants make an ultimate decision about choosing an adoptee. Hastie (2001) defines decision making as "the entire process of choosing a course of action" (p. 4). Tallman and Gray (1990) note that decisions are consciously chosen outcomes in response to non-routine situations, with degrees of uncertainty and risk, where several alternative courses of action are possible, and which flow from a decision-making process. Therefore, the decision-making process encompasses all of the factors that motivate an individual to consider a course of action such as sustaining the idea, developing intentions by consideration of alternate options or plans and selecting next steps. Hastie (2001) notes that the main focus of research on the decision-making process has been on understanding how people weigh their various desires and beliefs in choosing among alternate courses of action.

Numerous psychological models of decision making or closely related theories (e.g., motivation theory, theory of reasoned action, theory of planned behaviour [TPB], goal pursuits, self-completion theory) have been developed and promoted over the past few decades as ways to explain and predict human decision making. Nevertheless, experts have identified numerous methodological and theoretical challenges related to decision-making research especially limitations with the generalizability to real-world complex decisions. These include the tendency of decision-making research to be concerned only with and be applicable to simple decisions between two or, at most, three, relatively simple alternatives (Hastie, 2001; Roe, Busemeyer & Townsend, 2001; Tallman & Gray, 1990), a lack of focus on the effects of a decision maker's emotional states on his/her decision-

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making processes (Busemeyer, Weg, Barkan, Li & Ma, 2000) and an over emphasis on researching the final decision versus the process in arriving at a decision (Godwin & Scanzoni, 1989). Furthermore, there are difficulties in measuring a decision maker's internal weightings of costs, benefits and personal values of his/her goals in given situations since these have relative and not absolute values (Emerson, 1987, as cited in Tallman & Gray, 1990; Hastie, 2001). Given all these challenges cited by experts in this research area, it is notable that after years of conducting research aimed at the development of decision theory, Busemeyer et al. (2000) state that 'very little is known about the principles of multistage decision making' (p. 530). Therefore it is not surprising that such researchers limit claims on the generalizability of their laboratory-based studies' results as, only 'potentially applicable' to real life decisions (Roe et al., 2001, p. 371).

If social scientists are to lead the way in informing practice in the adoption field then theories concerning decision-making processes among adoption applicants are necessary. The noted lack of sufficient research attention on applicants' decision-making processes bears a price since many international jurisdictions have witnessed an overall increase of children awaiting adoption as decreasing rates of these children leave care via adoption (Burge, 2007a; Jones, 1999). The increasing number of children with disabilities who are wards of the state has resulted in a social policy crisis and therefore contributes to the timeliness to addressing the gaps in our understanding of adoption applicants' decision-making processes. The purposes of the research presented here were to identify and examine the decision-making processes among applicants when considering available children with and without disabilities for domestic public adoption (DPA) in order to present a grounded theory of these processes.

5.2 Methodology

5.2.1 Data Collection

Procedure

In order to develop an advanced understanding of agency processes and prepare to recruit adoption applicants, the first author approached 17 Executive Directors (EDs) of child welfare

agencies operating in southern Ontario. EDs of nine agencies expressed interest in participating in the study. The first author then selected six of these nine agencies for their representativeness on several factors (i.e., agency size, catchments area, population served) and asked their EDs to each specify one adoption worker who the first author would meet to discuss the adoption procedures at his/her agency and eventually to act as recruiters of adoption applicants. The six workers (five were female) were formally trained social workers who had between 7 and 32 years of experience (*Mean* = 15 years) arranging DPA in southern Ontario. In April or May 2004, these workers provided the first author with factual information and professional perceptions about their agency's adoption procedures and about the factors they believed affected specific adoption timelines, phases and decision-making processes of adoption applicants. Workers were asked in-depth questions about their perceptions of applicants' decision-making influences and applicants' preferences for or against certain child characteristics especially concerning disability, and their views on how and why such preferences changed over the phases of the application process and under what circumstances. Workers were also asked about how they consciously used their role to try and influence applicants' decision-making processes. Workers' responses informed the development of the initial interview schedule for adoption applicants and four of these workers also agreed to engage in member-checking activities and establishing credibility at a later analysis stage of the study. Five of the interviewed workers, and later, other agency workers at all six agencies agreed to assist with the recruitment of applicant participants.

After receiving education about the study and information sheets for distribution to potential applicant participants and when requested by the first author, adoption recruiting workers intermittently informed eligible adoption applicants about the study and invited them to either contact the first author or allow the release of their contact information to this author for purposes of future contact. The eligibility criteria of adoption applicants as study participants are described later. When prospective participants were contacted by the author, their eligibility for participation was confirmed, the purpose and the scope of the study were reviewed and, if deemed eligible, an

appointment was set for an initial interview with this researcher. All participating applicants agreed to receive a copy of the transcribed interview, review this and confirm their agreement that the contents reflected their views or experiences or suggest corrections to the transcript if needed.

Data collection occurred over multiple fieldtrips. A third of the applicant interviews were conducted in July-October 2004, a third between October 2004 and March 2006 and a final third in the fall of 2006. Interviews with applicants were conducted in their homes (n=12), workplaces (n=2) or the first author's office (n=1). Applicants who had spouses were interviewed alone. Infants or young children who were on adoption probation with interviewees were present for all of or portions of five interviews. The Research Ethics Board of Queen's University approved all procedures. All participants indicated their consent to participate in writing prior to the first interview. All interviews were audio recorded and applicant participants completed a brief questionnaire which was returned by pre-paid mail. The questionnaire was comprised of questions on socio-demographic variables (e.g., age of participant(s), family income, religious affiliation, and contact with family members including relatives with medical conditions or disabilities). All participants were later mailed a copy of their transcript for corrections and comments and a small honorarium.

Participant Interviews

Interviews ranged in duration from 30 to 100 minutes, with most lasting approximately 60 minutes. The initial 6 interviews lasted on average 75 minutes. Overall, as data collection and analysis progressed, questions became more focused and interviews were generally shorter. Initially, a semi-structured interview guide was employed. Questions focused on uncovering factors which applicants viewed as influential to their decision-making processes. They were asked about motivations to adopt, influential pre-adoption application experiences, processes for arriving at preferred child characteristics, how they considered specific children (e.g., especially those with special needs such as disabilities), and the influence of agencies or adoption workers upon their decision-making processes. Later interviews became more focused on specific areas of the emerging theory (e.g., applicants' experiences of the impacts of emotions or the lengthy waiting periods on

decision making). Interviews were conducted and recorded by the first author and transcribed

verbatim by this author or a paid assistant shortly after the fieldwork trips. When the paid assistant

completed transcriptions, the first author listened to the recordings and corrected all transcripts.

Applicants received corrected transcripts and were asked to read these and further correct or comment

on them if they found any content that did not reflect their views.

5.2.2 Participants

Participants were 15 adoption applicants who were required to have never previously adopted or

fostered a child and could not have sought approval to foster a child simultaneous with their adoption

application. They also had to be Canadian citizens seeking adoption from any of the six child welfare

agencies located in southern Ontario which were formally assisting with the study. Given the lengthy

adoption process and the authors' recognition that the temporal location of an applicant within the adoption

time phases may impact his/her decision-making processes, recruitment attempts with applicants were

initially targeted to ensure exposure across the procedural phases of adoption application (i.e., early, middle

and late phases). After several months of no success in recruiting early-phase applicants and upon the advice

of our agency recruiters, attempts to recruit early-phase applicants were abandoned. Middle-phase applicant

participants were those who had already completed lengthy formal applications, attended educational

sessions, and completed home studies, and finally had been approved to adopt in Ontario but had not yet been

contacted by their assigned social worker to facilitate matching with a child. Late-phase participants were

those who had completed the earlier phases' activities and were amidst the matching activities or had very

recently accepted a child on adoption probation. This study did not attempt to recruit applicants who were

eligible to finalize an adoption by having a child in their home for six months or more. As well, recruitment

efforts were undertaken to ensure the participation of applicants with high and low interest, as expressed to

agency personnel, in adopting a child with disabilities.

Characteristics of Participants

Fifteen Canadian adults aged between 34 and 45 (*Mean* = 39.1 years) were applicants for domestic

adoption at one of five public child welfare agencies located in southern Ontario. Fourteen were recruited to

participate by a worker at four of the six agencies who agreed to assist with recruitment. For the sake of convenience only, one other participant, who became known to the first author and enrolled to adopt with a fifth southern Ontario agency, volunteered for interview. Eleven of the participants were female. Fourteen participants (i.e., 11 identified as straight, 3 identified as lesbian or gay) were married or co-habitating with a spouse with whom they had resided for between 3.5 years to over 20 years (n=12, *Mean* = 10 years). All participants were employed on a full-time basis, though six were on temporary parental leaves following the reception of a child on adoption probation. A seventh participant had also received a child on adoption probation but continued to work while his spouse was granted the parental leave. The estimated level of annual household income for participants was reported to range from between "$50-59,000" to "over $110,000". The education level of participants ranged from a college diploma to a university master's degree. Fourteen of the participants were Caucasian and one was from a visible minority. Fourteen were able bodied and one experienced significant mobility impairments and regularly used a wheelchair. Thirteen participants reported ascribing to a religion and in every case it was reported as one of the Christian denominations. There were 4 participants in the middle adoption phase (i.e., who had been approved to adopt but were waiting to be presented with specific children) and 11 in the late phase who were actively being offered children but had not been short listed or indicated interest to be short listed for presented children (n=4) or had recently accepted a child on adoption probation (n=7). Table 5.1 depicts a profile of the participants.

Table 5.1

Profile of Participants

Name[a]	Gender	Age	Spousal status	Usual employment	Other parenting routes explored	Adoption phase
Sandy	Female	34	Single	Teacher, Private school	None	Middle
Ken	Male	36	Couple	Manager, Developmental services sector,	Surrogacy; co-parenting arrangement	Late
Amy	Female	41	Couple	Clerk, Government	None	Middle
Terry	Male	42	Couple	Operations Specialist, Private company	Fertility Clinic	Late
Kate	Female	37	Couple	Parole officer	ART[b]	Middle
Adam	Male	43	Couple	Industrial Mechanic	None	Late
Sarah	Female	36	Couple	Social Worker, CAS	Private and international Adoption	Middle
Jenn	Female	38	Couple	Small business owner, Service industry	CAS foster-adoption program	Late
Karolina	Female	43	Couple	Business woman	ART	Late
Kasey	Female	45	Couple	Social Worker, Youth services	ART	Late
Carol	Female	42	Couple	Staff, Nursing home	ART	Late
Barb	Female	39	Couple	Teacher, Public system	ART	Late
Sharon	Female	-	Couple	Social Worker, CAS	None	Late
José	Male	34	Couple	Computer consultant, Private company	ART	Late
Lisa	Female	38	Couple	Early Childhood Educator, Private Daycare	ART	Late

Note: The dash indicates unknown information. [a] All names are pseudonyms selected by the first author. [b] Artificial reproductive technology.

5.2.3 Data Analysis

The approach used in this study to analyze the applicants' data was based on the version of grounded theory detailed by Strauss and Corbin (1998) as this systematic approach had been deemed

to offer high potential to discover theory specifically related to adoption applicants' decision-making processes (Julie Corbin, personal communication, August 26, 2003). Their analysis system involves several progressive, and usually overlapping, coding steps including open coding, axial coding and selective coding. The goal of the coding techniques is to arrive at a substantive-level theory of the phenomena under investigation. Textual data from interviews with applicants were imported into the computer software program NVivo and coded there following the steps described below.

Open Coding

Initially, through open coding, the applicants' data were broken down; concepts were identified, grouped and named; and dimensions discovered (Strauss & Corbin, 1998). For example, raw data extracts from the interview transcripts related to 'emotions' were identified and then efforts to identify different types of emotions, their properties (e.g., such as intensity, duration, location of expression, purpose of expression) and dimensions of these were made. As analyses proceeded, other data were identified, and if conceptually similar to emotions, were grouped into this concept or into new concepts if characteristics were found to be substantially different. As is typical in the grounded theory approach (Creswell, 1998), recruitment and interviewing were stopped once saturation of categories was deemed completed by the authors, that is, when subsequent interview data did not provide further insight into the category.

Axial Coding

The second step known as axial coding involves reassembling data by categorizing them into related sub-categories and concepts. Categories were linked or related with their sub-categories and associated concepts and were developed to become more distinguishable explanations about the decision-making processes engaged in by adoption applicants. As well, the consideration of causal and intervening conditions which appeared to impact applicants was made and included in the developing model.

Selective Coding

Selective coding aims to integrate and refine earlier categories in order to develop

explanations between categories and form a larger theoretical scheme (Strauss & Corbin, 1998). The

first step in integration is generally to identify a central category, as identified in this paper, while

other key categories and sub-categories and related concepts are more firmly ascertained later.

Statements of relations between categories were developed and theoretical integration was promoted

through comparing findings to previous research. The development of our narrative story line is an

example of a product of this coding process.

Analytic Tools

A variety of analytical devices and techniques (e.g., flip-flop technique, systemic comparison

of two or more phenomena, waving the red flag) as described by Strauss and Corbin (1998) were used

to facilitate the coding process and further stimulate the inductive process. The examples above were

techniques utilized during the coding steps to compare and contrast categories in order to progress

with theory development. As well, early in the analysis, data were written into a narrative (i.e., story

line) to attempt to explain interrelations between categories and concepts and explain the decision-

making process of applicants engaged in the DPA system. Memos and notes were recorded after

many coding sessions and were intermittently reviewed[7]. As well, trustworthiness was enhanced

through collaboration between the co-authors who each independently reviewed and coded applicant

interview transcripts and met frequently to share and discuss interpretations and depict categories of

decision-making processes and key conditions impacting applicants' processes over time.

A final analytic tool employed to help facilitate the development of the theory was the use of

a delayed literature review. While some literature had been reviewed prior to the data gathering

period, which supported the need for this investigation, a much more in-depth literature review

occurred following most analyses. This final literature review identified prior research related to

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[7] The first author held several informal interviews with experts in DPA in Ontario. As well, field work observations such as his attendance at a bi-annual Adoption Resource Exchange conference, wherein Ontario child welfare agencies present videotaped portrayals of children they have had difficulty placing on adoption to approved applicants, were undertaken to supplement the interview data presented here. These data collection methods provided valuable contextual information to the authors and assisted with interpretations of meanings. They are not presented as raw data and were not coded.

categories as well as decision making generally in order to compare our nascent theory with the previous research noted above.

Member-Checking and Credibility

Three techniques were employed to ensure that the study findings both portrayed a recognizable reality for adoption applicants and tested its representativeness with other knowledgeable actors in adoption. The first entailed sending all participants a transcribed copy of their interview within a few weeks of their interview. They were asked to review it for accuracy and to indicate revisions if they did not believe the transcript content accurately represented their views or experiences. Only one applicant suggested minor grammatical revisions.

As the analysis was nearing conclusion, and in part due to the lack of feedback received following the traditional member-checking activity described above, a second and third technique were employed. The second involved mailing to the six most recently interviewed applicants the emerging theory as outlined in a narrative story line, and a Table (i.e., similar to Table 5.2 below) listing categories, sub-categories and concepts. Only the most recently interviewed six participants were contacted for this purpose since the authors viewed seriously Morse's (1994) cautions of the confusion which can be created when the passage of time or other intervening events cause participants to change their assessments of their experiences and disagree with researchers interpretations. Since the interviews of the initial nine applicants had been so long ago they were excluded from an invitation to participate in this step. While the period of time passed for the final six interviewees was significant (i.e., between 16 and 17 months) it was nevertheless deemed important to solicit feedback. The third technique involved mailing four adoption workers, who indicated their availability for this purpose, a similar package of information as in the second technique. Both applicants and workers were asked to comment on the authors' interpretations of the applicants' data and the degree of coherence and completeness in the emerging theory.

5.3 Results

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One central category *Gaining Balance* was identified through the analysis along with three

main categories *Commitment, Persistence,* and *Evaluation*. Explanations of the interrelations of these

categories, nine sub-categories, and numerous associated concepts are described below.

5.3.1 Gaining Balance

The decision-making processes of adoption applicants committed to the DPA route and

considering available children with and without disabilities are best represented by the central

category label *Gaining Balance*. Adoption applicants enter the DPA system in order to achieve their

goal of becoming a parent of an adopted child as soon as possible. As these applicants progress

through the system they are confronted by a series of situations in which they are requested to

evaluate and reevaluate who they are and their abilities as future parents; the information about

potential adoptees in order to appreciate their needs; and the characteristics of their preferred child.

These evaluations by applicants were permeated by their knowledge about the high rates of

disabilities among the pool of available children. Although these situations seemed to be accepted by

applicants as supporting their smooth progression toward goal attainment, each could result in

applicants' 'loss of balance' which could be re-gained through sufficient effort on the part of

applicants to overcome challenges to achieving their goals. Here, the term 'balance' identifies the

focus of applicants on equilibrium or steadiness as the applicants proceeded step-by-step through the

system. The qualifier 'gaining' supports the notion of a dynamic and fluid process marked by

conditions which cause a destabilization and result in efforts to persist in the process by bringing the

applicants back or toward equilibrium or balance.

Three categories help explain applicants' endeavors to 'gaining balance': *Commitment*,

Persistence and, *Evaluation*. Commitment is concerned with what drives applicants to meet their

parenting goal and specifically through the DPA route. The category Persistence is closely related to

Commitment and refers to the efforts and degree of effort employed by applicants to counteract the

challenges to achieving their adoption goal. Evaluation refers to the ongoing considerations and

assessments of three areas outlined above (i.e., their personal abilities; knowledge about adoptees;

and their preferred child characteristics) and strategies employed to facilitate these evaluations. Only when the applicants' level of commitment was adequate and the various internal and external, potentially destabilizing, demands were addressed through their persistent efforts, was sufficient balance attained or regained to allow applicants to proceed to the final matching phase of decision making. This matching phase required intense evaluative activities and invariably presented numerous challenges which further de-stabilized applicants. While applicants could frequently alter their assessments of their abilities, knowledge of children's needs and their preferences for children, in order to evaluate their willingness to proceed or cease considerations of specific available children, they had to gain a subjective sense of balance in each of the areas of assessment before a decision could be made to restore stability.

The interpretive codes of the three categories, nine sub-categories, and numerous associated concepts and their interrelationships are depicted in Table 5.2 and described below.

Table 5.2

Categories, Sub-categories and Concepts for Central Category "Gaining Balance"

Categories	Sub-categories	Associated concepts
Commitment	motivations	desire to parent
		acceptance of domestic adoption route
		specificity of motives
	financial considerations	
Persistence	determination to succeed	self-advocating
		controlling the process
		self-preserving
	coping with emotions	steadying emotional investment
		controlling desperation
		addressing conflicts
	counteracting pessimism	
Evaluation	assessments of personal abilities and resources	self-awareness
		life stage
		life style
		enhancing abilities
	assessments of knowledge of potential adoptees' needs	recognizing prior experiences or knowledge
		enhancing knowledge through information gathering
		seeking knowledge of special needs
	assessments of preferences for specific child characteristics	keeping an open mind
		motives
		degrees of entitlement
	strategies for matching preferences to abilities and knowledge	screening in
		taking time
		determining the fit
		imagining parenting in the future
		comparing to the imaginary biological child
		tuning into the emotional level
		meeting the child

5.3.2 Commitment

Commitment is concerned with what drives applicants to meet their goal of parenting through the DPA route. In order to address the numerous systemic demands placed upon applicants in the early and middle phase of the process (e.g., compilation of the complex application, engagement in an intensive home study), applicants had to demonstrate a substantial and ongoing commitment to the adoption route in order to fulfill their desire to parent and form or enlarge their family. Data showed

that applicants' degree of commitment was influenced by their motivations and financial considerations.

Motivations

Motivations represent the reasons and the intensity of the reasons why applicants were involved with adoption generally and the domestic public route specifically. It was obvious from the data that many differing motivations underpinned the commitment to adoption and could be grouped as: the desire to parent, acceptance of the domestic public route, and specific motives.

Desire to parent.   A strong degree of desire to parent was a necessary prerequisite to the commitment to the adoption application process that could result in them being found ineligible to adopt. For many of the applicants, the degree of commitment was highly influenced by prior difficulties trying to conceive a child; for some it was also heavily influenced by the need to meet the cultural and family expectations regarding adulthood and assuming the role of parent. José describes influences in his case.

> …we were sort of culturally programmed to have kids at an early age, ... it got to a very painful
>
> point where we realized that a medicine was not going to give us control over our lives. We
>
> were in fact slaves to all the medical advances and we said that is the one thing we can not
>
> tolerate.

Acceptance of the domestic adoption route.   All applicants were aware of other routes to conceive a child or to adopt and many confined themselves to the DPA route[8] as it aligned with key personal values such as to help an existing domestic child and avoid a negative sense of participating in a baby trade, "The reason why we didn't go international … It felt like we would be buying a baby." One participant spoke to the gradual acceptance of the DPA route due to her husband's recollections of the negative experiences of extended family members with DPA and his concerns that they would be forced to accept a child with disabilities, "…even when we were going to the information sessions ah you could hear it in his tone when he'd ask questions and ah but I knew when

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[8] A small minority of applicants simultaneously explored the international adoption route.

we had finished he was ready." Four female applicants assumed they were fertile but for varying

reasons (e.g., medical advice related to potential illness resumption) preferred to adopt a child. A gay

male applicant viewed adoption via this route as less risky to subsequently breaking down than would

similar arrangements via surrogacy.

   Specificity of motives.   The motivation to parent could be influenced by many formative

experiences, as noted above, but also by specific personal motives, such as improving the life

outcome of a specific child who was presently in foster care following experiences of maltreatment or

for reasons of abandonment due to biological parents' inability to accommodate the child's disability.

Adam's motives were less altruistically stated but very strong:

> And me, I love children. Anybody who knows me, the children who come here, they hang on to me,
>
> they don't hang on to my wife. …But to be honest, … I have a great need for that (parenting via
>
> adoption sic) in my life because it's something, because first of all, I've never had a father…

Financial considerations

   For many applicants, especially those with reduced financial means, part of their

commitment to the DPA route came following the realization that financial costs associated with

this route were significantly lower than those associated with other routes. As expressed by Terry,

> Do I put myself in debt so much to have a child [via infertility treatments] where I can't support
>
> the child? …and we said … let's stop it now and let's go to this next level, go to the adoption
>
> side.

   And later he stated: "Private adoption we're not thinking about because my sister went

through that and that was, I don't know if I should tell you or not, but that, her social worker

worked private adoption, was all money, money, money, no results". The relative influence of

financial means on commitment was not universal across applicants and a few simultaneously

explored multiple routes in order to improve their chances of success. Those who explored the

international option perceived it as both a quicker route to adopting generally and a more likely

path toward adopting a baby who would have no experiences of maltreatment and no known disabilities.

5.3.3 Persistence

Persistence represents the applicants' efforts to maintain balance and, as they confronted challenges, remaining on track to achieving their goal of parenting. Three sub-categories underpinned the persistence required by adoption applicants; a strong degree of determination to succeed, a willingness to cope with their emotions, and counteracting pessimism to neutralize thoughts of withdrawing from the process.

Determination to succeed

Applicants' resolve to succeed at adopting and receiving the child with their preferred characteristics into their home fueled their efforts to persist and retain or gain balance as they proceeded in the process. It was apparent that various strategies (i.e., self-advocating, controlling the process, and self-preserving), were used by every applicant and to differing degrees, bolstered their determination to succeed. Being out of balance was exemplified by a low effort seen in Amy's loss of determination when asked if she was confident that she would succeed in finding a child who would fit with her existing son and family circumstances, "No, no….. I mean I don't know if it's ever going to happen. Which is something that will be very sad for me."

Self-advocating. Self-advocacy efforts, undertaken by several applicants and occasionally their partners, usually involved efforts to speed up the process by initiating contact with their adoption social worker, their key liaison in the process, and requesting that specific children be presented to them, as in the case of Lisa.

> So, on the last day I said to our worker, I'm going to hear from you again aren't I? She said 'of course' so Matthew was calling her every week, 'Joan do you have a child for us yet? Do you have a child? What would you like us to get you, a BMW?'

Controlling the process. Feeling a sense of control over the pace of progress through the adoption process was important to most applicants' determination to succeed. The strong desire for

control in adoption was especially evident for some applicants, who had previously experienced an intense lack of control in the infertility treatment process as expressed by José,

> …our objective was to have a family and ahh we needed to do it in a way that we can control. And umm we started evaluating different options but adoption was kind of very clearly in our minds the one thing that, even if it was going to take a bit longer, we would be able to drive the process. It would be mostly up to us to get things done, and that was it it was really about accomplishing that mission in a way that we could control it.

Several applicants sought to speed up the process and some of these elected to attend the bi-annual Adoption Resource Exchange meetings in Toronto to see if they could locate an available child for themselves[9]. A few applicants paid for private home studies after determining that the waiting period to commence a home study by a child welfare adoption worker was too long. Sarah stated, "And then if you are willing to pay for your own home study it can be done more quickly because you are doing it privately and you're paying a private practitioner." Some applicants, such as Sandy, voiced a belief that appearing very open to accept children with various disabilities and special needs (i.e., by indicating so on a form from her agency which asked her to comment on her willingness to accept each of a long list of specific disabilities and other child characteristics) might help speed the process, "But you do think when you're filling out that form, if I say 'yes' to everything I might get a child faster."

Not surprisingly, given the common length of the adoption process (i.e., up to 24 months), many applicants had life events arise to which they chose to attend while placing on temporary hold their adoption goals. This flexibility within the adoption procedures contributed to applicants' sense of control over the process and supported their ability to persist within it. Jenn reported, "Uh, in our case, in the beginning, because we had several trips planned that we've been really clear that we're taking, um, so we kind of stalled the process." Adam required a longer delay,

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[9] At Adoption Resource Exchange meetings CASs present children who they have had difficulty placing to approved applicant attendees from across the province. Children presented there typically have disabilities or other special needs such as being older or a member of a sibling group which must be placed together.

We put everything on hold because in February we sold our house in Mississauga and we wasn't

sure what was going on, and we put everything on hold for that period after, we ended up buying a

house and moving in September. And only this year, when we got ourselves time to settle in.

Self-preserving.   Applicants were challenged to balance personal life demands with the

challenges of remaining in the adoption process. As expressed by Adam,

We are not getting younger, I mean it's a, what we've come through, it's a painstaking process. It's a

slow, patient, painstaking process, and we learned to go as far as they're willing to keep us in, within

the system.

Many applicants also learned to steady their emotional investment in any one child and

diffuse wishes to exercise control through quickening the process. Kate noted learning to avoid

voicing repeated requests for predictions of success from her social worker, "…when you ask people

to give you likelihoods you just get excited about things, and there's no point." Or as Sandy noted,

"So I had to get over that…, you know, trying to accelerate the process." These self-preserving

activities were undertaken because of the applicants' determination to succeed at adopting and

realizing their parenting goals.

Coping with emotions

The data highlighted the importance for applicants of steadying their emotional investments

(e.g., to any one child), controlling any encroaching sense of desperation (e.g., often as a result of

waiting a long time) and managing conflicts in a manner acceptable to them.

Steadying emotional investment.   Many applicants described their crucial need to steady their

emotions, especially while waiting for the worker to approach them with a new child profile or after

indicating interest in a specific child profile and awaiting news about whether they had been selected

as the top applicants to proceed to meet the child. When applicants had been approached by their

worker and indicated their interest in being considered for a specific child, but were not ultimately

selected at the child's adoption conference to proceed, they could become unbalanced. A rebalancing

response was necessary for many applicants in order to persist in the process. In Karolina's case, she

was required to reduce her emotional excitement and overall investment following a major disappointment in order to be able to move forward and consider other children:

> We were crushed…So subsequent to that experience, we didn't go down the emotional pathway that we did with the other children, ...we didn't invest ourselves in it to the degree we had … we insulated ourselves a little bit, I would say, as we moved forward.

Controlling desperation.   Many applicants needed to actively counteract desperation in their approach to prospective children. This desperation resulted from the passage of time and fears of failure to achieve their adoption goals, and was exacerbated by workers presenting children's profiles that were dissimilar to the characteristics for which applicants had expressed preferences. Most frequently these non-preferred characteristics of children were types of disability or older ages. Sandy remarks, "Well she [the social worker] does try to, not sway you, but open your mind. Like I do think, and that's where you have to be kind of firm yourself, and not let that level of desperation or whatever overpower you." As Lisa noted, "I had to set in my mind that this wasn't going to happen soon, so that I was living life and enjoying life and not sitting there waiting day after day."

Addressing conflicts.   Internal stress and frustration arose for some applicants when hearing of the complexities of the matching process. Lisa noted the stress inducing explanation received from her social worker, "'There's a toddler that I'm thinking of putting your name in for but there are people who have been waiting a year and a half and if everyone's a good match of course they're going to get the child first'." Some applicants took pains to avoid directly expressing their emotions of disappointment or anger at adoption social workers as they held a belief that an appearance of cooperation would best achieve success in their adoption quest. Applicants often shared complaints about the process with their partners as a means to discharge anger. Karolina noted that in the late phase of applying she would be commonly informed by her worker of the mismatch between her preferences and the characteristics of available children, "… we would leave [our worker's office], and I would say to Garry 'that's bull shit, it's just a queue and we haven't been in the system long enough!'". Others directly expressed their displeasure with workers or their workers' supervisors who

had suggested they consider children who clearly did not fit their previously stated preferences. Ken sensed discrimination against him adopting children who had no special needs based on his sexual orientation (i.e., gay man), which he believed placed him lower on a CAS hierarchy of valued applicants:

> And then she [the social worker] said, 'I'd like to be honest with you; it goes heterosexual, gay couple, single'. And she actually said that to me, and I brought that to a supervisor's attention too, because I was really pissed off. I thought, you know, you know that there's a bias there and you're pretty much partaking in that if you're not calling them on it…

Counteracting pessimism

In addition to being determined to succeed and coping with emotions, most applicants could envision future circumstances which could ultimately result in their resignation from the adoption process. For instance, many applicants who had waited many months entertained thoughts that they would soon be getting too old to be an energetic parent or to fit parenting into their life course. It was common for such applicants to encounter destabilizing periods of pessimism about their likelihood of being matched with a child or a child with characteristics they preferred: especially when they preferred to avoid children with disabilities. To persist in the process, applicants had to actively overcome these sentiments even if only marginally as expressed by Karolina;

> Should we go forward? And Garry's [spouse] like, you know what, we know there's three other people going for him [a desired available child], the reality is we're not going to get him anyhow. … I said, okay, well, you know, you can't win if you don't play, kind of thing. … we honestly, we were that lack luster about it.

Kasey needed to make frequent contact with her worker to stave off a sense of pessimism, "you know, to have no contact you just feel like you're lost, kind of thing."

5.3.4 Evaluation

The term evaluation refers to the ongoing process of considerations and assessments (i.e., appraisals) which is central to applicants' decision making. While the data showed that evaluation had

commenced for applicants before their formal application to adopt, once applicants' committed to the DPA route and their efforts of persistence were initiated, evaluation became more active and intensified. Applicants' data indicated that the sub-categories of evaluation were active assessments of their personal abilities and resources (i.e., as future parents), knowledge of potential adoptees' characteristics and consequent needs and, preferences for specific child characteristics. Applicants employed a range of strategies to gain balance in their perception of the fit between their abilities, their knowledge of potential adoptees' characteristics and needs, and their preferences.

Assessments of personal abilities and resources

Assessments of personal abilities represent the considerations applicants made of what they had to offer a child and any related limitations to the applicant's abilities to parent. This category was particularly influential in decisions about the ability to parent children with disabilities. Several areas of assessments of abilities underpinned the decision-making process in adoption including: self-awareness, life stage, life style, and enhancing abilities.

Self-Awareness. Applicants typically reported learning more about their particular strengths and predicted their future comfort level with children with various needs as the application process continued. They credited mandatory education sessions and home studies as key contributors to this increasing self-awareness, as described by Sandy, "Um, it just made me more introspective. It made me think, okay, what is your motivation, and, yeah, about, thinking about your own life and how well prepared are you for a child?". For some applicants, self-awareness of their personality and personal style of interacting with others may have helped them achieve a balance when interacting with the agency and assisted them to assess and express their abilities when they felt pressured to acquiesce with their workers.

Many applicants reported consciously assessing their comfort level with potentially disturbing traumatic histories that children may have experienced prior to being placed in care. In an evaluative manner they would place themselves in hypothetic scenarios to help gauge their comfort level. For example, Ken:

…how are we going to, uh, you know you always plan the years ahead, you know, how are you going to like tell your child that this is the kind of trauma that they incurred, and, you know, just go through this whole thing like, you know, okay, where is this child going to go to school, how are we going to get to daycare, it's just, it's all that kind of stuff, like you're planning and planning.

Life stage. Applicants' assessments of their life stage (e.g., their age, physical energy level, their life stage vis-à-vis parenting stage of their friends) were key considerations when gauging their capabilities to parent children with characteristics which may vary greatly such as age or degrees of special needs associated with disability. Barb states it clearly, "If I was in my 20s or early 30s doing this I might have considered a child that might have more extreme [needs]…". Assessments of life stage were often influenced by current work life considerations including applicants' abilities to take time away from a workplace or career, or by family life responsibilities. Amy hesitated to consider a child with disability, "If we didn't have a son then that's totally different, but already having a child, so we had to decide what things we thought we could, would fit into our family properly."

Life style. Assessments of abilities included awareness of life style values and ideas about how their current living circumstances influenced receptivity to certain children. Jenn, a lesbian women, expresses her value, "we were quite firm that we won't have a child in the Catholic school system… because of their teaching which is so much against our lifestyle". For a variety of reasons some applicants believed their life circumstances precluded them from accepting a child from a different culture, ethnicity and /or race, "There's not a lot of cultural opportunities [here] and certainly if I had a child of another culture I would want that child to learn as much about their culture as they could….". For a minority of applicants with personal health concerns, health status could impact their assessments of abilities especially regarding acceptance of a child with ongoing medical needs. As Terry expresses this, "I really don't want the hospital because I'm there enough myself, right?"

Enhancing abilities. Some applicants began making changes in their lives to ensure they could accommodate a child physically in their home, have sufficient financial resources to support the

child, or had a social support network to help them with the demands of parenting. Sandy made

changes early on, "So even though I started the process last summer, I started thinking about it before.

So, I moved prior to even starting it. Then I would have, the child would have a bedroom and…".

Assessments of their knowledge of potential adoptees' needs

Assessments of knowledge represent the considerations that applicants made concerning

whether they had sufficient information about and understanding of the characteristics and needs of

the pool of children who were adoptable. Several areas of assessments of knowledge were influential

including recognizing the applicants' prior experiences and knowledge, enhancing knowledge

through information gathering, and seeking specific knowledge on particular needs of children

whether they had a disability or not.

Recognizing prior experiences or knowledge. Prior professional training or experiences and

personal or familial experiences influenced the comfort level of a number of applicants when

considering the parenting of children with a range of characteristics such as disabilities or experiences

such as maltreatment. Prior experience seemed to strengthen applicants' views, for or against specific

characteristics as preferences. Terry described his strong preference to avoid adopting a child with a

physical disability because of his lived experience with disability and his frequent hospital visits,

"…but to bring my child [to the hospital]? I don't want to live in the hospital…". Applicants who

worked in sectors of social services or education tended to express the effects of prior knowledge on

strengthening negative views as in the case of Sarah, "And I know a lot about fetal alcohol and more

than I want to know probably … it's very difficult to raise a child with fetal alcohol syndrome and I, I

don't think I could do that." For a minority of applicants, their current work experiences with children

with special needs was closely associated with their willingness to adopt a child with significant

disabilities as in the case of Sharon, "we were interested in children who had you know maybe come

in … been born with addictions or been born with fetal alcohol kind of syndrome or some kind of

developmental issue. Those kinds of things interested us…".

Enhancing knowledge through information gathering. Applicants often employed information gathering approaches to investigate child characteristics and this information was later integrated into their evaluations when selecting from amongst several child profiles which workers presented to them. Information gathering could take the form of contacting family, friends, colleagues, professionals or public media sources. As well, information about a specific child was also gathered from the DPA social worker or from foster parents who had had the day to day experience with the child. Invariably, applicants encountered information which was completely new to them or challenged their preconceived notions about certain child characteristics such as very specific medical conditions.

Seeking knowledge of special needs. Given the information about the special needs of available children encountered at mandatory adoption education sessions, even applicants who had expressed minimal interest in adopting such children expected to be asked to reconsider them when presented with profiles. At this phase in the process they sought information about children including evidence of children meeting developmental milestones, their ability to form healthy human attachments and, predictions of the permanence and medical management of certain conditions. They approached various information sources including formal (e.g., professionals, information telephone lines, support group or advocacy websites) and informal (e.g., family members, friends, professional colleagues) sources. As Ken noted, "…I talked to my clinical psychiatrist and psychologist on staff where I work and they're like, you know, you need to, you need to get like an independent [assessment] done if you're really serious about the kid…".

Assessments of preferences for specific child characteristics

Assessments of preferences for specific child characteristics represent the applicants' considerations of their preferred images of family life with an adoptee and about the child characteristics which they perceived as fitting with this image. These assessments were usually reported to change over time as prior experiences and presumptions were examined and challenged and, as assessments of personal abilities and knowledge about supporting children evolved. Concepts

influencing assessments of preferences included keeping an open mind, motives and, degree of entitlement.

Keeping an open mind. Several applicants reported that their social worker stressed that their stated preferences of acceptable child characteristics could be changed if they arrived at new preferences. These workers also cautioned applicants to not be surprised should the worker present information about an available child who did not completely match their stated preferences. Jenn noted that the preference rating scale she was asked to complete to rank her willingness to accept various listed child characteristics including disabilities, was not viewed as the definitive declaration of preferences, "…keeping in mind that nothing is written in stone either, so yeah we could say we'll do this but, you know, we'll see when … [the workers] come to us…". As well increasing knowledge of available children and their potential special parenting needs encouraged some applicants to broaden their list of acceptable child characteristics. Some applicants acknowledged their flexibility to change previously stated preferences should the passage of time cause them to conclude that their top level preferences were unlikely to result in success, as in Adam's case, "If that age group proves to be difficult, a kind of difficult obstacle to overcome, then we could extend the border, extend our line a bit." Kasey became willing to accept a boy,

> …you know I think there's a number of factors: one, we were both getting older and, um, you know, we'd been waiting a year and it was sort of like, well are we ever going to get a call. That sort of stuff, and then you know hearing that, you know, more boys probably coming up for adoption.

Motives. This concept exemplifies an area of overlap between categories *Commitment* and *Evaluation*. Applicants' motivations to adopt through the DPA route were not only key to their overall commitment but also influenced applicants' assessments of child characteristic preferences. Applicants varied in the extent that they wanted to fulfill their own desire to parent versus their personal humanitarian or religious ideal of considering a child with disabilities. Applicants who worked in social services or education and were single or had spouses who supported their preferences, such as Sharon, were most likely to express comfort with various disabilities,

I don't know how I knew, that's the only kind of child [a child with disabilities] I wanted to adopt.

For me there was no question uhmm I don't know I don't know if I actually persuaded [my partner]

or if she felt that way.

The degree to which they were willing to waiver from an early expressed comfort zone was partially related to these motives, as in the case of Sandy,

…you're saying no, no, no, no, no, I won't take that, I won't take that, and they're already here

[alive], and so a little bit of your conscience is like, oh, I can give them a good home, and so it's

hard.

Finally, the degree to which applicants' partners were committed to the adoption route had bearing on their openness. If a participant's partner, as in Lisa's case, had taken a long time to accept the adoption route then the openness to consider various disabilities appeared constrained,

I'd be open to examining and investigating and seeing if I could handle a child who may have had

developmental needs or …, I think it's just we went with our true dream which was to have a child

that was healthy.

Degrees of entitlement.   While most applicants wished they could have conceived and birthed their own child and thereby have avoided an adoption application, a few indicated that their lost fertility justified their stance that they were entitled to select the child characteristics they preferred most and avoid children with non-preferred characteristics or experiences. José stated, "we didn't want to go into known cases [of children with health concerns] that would require lots of attention because, I mean, we didn't think that would be fair after this whole process [of unsuccessful infertility treatments]…".

Strategies for matching preferences to abilities and knowledge

A variety of strategies were employed by applicants to balance their assessments and make the final determination about proceeding or ceasing investigations about specific children.

Screening in.   When social workers communicated to applicants multiple child profiles in rapid succession over the course of a day or two or during one contact, participants often adopted

efforts to actively manage both the volume of information and their emotional investment by quickly

screening in only those children who best fit their preferences and their abilities,

> …so you're getting 3 profiles or 4 profiles and, you know, 'ooh this one, yeah a lot of unknowns
>
> there, so okay, let's not deal with that one, let's focus on this one'. So that's kind of part of what you
>
> do. (Karolina)

Some applicants noted that this screening in actuality meant they screened out children that

they might have seriously considered had they not heard so many child profiles almost

simultaneously and had the workers not pressed them to indicate their preferences so quickly.

Taking time.   Applicants often needed to slow the process down in order to fully appreciate

information that they gathered about the specific child and to make their assessments. Sandy

demonstrates this when stating, "I think it's important regardless to go away and think about it and

then, um, it's like with any big decision, you need to have time to absorb."

Determining the fit.   Each applicant was influenced by their commitment to adopt and their

ongoing persistence in the process (e.g., self-preserving, controlling desperation) but was forced also

to consider their assessments from a position of wanting to have a balanced post-adoption life. Ken

was very concerned that the child must fit in well,

> I want us all to set up for success here, and this is not, this is to enhance like everybody's life. This
>
> isn't to, um, you know, it's not like to be an emotionally draining experience that's going to divide
>
> us, you know, like that's going to put a lot of stress on us as a couple, because parenting is stressful
>
> enough, so… and I'm very honest about that. And as much as we'd like to have a child, we want to,
>
> like I said, we want it to be right.

Imagining parenting in the future.   Applicants would envision their ideal family life and

parenting at some future point and try and decipher a prospective adoptee's support needs in light of

this image. Barb alludes to this, "I think for us, it was, as long as they weren't going to be, you know

needing medical attention constantly and uhm were just going to be generally happy and healthy and

OK."

Comparing to the imaginary biological child. Applicants were aware that they were being given the opportunity via the adoption process to state preferences which are not available to those conceiving and birthing a child. Comparing a real available child to an imaginary biological child who may have had significant medical concerns allowed applicants the mental and emotional space to justify considering either a 'perfect' or a less than 'perfect' child. Terry makes this point, "…if it was my child, my blood child that was born with it [disability], but do I decide [via adoption] to bring that child into my life? And we opted no."

Tuning in to the emotional level. A few applicants noted that the emotional element was critical when making the final decision to accept a child on adoption probation. Sandy was asked how she would know if the match was right for her, "How do you know when you fall in love? How do you know?... there's something in the pit of your stomach that tells you if it's the right choice or not." As Kate explained, "So there was a point where we did finally say, okay, let's put some emotion in it, you know, let's try to not just be rational and think this through, let's also put some emotion here." For Adam it related more to his motive to save a child. Adam noted that the child's story would likely be gut wrenching and this would draw him closer to a positive final decision concerning that child, "It's a process, … when I hear, I hear who the child is, what is the circumstances and I see the child, then I know all of the pieces will come together."

Meeting the child. Meeting the child was a strategy made available by the system only as a last step (i.e., along with daytime and overnight visits with the child) in deciding if a child would be accepted on adoption probation. Most applicants who had met children for this purpose reported scrutinizing the child for his/her ability to respond to them, as evidence of attachment potential. However, those who had already accepted a child on adoption probation noted the decision to accept this particular child had almost entirely been made in advance of the meeting.

Results of Member Checking

Five of the six applicants who had agreed to review the initial interpretations conveyed in the narrative story line and Table responded with a detailed written response. As well, all four adoption

workers who indicated willingness to respond did so. Their information supported our interpretations of the data though two of the applicants expressed that their own situations in the late phase matching activities were slightly unique for different reasons. A minor modification in the wording to the narrative story line was made to reflect this variability in the late phase.

5.4 Discussion

Our key finding is that applicants who entered the DPA system in order to adopt a child as soon as possible are engaged in ongoing and complex decision-making processes of evaluation that could destabilize them. If applicants were strongly committed to their goal of being a parent of an adopted child and generated sufficient effort to persist despite a variety of intervening challenges to goal attainment, they gained or regained sufficient balance to carry on. Some applicants reported that the challenges that they encountered were major obstacles and could imagine a future point when rebalancing efforts in response to such challenges might be impossible and result in their withdrawal from their DPA pursuit. In this discussion, we first present a narrative story line of the central category Gaining Balance and categories: Commitment, Persistence and Evaluation. Next, a review of the categories will be outlined and related to the existing literature.

5.4.1 Toward a Grounded Theory

The narrative story line below represents our theory of Gaining Balance and the interrelation of the various categories and concepts.

Narrative Story Line of Gaining Balance for Adoption Applicants

Adoption applicants enter the DPA system in order to achieve their goal of becoming parents of an adopted child as soon as possible. As these applicants progress through the system's procedures, they are confronted by a series of requests in which they are asked for example, to provide information about themselves and their abilities as future parents; to gather information about the children who are available for adoption in order to understand and appreciate their needs; to consider what resources/supports would be required to address adoptees' needs; to verbalize to their partners and to the DPA staff the characteristics of the child who they believe would match with their abilities and resources to parent and their image of their future family; and to short list the profiles of children who have been presented to them as potential adoptees in terms of their

sense of parent-child match and so on. It should be noted that applicants were told that the DPA procedures had been created, not to achieve the goal of applicants to become future parents but rather to ensure the best interests of available adoptable children.

Although a number of the requests seemed to be accepted by interviewed applicants as supporting their smooth progression toward meeting their goals of adopting a child as soon as possible, a wider range of the requests were received as obstacles. Each request could lead to a feeling of 'losing balance' and only through the applicants' selected considerations and actions (decision-making) could they gain balance and proceed on. If balance was not achieved then applicants reported that withdrawal from or dropping out of the DPA procedures would be the result. Applicants worked hard to maintain or to gain this sense of balance as they proceeded toward their goal. *Gaining Balance* seemed to be the key idea that explained the interviewed applicants' process of decision making. Therefore *Gaining Balance* was chosen as the central category for this theory of the decision-making process of adoption applicants.

To understand the key idea of *Gaining Balance*, three other main categories were identified: *commitment*, *persistence* and *evaluation*. *Commitment* was concerned with motivation and the drive to meet the goal of parenting. *Persistence* referred to the level of effort employed to respond to requests and overcome obstacles. *Evaluation* reflected the process of consideration and assessment in which applicants determined their abilities and resources as future parents, gained knowledge of the characteristics and needs of potential adoptees and matched their abilities and resources to the characteristics and needs of potential adoptees in order to generate an understanding of the characteristics and limits of their preferred child. Most interviewees were highly committed to their adoption goal and to the DPA route. This high level of commitment was a necessary foundation to the applicants' process of decision making or *Gaining Balance* since it fueled their *Persistence* to address requests and overcome challenges and it maintained their engagement in the necessary and complex process of *Evaluation*. See Table 5.2 to appreciate the sub-categories and concepts related to each main category.

The level of *Commitment* was influenced by: a) the reasons why applicants were motivated to adopt a child in general and the DPA route in particular and b) financial considerations. For example, all applicants had a strong desire to parent. For many, this desire to parent was a longstanding and central goal which they had yet to achieve despite trying other options (such as fertility treatment). This desire to parent had remained strong despite these prior, lengthy, unfruitful and emotionally trying efforts. Applicants' desires to parent were shaped by their age and the perspective that given their age, time was 'running out' and by cultural or familial expectations to parent. All applicants were aware of a number of routes to conceive or adopt a child but many had

selected the DPA route since this route aligned with their altruistic values of helping an existing Canadian child. Many applicants expressed the need to be financially able to support a child. Some believed that the international adoption route could satisfy their desire to be a parents more quickly and perhaps even meet their specific desire to raise a child from infancy and avoid a child with disabilities but they also indicated that the financial costs of following the international route could reduce their personal resources, thus minimizing the financial resources available to address the future needs of their adopted child.

Applicants' *Persistence* or their efforts to respond to requests and overcome obstacles hinged on their determination to succeed, their abilities to cope with their emotions and counteract pessimism. For example, many applicants were thrown off balance by unanticipated lack of contact with the staff who had been assigned to work with them (i.e., adoption workers); learning about the troubling histories of available children (e.g., such as prenatal exposure to alcohol or later to sexual abuse); being asked to voice their preferences and limits regarding the characteristics of those children who they were willing to consider for adoption and later being directly challenged on these limits by their adoption workers; and the unanticipated long wait to achieve their goals (e.g., 18-24 months). Of particular distress for most applicants, were situations in which applicants were presented with the profiles of children whose characteristics were not in keeping with the applicants' stated preferences and limits (i.e., workers suggested consideration of children who had certain disabilities or medical conditions which applicants expected to avoid) . After multiple presentations of such children, some applicants expressed desperation and even pessimism about their chances to succeed at parenting through DPA. Desperation was also expressed by a number of applicants who had been short listed for children who met their criteria but, who in the end, were not selected as the top candidates. The practice at a minority of agencies was to not inform applicants of when their name was being considered for short listing for a particular child and this practice seemed to eliminate one, potentially major, destabilizing factor for those applicants. Most applicants reported on the need to steady their emotional investment in particular desired children as they approached considerations as a way to shield them from possible grief, sadness and frustration if they were to persist in the process.

Applicants demonstrated their *Persistence,* and thereby *Gaining Balance*, by advocating for themselves and reminding workers of their goals. For example, in order to minimize their frustrations, and at times despair with the slow adoption process, and to grant them a sense of personal control, applicants might attend an Adoption Resource Exchange conference and identify available children to pursue or they might broaden their list of preferences of child characteristics. Applicants' *Persistence* was also bolstered by the flexibility in the DPA system that allow several

of them to slow the process down while they dealt with life events unrelated to their adoption request such as moving residence or taking a trip. For these applicants, being able to draw on this flexibility provided a sense of personal control. Many applicants channeled their frustrations and desperations by venting to their spouses, by adjusting their emotional response to events or by contacting their worker for reassurance. In some cases, they addressed their frustrations with the system by contacting the adoption workers or supervisor to assert the need to speed up the process or improve the system by addressing perceived discrimination issues. Where *Commitment* and *Persistence* wavered, some applicants struggled with doubts as to their success, reported significant frustrations with aspects of the DPA processes and contemplated withdrawing from the process.

Evaluation referred to the process of consideration and assessment in three areas: a) the applicants' personal abilities and resources as future parents, b) their knowledge of the characteristics and needs of adoptable children and c) the characteristics and limits of their preferred child based on their perceived fit between the applicants' abilities/ resources and the characteristics/needs of potential adoptees. *Evaluation* was a continuous process and the applicants drew on a number of strategies to maintain or *Gain Balance*.

Applicants' overall assessments of their personal abilities varied across applicants and were influenced by their level of self-awareness of their personality and specific personal abilities, by their life stage (e.g., given their age would they have the energy to parent), and by their current life style. Most interviewees noted increases in their self-awareness following their attendance at required education sessions and as the adoption process continued. Most applicants accepted that they would be unable to parent a child from a different culture due to anticipated lack of acceptance by their extended family or community. Some made changes to their assessments of personal abilities and resources by making life style changes such as moving residences to better accommodate children.

Applicants' *Evaluation* of their knowledge of characteristics and needs of potential adoptees was influenced by their recognition of their prior experiences and knowledge and was enhanced through future information gathering such as books, internet searchers or questioning friends and colleagues. The *Evaluation* of the child preferences changed over time as applicants' gained a more balanced sense of who they were, who the adoptees were, how the system worked and the strength of their image of the child they envisaged parenting. For example, just prior to or during the required education sessions, many applicants came to beleive that if they had a more inclusive list of child preferences, such as regarding disabilities which they might accept, they might realize their goal to parent sooner. Many indicated that they actively tried to remain open to the different child characteristics that they believed they could accommodate.

Some applicants expressed broad preferences initially but became more discriminating as they learned more about potentially available children. During such events as education sessions or the home study, they became more aware of their personal abilities and the needs of potential adoptees and how to parent them and persisted in the process by altering assessments for instance by fine tuning their preferences. This fine tuning might include the consideration of older children or children with certain disabilities. This fine tuning also appeared to occur for some when their request to be short-listed for a child had been declined several times.

Applicants' assessments of their personal abilities highly influenced their *Evaluation* of their knowledge of adoptees and their child preferences. At the outset of the application process, their assessments of child preferences balanced primarily their prior experiences with children, disability and their spouses' views and comfort level with adoption against their knowledge of the parenting needs of children and their goal as future parents. After increasing their awareness of their own abilities and the needs of available children, through such experiences as attending education sessions or discussions with friends and professionals, child preferences were continually re-assessed and often modified to include characteristics that in the past had generated discomfort. However, at the same time, most applicants' views became more exclusionary about certain characteristics (e.g., those with fetal alcohol spectrum disorder, risks of schizophrenia or with significant physical or intellectual disabilities). Most approved applicants who had waited for what they perceived to be a long time (e.g., 8 months) with no match to a child, re-assessed their preferred age range to include slightly older children.

Applicants attempted to regain a sense of balance prior to making their final decision about whether to accept a specific child on adoption probation by seeking answers to the common key questions: can I accommodate this child and, is this child sufficiently similar to what I had expected and preferred? Many chose to rebalance through actively seeking what they hoped would be sufficient information about the child whose profile they had received through ancillary research (e.g., books, internet searches, telephone resources such as Motherisk) or by checking with family, friends and known specialists. They actively filled in the missing information that they considered critical or classified that missing piece as unimportant. Some applicants actively recalled their fantasized child and considered if the profiled child fit their fantasy. If workers presented multiple profiles during one appointment or call, applicants described quickly screening out those who were least in keeping with their expressed preferences. Throughout the final phase of the *Evaluation* process, applicants had to actively persist at steadying their emotions in order to retain their balance as they made the final decision to accept a child.

5.4.2 Using Previous Research to Assist in Theory Development

As noted, a detailed and up to date literature review was delayed until after most interviews had been completed and initial steps of analysis concluded. The next step in our grounded theory development involved the comparison of our current findings to those in the previous professional literature as proposed by Creswell (1998). After multiple searches of the professional literature using various search engines and key words, only limited literature was found which specifically concerned decision-making processes of adoption applicants and most were only peripherally related to the topic or originated from adoption research conducted retrospectively. Therefore, our search was broadened to include studies in the psychological and medical literature on decision making in general as well as sociological and other adoption research. The following discussion represents a comparison of our inductively derived theory of categories and associated concepts with findings of existing literature.

Gaining Balance

The central phenomenon of our theory of adoption decision making is the idea of gaining balance, with decision making being ongoing processes of evaluation with the repeated possibilities of losing and gaining balance. Although none of the reviewed literature specifically identifies gaining balance as the central feature of decision making, Hastie (2001) does allude to this idea when he notes that the main focus of research on decision-making processes has been on understanding how people weigh their various desires and beliefs in choosing among alternate courses of action. This notion of weighing relates to our concept of evaluation. Our participants spoke of assessing their parenting abilities and resources and considering how these might fit with the needs of potential adoptees. Hastie's concept of weighing also hints at our idea of balance in that the weightings that people apply may lead some to actions that would keep them in the system and others to leave the system. Also, Kelly-Powell (1997) conducted a grounded theory study of patients making health care decisions under potentially life threatening conditions. Though she does not identify gaining balance as a key concept of explanation, her results are replete with examples where participants make treatment evaluations and ultimately choices based on balancing knowledge gained from past experiences and

attempting to sustain their current sense of self (i.e., as individuals and in relation to others). These choices appear to result from their efforts to balance these two forms of information.

Commitment

In our theory, commitment was seen as the foundation to the decision-making processes of gaining balance and encompassed the notion of motivation or the force that drove people to apply to adopt through the DPA route. The idea that motivation is a key factor to decision-making action is consistent with the literature on decision making (Eccles, Wigfield & Schiefele, 1998; Verplanken & Holland, 2002; Wigfield & Eccles, 2000). Pintrich and Schunk (1996) identified motivation as "the process whereby goal-directed activity is instigated and sustained" (p. 4), an interpretation which exposes the strong link or overlap between the categories of commitment and persistence. We have preferred to reserve commitment for the instigation of the application and foundational drive to parent while discussing sustainability or the applicants' resilient efforts to gain balance in the face of challenges under the category persistence. Lydon (1996) reviewed multiple definitions of commitment and broadly noted that a person's commitment is highly influenced by his/her core values and that the person expresses these values through his/her commitment to actions.

For our applicants to be committed, they had to be highly motivated to parent and to following the DPA route. For all, personal reasons such as improving the outcomes of children presently within the system and for some, financial concerns were also critical to commitment. We found a strong desire to parent was a formidable intrinsic motivation and the literature on adoption supports this idea (Daly, 1992; Rabin & Greene, 1968). Our finding that the desire to parent can be heavily influenced by cultural and family expectations concerning adulthood and role expectation finds support in the sociology research (Hoffman & Hoffman, 1973).

The work of Verplanken and Holland (2002) may broaden our understanding of the role of values in adoption decision making. Verplanken and Holland found that values were important ingredients of a person's sense of identity and self-concept, and that a small subset of a person's strongly held values formed the basis for moral and ethical rules that determined their conduct. Since

the role of parent seemed to be part of our applicants' sense of self, it is not surprising that their values influenced their conduct and they sought to become parents through the DPA route when other options were perceived as not available.

One of the specific motives identified by some of our applicants was the desire to help a child who was presently in the adoption system to ensure that he/she had a good quality of life. Casler (1995) has argued that the dominant and current societal view on the worth or place of children in society assigns value to the children themselves and appreciates them merely for being. In addition, this view confers rights and entitlements such as entitlement to a good quality of life. According to Casler, this view has displaced a sentimental view and made completely obsolete the economic view of children, at least in western society. Significantly, in our study, most participants labeled their personal values and specific motive of helping an existing child as key to their commitment to the domestic adoption route.

Persistence

Our category of persistence encompasses the notion of effort that sustains committed activities and pursues actions to overcome challenges. According to Lydon (1996), this notion has been encompassed by some professionals within the definition of the term commitment. Holt and Dunn (2004) labeled this notion as 'resilience' in the sports psychology literature. In our study, persistence concerned the applicants' determination to succeed, to cope with emotions and to counteract pessimism.

Findings from a study by van Balen et al. (as cited in van den Akker, 2001) on 131 infertile couples, who overwhelmingly opted to explore fertility treatments and some of whom only much later considered adoption, alludes to the high and sustained degrees of determination we observed in many of our adoption applicants. Van Balen et al. noted that the motivations of infertile adopters tended to be more instrumental, focusing on their need for a child. Perhaps the instrumentality of this need propelled their willingness to address adversities and persist in the process. This proposition would

seem to be supported by experimental laboratory findings in self-completion theory research (Gollwitzer & Kirchhof, 1998).

Gollwitzer and Kirchhof (1998) proposed that people may act in accordance with strong personal values in order to achieve a sense of completeness. It is plausible that the strong desire to parent reinforced by cultural and familial expectations or the desire to meet the needs of children presently in the system may have driven some childless, infertile adults and those for whom pregnancy has been contraindicated (e.g., due to high likelihood of developing potentially fatal medical conditions) to a determination to succeed. These prior infertility experiences may have undermined their core identity of being a parent, leading to the strong sense of incompleteness that drove them to first seek alternative routes such as adoption and weather adversities in the process to overcome this personal sense of incompleteness. This determination of infertile adopters and willingness to persist in the face of adversity is supported by studies by Glidden (1985, 1986, 1992). Glidden reported that one group of adopters of children with intellectual disabilities were couples who had experienced infertility and, in many cases, had undergone trials of unsuccessful fertility treatments. These infertility experiences were considered to be associated with participants' high sense of urgency to adopt (i.e., versus fertile couples) and a willingness to greatly widen their views of acceptable characteristics of children, including that of disability, during the adoption process.

Daly's (1989) grounded theory on the role of power differentials between applicants and adoption workers and emotions in the decision-making processes of adoption applicants is likely applicable to our concept of persistence through coping with emotions and pessimism. Daly's participants expressed considerable anger toward the adoption system due to what Daly contended was an imbalance in power between the adoption agency who controlled the timing of the adoption process and determined the applicants' suitability to adopt and the adoption applicants who were dependent on the agency to meet their parenting goal. While the contemporary adoption process is much shorter in duration than when Daly conducted his Canadian study in the 1980s and the lack of adoptable typically developing babies is now broadly appreciated by applicants, nevertheless, some of

our applicants experienced significant levels of anger. Our applicants were required to deal with this emotion, either directly or indirectly, in order to persist in the process. Daly's findings suggest that wherever high degrees of applicant dependency on adoption workers or agencies exist, applicants' feelings of frustration and anger are likely to be common ingredients impacting adoption decisions and the willingness to persist. In our study, frustration and/or anger challenged applicants' determination to cope with emotions and counteract pessimism in order to persist. In some cases, applicants elected to vent their anger indirectly by voicing these feelings to their partner only, believing that the appearance of cooperation with the workers was the best approach to achieving their goal. In other cases, applicants vented their anger directly to workers or worker supervisors sensing system discrimination or failure.

Evaluation

We found that applicants were continuously absorbed in three areas of assessment (i.e., their abilities and resources as future parents, their knowledge of potential adoptees' characteristics and needs and, their preferences for specific child characteristics) and employed strategies to balance these assessments right from the beginning of applicants' engagement with the DPA process but especially during the final phase when they approached their decision to accept a specific child on adoption probation. The concepts of evaluation and assessment have been, and continue to be, central to the decision-making literature (Bryson & Mobolurin, 1995; Kushniruk & Patel, 1998; Payne, Bettman & Johnson, 1992). Much of the early literature on decision making employed the gambling paradigm which involved laboratory-based studies where participants made one shot choices between a low set number of highly defined alternatives. Over the past two decades, modern decision making research has focused more on multilayered decisions in real life (Betsch & Haberstroh, 2005) and very recently has begun to highlight how past decisions impact the present situation and how appraisals of prior experiences inform new decisions (Shanteau, Friel, Thomas, & Raacke, 2005).

Psychological research on life-sustaining medical treatments has examined evaluation activities and their findings add support to our evaluation category. Jacob (1998) studied family

member's life-sustaining treatment decision making for incompetent relatives and highlighted the role of two key evaluative processes used in arriving at a judgment. First, Jacob's participants assessed information about their relatives' physical condition and engaged in a variety of information gathering activities to satisfy their need for such information. Second, they used strategies to assess their relative's likely treatment preferences. These evaluation processes were ongoing and spanned the time period between the point of learning about their relative's physical condition with possible future prognosis and his/her likely expectations and wants concerning life support decisions. Jacob's results seem to lend support to our study's evaluation processes of assessments of knowledge (i.e., both personal and adoptee knowledge) and assessments of child preferences and our study's concept of strategies used by applicants to match preferences to this knowledge.

Ditto et al. (2003) examined the stability of older adults' preferences for various life-sustaining medical treatments over time. Three of the findings noted by Ditto and colleagues are of particular interest to our study. First, they found that the preferences of participants which reflected the most common and entrenched views of the general population appeared most stable over the three-year study. Second, participants who had previous to the study engaged in significant pre-planning and even formalized advance medical directives were more likely to retain their positions over the time of the study. Finally, participants' views concerning the most and least serious medical scenarios, and related proposed decisions to refuse treatment, were more stable over time than those views regarding more moderate or middling scenarios. In adoption, applicants are required to express child preferences early on and at numerous intervals through the adoption procedure. The preferences of most applicants appear to change over time, especially after the education sessions and attendance at an Adoption Resource Exchange and as applicants become increasingly frustrated over the passage of time coupled with their lack of success in achieving their adoption goal. Nevertheless, as in the Ditto et al. study, it appeared that our applicants with firm (e.g., those commonly ruling out children with FASD or, elevated risk of schizophrenia) and well-informed child characteristic preferences from an early period were less likely to change them regardless of their system experiences. Future

research on adoption decision-making processes could focus on confirming this impression and shed light on related influential factors.

Some investigators such as Simon et al., (2001) have suggested that, as an inherent mechanism of evaluative strategies, research participants attempt to differentiate their decision from the other alternative choice(s) to consolidate their decision and develop a high degree of confidence in their selected response. This mechanism could partially explain our study finding of a complete lack of regret or doubt about the selected child, held by all applicants who had this child on probation. All six applicants reported absolute intentions to proceed with the legal adoption finalization as soon as they were eligible. Wagener and Taylor (1986) suggested that participants remembered their decision-making processes in such a manner as to justify their previously made decisions which suggests that research efforts to access evaluations may encounter challenges especially when the research is conducted long after decisions are made.

Conclusions

We presented a systematically developed theory resulting from a qualitative methodology consistent with the analytical processes used in grounded theory (Strauss & Corbin, 1998). The theory generated can best be described as a substantive level theory. Substantive theories can be useful stepping stones toward more encompassing formal theories (Strauss, 1987).

In our study, the core category of gaining balance and categories of commitment, persistence and evaluation may be useful to adoption workers when guiding applicants through the DPA system. Workers may find that understanding the theory of gaining balance, and all the categories and concepts that underpin it aids them in identifying applicants who are clearly committed to DPA and will likely persist with ongoing evaluation and the process of gaining balance. The information may also help workers anticipate and/or identify obstacles to stabilization and continuation. If applicants show signs of great disappointment, frustration or disengagement, workers may wish to intervene to facilitate a return to a balanced position. A variety of formal or informal supports could be made available or recommended to applicants. For instance, applicants may benefit from workers

extending: 1) opportunities to explore their emotions, 2) invitations to voice concerns, 3) offers to explore any perceived conflicts or irritants, and 4) offers of instructions on strategies used by other applicants to achieve balance in matching child preferences with personal abilities and knowledge of children.

There are no guarantees that all our applicants will one day have a child placed with them or that, those who already had received one, will legally finalize the adoption. Our interpretations are not intended to suggest that withdrawing from the DPA process or deciding to significantly alter a personal goal of adopting a child represents a failure of the applicant or adoption system but rather that a sufficient balance was not found to allow applicants to progress toward final adoption. Indeed, a limitation of our theory is this lack of data from former applicants who withdrew from the process. Future extension of our theory should aim to include such data.

CHAPTER 6: DISCUSSION

6.1 General Discussion

The complementary mixed-method research approach used in this thesis aimed at creating new knowledge about domestic public adoption (DPA). It simultaneously cast a lens on DPA by first revealing the profile of children legally available for adoption in Ontario in 2004, and, then investigating the decision-making processes of a sample of applicants who were considering adoption between 2004-2006 from a pool of available children likely very similar to those profiled. By first detailing the profiles of the population of adoptable children, it was possible to more fully contextualize the decision-making processes in which adoption applicants were engaged since we were able to appreciate more fully the potential adoptive children about whom applicants were directing their decision-making efforts.

Prior to this thesis, research from jurisdictions such as the US had demonstrated that a high proportion of children available for adoption had some form of disability (Coyne & Russel, 1990; National Adoption Information Clearinghouse, 1997). As a result of such findings coupled with anecdotal impressions of Canadian child welfare experts or limited information from provinces (e.g., see Ontario Ministry of Community and Social Services, 2000), it was assumed by those in child welfare that a high proportion of children available for adoption in Canada had disabilities too. Internationally, researchers in child welfare have emphasized that the particular assessment, treatment, adaptive-technology and/or environmental-access needs of the children with disabilities in their care must be identified and addressed as permanency plans such as adoption are selected and prospective adoptive parents recruited and prepared (Brown, 1988; Chambers, 1973; Franklin & Massarik, 1969a, 1969b; Hamilton, 1949). Prior to the many important findings published as a result of this thesis, scant information was available from Canada regarding the specific population of children who were legally available for adoption. This thesis is perhaps the first independent study to focus attention on the profile of a large sample of Canadian children available for adoption, use an

advanced sampling methodology to ensure proportional representation from a province or territory, and shed light on the prevalence of disabilities and the factors impacting the permanency planning undertaken on behalf of these Canadian children.

While a successful adoption is widely viewed as the best permanency plan in child welfare, even a best practice outcome for most children who are permanent wards without access (Barth, 1997), detailed knowledge of how adoption applicants make their numerous decisions is largely unavailable. It seems to be a commonly held perception of adoption workers that the vast majority of applicants prefer to adopt children who do not have disabilities (authors' unpublished raw data). In an attempt to determine if this perception is valid and to understand the complex decision-making processes that lead applicants to adopt children, specifically those with disabilities, this thesis employed a qualitative methodology consistent with grounded theory (Strauss & Corbin, 1998). Application of the grounded theory approach to the decision-making processes of applicants for adoption represents a novel advance and reports of similar applications were not encountered during extensive searches of the professional literature. The outcome was the generation of a substantive-level theory of adoption decision making based on the perspectives of applicants who considered both children with and without disabilities.

This thesis focused on multiple sub-areas of enquiry. A number of important findings warrant further discussion.

6.1.1 Profiles and Disabilities

It has long been believed that children with disabilities were disproportionately represented among the population of permanent wards without access in Ontario. As noted, disability rights and adoption advocates such as Judy Grove, the former president of the Adoption Council of Canada and Canada's Waiting Children program, have contended that there is a high prevalence of Ontarian children with disabilities who are available for adoption and who have remained unmatched for lengthy periods (Judy Grove, personal communication, August, 15, 2002).

From the data collected for this thesis, we have been able to definitively demonstrate that children with disabilities are indeed disproportionately represented among the population of permanent wards without access. They are the majority. The disability rate of 57.8% is more than 16 times higher than that found among the general population of children in Ontario, which was approximately 3.5% (Statistics Canada, 2002). A comparison of the descriptive data of the children with differing disabling conditions indicates that children with disabling conditions are a heterogeneous group and the needs of any one child may vary greatly from those of another.

The rates of specific disabilities among children who were permanent wards without access appeared to be reported for the first time in the recent professional literature with the publication of the Ontario Crown Ward Survey (see Chapter 3, Manuscript B). The rates of these specific disabilities in many cases did not match the prevalence rates among the general population of children or conform to the expectations of some adoption workers interviewed (authors' unpublished raw data). For instance, the rate of children with intellectual disability or pervasive developmental disorder (i.e., 7.5%) we found was much higher than the 1 to 3% range usually reported among the general population of children (Ouellette-Kuntz & Paquette, 2001; Roeleveld, Zielhuis & Gabreels, 1997). Contrary to expectations of many adoption workers surveyed, the relatively low prevalence rate of children with FASD (i.e., 3.2%) raises questions about diagnostic accuracy of those diagnosing or factors impacting workers' impressions. As noted in Chapter 4, the lifelong nature of intellectual disabilities and the common reliance of people with these disabilities on formal supports make the ability of government planners to forecast the population of youth with intellectual disabilities of heightened importance. As well, the presence of children with disabilities in general and intellectual disabilities in particular at such high rates among permanent wards raises a variety of questions about the association between disabilities and children becoming permanent wards.

Our findings on the profile of Ontario's permanent wards without access have many implications for service delivery, policy, and broadly for research in the fields of child welfare, and disability. For instance, major policy reviews with stated goals of transformative change are

underway at two Ontario government ministries, the Ministry of Children and Youth Services and the

Ministry of Community and Social Services. Findings from this thesis have been deemed important to

the child welfare sector as evident by dissemination efforts regarding our results generally and of

Manuscript C specifically by the nationally funded Centre of Excellence in Child Welfare (e.g., see,

http://www.cecw-cepb.ca/pubs/research_brief_e.html Burge & Gough, 2007) and the provincial

association of children's mental health centres Children's Mental Health Ontario (e.g., see,

http://www.kidsmentalhealth.ca/resources/clinical_research.php). As well, the OCWS technical report

(Burge, 2005) was circulated to every executive director at Ontario CASs and staff and policy

analysts at numerous government departments within two Ontario ministries. The OCWS report

author was an invited speaker at a conference for Ontario's CAS adoption workers and presented the

OCWS results over a half-day to all attendees and to groups of researchers at several provincial or

international conferences. These dissemination efforts of our results may inform both government

reform efforts and considered changes to agency practices in the child welfare, children's mental

health, and developmental services sectors.

6.1.2 Mental Disorders and Maltreatment

Determining the prevalence of mental disorders was of particular importance since adoption

workers have reported that applicants express preferences for children who are able to form emotional

attachments and behave in a sociable manner (author's raw unpublished data). Indeed, a study on the

outcome of adoptions of children with special needs found that the absence of behavioural problems

was among the predictors of a positive adoption outcome and satisfaction for adopters (Rosenthal,

1993). The thesis findings on mental disorders among permanent wards, a focus of Manuscript C,

represents the first independent study, in over a decade, to clearly focus attention on mental disorders

among Ontario's permanent wards. Most similar Canadian studies concerning the mental health of

foster children (Lipman, Offord, Boyle, & Racine, 1993; Stein, Rae-Grant, Ackland, et al., 1994) or

children in the general population (Offord, Boyle, Szatmari, et al. 1987; Waddell, Offord, Shepherd,

et al., 2002) have used standardized rating scales of psychopathology and behaviour which are

usually not "normed" on children who have significant developmental delays or intellectual disabilities – as evident from this thesis, a sizable subgroup among children who are wards. To address this limitation, this thesis used the diagnosis of mental disorders, therefore, allowing for the inclusion of all selected eligible permanent wards and for the reporting on all categories of mental disorders. The high agency participation rate, the oversampling built into the methodology, and the conservative participation rule (which required each cluster to have at least one agency participate) also aimed to minimize any concerns about regional variability in participation.

This study's prevalence information on mental disorders alone should be important to the CAS administrators. These administrators may not recognize how the aggregate rate of their permanent wards without access and with mental disorders compares with the province-wide rate. Such recognition could help support agencies with their planning to address the needs of such children prior to permanent placement. This information may also be relevant to administrators and clinicians at the transfer payment agencies in other sectors, including children's mental health, adult mental health, and developmental services. Given that the literature repeatedly reports that foster children have higher rates of mental health concerns than community samples, it was not unexpected that our finding of a rate of 31.7% among permanent wards was over 1½ times higher than the 18.1% previously found among the general population of children in Ontario (Stein, Rae-Grant, Ackland, et al., 1994) or the average of 14.3% found across 6 international studies (Waddell, Offord, Shepherd, et al., 2002). If the 31.7% of permanent wards without access do not have their mental health needs addressed adequately, then many potentially negative long-term effects may be experienced by these individuals well into adulthood and also by the society in which they live (Bueller, Orme, Post, et al., 2000; Quinton, Rutter & Liddle, 1984). For this reason, planners in the adult mental health sector need to take note of our findings on the high rate of mental disorders amongst permanent wards in Ontario and are encouraged to put into effect a system that will continue to monitor this rate. This careful ongoing monitoring may contribute to better system planning and more proactive funding allocations in the adult mental health sector.

The children's rates of certain diagnostic categories, such as ADHD and others mentioned above seemed especially high. The most prevalent diagnostic category we found was ADHD (i.e., 20.7%) and was much higher than the 4% (American Psychiatric Association; 2000) or 6.1% (Waddell, Offord, Shepherd, et al., 2002) rate estimated to apply to children in the general population. This finding may merely reflect the difference between a child welfare sample and a community sample. If so it raises concerns about the nature of the development of attentional problems and whether they are the result of years of poor parenting and experiences of maltreatment or rather the result of some modifiable contribution of in-care experiences. In reviewing literature on high rates of hyperactivity and other behavioural problems in the adjustment among school-aged child adoptees Brodzinky (1987) proposed that key contributory factors may include adverse prenatal experiences such as poor nutrition and medical care, increased maternal stress, and the fetal exposure to alcohol or other poisonous substances. Other factors which may occur while a child is in care included multiple moves between foster homes and experiences of maltreatment (Brodzinsky, 1993). While the high rate of ADHD and comorbid mental disorders (85%) in our study mirrors findings from other studies (MTA Cooperative Group, 1999) it may prove to be useful to the CAS administrators to monitor the rates of ADHD and study the contributing causes of this high rate of disorder.

The relationship among children's specific disabilities, the onset of these disabilities, and becoming a permanent ward without access deserves comment. We found that children with disabilities were significantly more likely to experience certain abuses which may relate more directly to their older ages when they entered care than to the disability itself. For example, researchers have concluded that the high proportion of children with intellectual disability in foster care is partly a result of a general increased vulnerability to abuse and neglect among children with pre-existing disabilities and partly a developmental consequence of maltreatment of children who initially had no disability (Brown & Fudge Schormans, 2003; Fudge Schormans & Brown, 2002; Jaudes & Shapiro, 1999; Sullivan & Knutson, 1998). Furthermore, since at any given time, about 37% of adults with an intellectual disability can be expected to have another mental disorder (Yu & Atkinson, 1993), and

these individuals are represented at high rates in acute care psychiatric settings and in the province's psychiatric hospitals (Burge, Ouellette-Kuntz, Saeed, et al., 2002; Lunsky, Bradley, Durbin, et al., 2003; Saeed, Ouellette-Kuntz, Stuart, et al., 2003), it is especially important for clinicians and policy-makers to know the childhood rates of intellectual disability. Such information can inform planning for adequate mental health and social supports for this population as individuals leave the child welfare sector.

6.1.3 Permanency Plans

Children with disabilities were significantly more likely to be apprehended by child welfare authorities versus being voluntarily placed into care. They also entered care at older ages when compared to the children without disabilities. This finding challenges the commonly held notion of struggling parents unable to cope and voluntarily placing their medically fragile child into care. While such a pattern was observed in our data it was far out weighed by the pattern of parents with older children with disabilities requiring less extreme support needs who were apprehended at older ages. An enhanced understanding of these differing profiles and patterns should be the focus of future research and provide a link to our findings about influences in the decision-making processes of adoption applicants.

Although we found that many variables were associated with permanency plans, controlling for these factors using logistic regression revealed that age variables were the only significant predictors of permanency plans. Similarly, US research has consistently found that age is a strong predictor for children remaining in long-term care, with those who are older remaining longer (Barth, 1997; Finch, Fanshel & Grundy, 1986). A number of factors likely explain in part our key finding. Firstly, according to CAS adoption staff, there is a preference among Ontario's adoption applicants for babies or very young children, compared with older children (author's unpublished raw data). This was further corroborated by findings in Manuscript D in which several interviewees expressed this desire. Therefore, it is not surprising that in our sample a high number of instances when children entered care at older ages (i.e., at least > 2 years old) that they were not preferred for adoption.

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Secondly, older children may have strong memories of their early home life. Given their age, these children may be asked to contribute to the development of their permanency plan and given their memories and awareness of their biological parents and families may dismiss the option of seeking formal adoption. Thirdly, it has been well established in other jurisdictions that foster parents represent the largest pool of adoption applicants (National Adoption Information Clearinghouse, 1997) for available children; usually those to whom they have already been providing care for several years. As foster parents, they receive a small per diem financial payment as compensation for caring for the child and assurance that the child's medical and dental care will be covered by the child's supervising agency. As adoptive parents, in Ontario at least, they are likely to receive nothing, though there have been some instances in which orthodontal costs have been covered (Burge, 2005). The fiscal disincentives to adoption for foster parents have been well laid out elsewhere (Barth, 1997). One expert has written that research demonstrates that adoption subsidies to adopting parents "may be the single most important post-adoptive service for special needs families" (Rosenthal, 1993, p.77). These factors along with others yet to be identified may explain this tendency for older children in care to have a reduced likelihood of a permanency plan of adoption.

In Ontario, a child must be placed on adoption probation for a minimum of six months before legal finalization can occur. We reported that a majority of all children studied had a permanency plan of adoption (i.e., 64%), though only 33.1% of the children were on adoption probation at the time of the study. Key variables predicting whether a child had a permanency plan of adoption or long-term foster care were the age of the child on becoming a permanent ward and their age on December 31, 2003. Since children with mental disorders and other disabilities entered care permanently at later ages they were more likely to have a plan of long-term foster care. Since numerous studies have reported similar findings (e.g., Barth, 1997), it appears that these children must be provided with enhanced permanency planning efforts if adoption will be selected at rates closer to those of children without disabilities.

6.1.4 Decision-making Processes of Applicants

Our primary finding about the decision-making processes of adoption applicants committed to the DPA route is that they are structured around the concept of *gaining balance*. Here 'balance' is meant to imply the equilibrium or steadiness of progress toward the goal of parenting an adopted child as soon as possible as well as the on-going assessment and re-assessment of applicants' abilities, knowledge of available children and preferred characteristics of applicants' ideal adoptive child. Furthermore, they employ strategies for matching preferences to abilities and knowledge. The qualifier of 'gaining' supports the notion of a fluid and dynamic process that over time is marked by conditions that cause a destabilization and then a possible response which may bring applicants back into balance. Applicants for adoption engage in multiple and continual efforts to gain balance as they proceed through the processes of assessment and re-assessment addressing both their own internally competing values (e.g., to become a parent as soon as possible), emotions (e.g., fear of failing at achieving an adoption) and beliefs (e.g., belief that they will help an available child) and the externally imposed structures (e.g., agency's understaffing resulting in a long wait to be assigned a worker) and judgments (e.g., sole authority of the agency to approve an applicant's request to adopt) inherent in the formal adoption procedures. For this reason, all categories also include the notion of the fluidity and dynamism.

Data indicated that applicants applied substantial degrees of commitment and persistence in order to maintain this ongoing process of gaining balance and achieve their goal of building a family through the DPA route. While applicants entered the system with some assessment of their abilities, knowledge of children and preferred child characteristics, the intervening months and experiences resulted in significant re-evaluations of these assessments. Only when the applicants' levels of commitment and persistence were adequate would sufficient balance be attained or regained to allow applicants to proceed. The final matching phase was particularly intense requiring repeated evaluative activities and invariably presenting numerous challenges to balance.

Commitment is concerned with what drives applicants to meet their goal of parenting through the DPA route. In order to address the numerous systemic demands, applicants had to demonstrate a substantial and ongoing commitment to the adoption route for fulfilling their goal to parent. Data showed that applicants' degree of commitment was influenced by their motivations and in some cases, financial considerations.

Persistence represents the applicants' efforts to maintain balance and to counteract challenges en route to achieving their goal. Three sub-categories underpinned the persistence of adoption applicants: a strong determination to succeed, a willingness to cope with their emotions and an ability to counteract pessimism.

The term evaluation refers to the ongoing process of considerations and assessments which is central to applicants' decision making. While the data showed that evaluation had commenced prior to formal application, once applicants committed to the DPA route and their efforts of persistence were initiated, evaluation became more active and intensified. Applicants' data indicated that the sub-categories of evaluation were active appraisal of their abilities, knowledge of potential adoptees and preferences. They employed a range of strategies to gain a balance among their abilities, knowledge and preferences.

A key question in adoption recruitment concerns the impact of applicants' knowledge and beliefs about available children on their decision-making processes. Gaining balance provides an interpretation of how this information impacts applicants as they proceed through the system. Applicants tend to gather both formal and informal information continuously from the point just prior to the application and right up until they elect to accept a specific child into their home. Data indicated that all applicants had to consider the possibility of being offered a child with some form of disability; even those who early on had clearly indicated to their adoption worker a desire to exclude such children from consideration. Perhaps most applicants hold impressions at the outset about the frequency of disabilities among available children through the DPA route. Every participant who attended education sessions learned of the special needs of children with disabilities. In order for

those who had initially indicated very little interest in considering such children to remain in the adoption process in a level of comfort (i.e., in balance) they likely had to either resolve to seriously consider such children or were convinced that their wishes to avoid accepting children with disabilities would be respected and not adversely affect their likelihood of succeeding in DPA. Clearly, being presented with specific information about available children with disabilities activated further evaluation activities toward seeking balance in their decisions.

Several participants reported holding from the outset, or developing following education sessions, rather firm preferences against seriously considering children with certain disabilities (e.g., FASD) or other characteristics such as race or gender. As noted in Chapter 5 this degree of preference stability is reminiscent of findings of Ditto et al. (2003) regarding the study of the stability of older adults' preferences for the extreme options for various life-sustaining medical treatments over time. As with Ditto and colleagues' participants, many of our applicants also found it difficult to exclude serious consideration of children with a wide range of less definitive or less commonly known medical concerns or disabilities. When our applicants were within the matching portion of the later phase of the adoption process they often displayed a willingness to hear the information about a specific available child who had a disability or uncommon medical condition. That is, if given the time and not overwhelmed with the presentation by their worker of more than one child at a time, applicants seriously applied evaluative strategies to gather information about that child's special medical and non-medical needs and sought to test for a balance in assessments as they approached their decision about discounting or proceeding with the child. Our data pointed to the effects of time spent unsuccessfully in the adoption process as one contributing factor. Nevertheless, their high determination to succeed to become a parent, the strength of their various motivations, and the prospect of beginning their parent identity clearly encouraged applicants to assess their knowledge of the disability and the child's accommodation needs vis-à-vis the applicant's abilities and preferences in order to determine if their was a fit. Finally, very few applicants reported having personal experience living with a disability though those that did preferred to avoid accommodating children

who would need frequent medical appointments. It remains largely unknown the impact of applicants' prior experiences with disabilities among extended family members upon their preferences or sense of personal abilities.

<div align="center">6.2 Limitations and Directions for Future Research</div>

This thesis covered a range of topics relating to profiling child wards of the state who were available for adoption and the adoption decision-making processes of applicants. In prior research related to wards of the state in Ontario and other jurisdictions samples have been derived from one agency or a small catchment area. The measures used to identify characteristics such as mental disorders among children have resulted in only limited data being gathered on a small number of the possible disorders or characteristics which children may have experienced. While past research on the combined area of adoption and decision making has been sparse it has tended to involve participants who reported, several years retrospectively, on such topics as their motivations for adopting children with and without disabilities. Most decision research until the past two decades was conducted in laboratories with subjects engaged in prearranged controlled decision experiments which forced a choice among a small number of set alternatives with predefined impacts. After multiple searches of the decision-making research none was found which included actual adoption applicants who were within the adoption process. This thesis endeavoured to address these numerous gaps found in the available professional literature.

The thesis examined the profile of child wards who were available for adoption using a representative sample of children drawn from the Province's CASs using an advanced method (see Appendix III). As well, the measures and procedures used allowed for a wide range of file information to be gathered regarding every child included in the sample. When studying the decision-making processes of adoption applicants, all of our participants were actively engaged in the adoption process at the time of the data gathering. We included applicants who were at two distinct phases of the adoption process. As well, a qualitative method was used which allowed us to capture the complexities of real life decision-making experiences in non-laboratory or natural settings.

Nevertheless, a number of limitations in sampling, measures and procedures were encountered and encourage us into new directions for future research.

6.2.1 The OCWS and Profiling Available Children

The main limitations of the current investigation concerned minor data gathering challenges, the use of certain variables, and the cross-sectional methodological design. The insufficient level of research funding combined with the vast distances and high travel costs in the province led to the author's reliance in several instances on staff or students already familiar with each agency to gather survey data. While 85% of files were reviewed by only five people (i.e., the author, two key assistants, two lead participants); 15% of files (i.e., *n*=66) were reviewed by 12 other staff. To enhance coding consistency in data gathering, the author created a detailed instructional guide, outlining data gathering procedures, variable definitions, and the possible coding options (see Appendix IV for instructions on coding disabilities). The guide was circulated in advance to all lead participants to share with all reviewers. Nevertheless, some minor coding inconsistencies occurred[10]. When these instances were identified the author contacted lead participants to make further enquiries in order to correct the information.

A few variables proved of limited use. A family history variable (i.e., whether a birth parent had a hereditary disease or condition) was not sufficiently documented on case files or reviewers lacked the knowledge to recognize the hereditary nature of condition(s) recorded. Also, information on visible majority / minority status was gathered (i.e., following a version of Statistics Canada's collapsed classification; Statistics Canada, 2008) but was cumbersome to code. Findings related to this status were seldom reported in results and should be interpreted with caution.

The sampling procedure was developed in the absence of Ontario-specific information on numerous child welfare variables that normally would have informed the study sampling strategy[11].

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[10] Often when a regular case worker / reviewer only completed reviews of 2 or 3 files.
[11] A 2003 application by the researcher for detailed government data, under the freedom of information act, was denied resulting in the study being based on the observations of the senior policy analyst and, in some instances, Ministry data from 1999.

Examples of the kinds of information that could have shed light on sampling decisions include

knowledge about whether children's disability rates varied by the Ontario geographical regions in

which they resided, or whether the size of an agency influenced its practices related to efforts to

designate children as permanent wards without access or preferences for permanency plans. The

cluster sampling approach adopted stratified agencies by region and size (see Appendix III for in-

depth information about sampling procedures and participation among agencies). Two agencies each

from the Northern zone and Eastern zones declined involvement. As a result the participation rates

were lower for these zones and children in these areas were underrepresented in the data. In

particular, Aboriginal children from agencies funded to serve Aboriginals may be underrepresented[12].

The impacts of these limitations resulted in some data being withheld from manuscripts (e.g.,

rates of hereditary disease amongst children's biological parents) as it was classified by the author as

both unreliable and ultimately non-essential. Our experiences gathering data on visible minority /

majority status led to the recommendation that such status be only collected when research

participants have the option of self-identifying amongst categories. Regarding the underrepresentation

of agencies serving the Northern and Eastern zones and Aboriginals, our high participation rate

among agencies generally, along with our conservative participation rule, which required each cluster

to have at least one agency participate and the approach of over sampling, enhanced the

generalizability of findings to the Ontario population of children who are permanent wards without

access as a whole.

We have been able to definitively show that children with disabilities are highly represented

among the population of children who are permanent wards and have no access. Subsequently,

similar findings have been reported elsewhere in another Canadian province (Fuchs et al, 2005) but

never before in Ontario. Nevertheless, our cross-sectional research design limited our ability to gather

information and draw conclusions about the various factors which may over time relate to the manner

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[12] These agencies tend to have a much lower proportion of permanent wards without access among their permanent wards than do non-Aboriginal agencies.

in which children leave care via adoption or by transitioning upon reaching age 18. Currently

planning on behalf of children with disabilities who are permanent wards is individualized with

reliance on professionals working for both CASs and external agencies or programs. Some CASs

designate workers to focus on serving this population of permanent wards without access. While these

approaches may be sufficient for meeting the case management, assessment and medical needs of

most permanent wards without access, there appears to remain considerable variation across agencies

in intra-agency assessment of these permanent wards without access and attention to permanency

planning.

A repeat of the OCWS could be conducted in the future using the same methodology in order

to begin to look for signs of a trend in the permanent ward population profile. However a more

promising approach for future research in this area may be to examine child wards' (i.e., with and

without disabilities) transition through time in care, by applying an advanced statistical methodology,

such as survival analysis, to reveal in-depth information on these issues and uncover factors

predictive of an earlier exit from care via adoption.

As noted in Chapter 3, in some jurisdictions, an approach to addressing concerns related to an

over abundance of permanent wards without access remaining in care for the remainder of their

childhoods has been for government departments to simultaneously promote and fund research on

select groups of children. These children may have their interests served by staff of newly established

pilot projects aimed at addressing issues of concern to policy makers and service providers (Feuz,

1991; Lahti, 1982; Macaskill, 1988). These simultaneous and collaborative research efforts focusing

on concrete outcomes in child welfare have reportedly been fruitful in both developing knowledge

and addressing the need for structural changes in child welfare practice. Given the apparent crisis

represented by the burgeoning population of permanent wards without access in Ontario perhaps this

approach should be more frequently initiated in the future.

A variety of methodological approaches may prove valuable in future explorations of the

many factors which have been proposed in the professional literature as associated with the observed

high rates of children with disabilities entering care. The survival analysis approach recommended above may also be devised to allow an examination of factors which lead to the high rate of children with disabilities, versus those without these conditions, entering care and becoming permanent wards without access. Such research could focus on various categories of disability including the high rates of mental disorders which we have found among our sample of children. For instance, a recent focus in US research on mental health and child welfare has been on patterns of mental health service use for foster children (Hurlburt, Leslie, Landsverk, et al., 2004). There should be a similar focus on Canadian populations to determine predictors of psychiatric and other mental health service use among children who are permanent wards as a first step toward identifying and addressing any inequities that may be exposed for various subpopulations.

A second approach which may prove fruitful is the case study approach. The application of this approach may shed light on the range of family, societal and service system factors, which may impact children developing disabilities, whether as a consequence of maltreatment or due to other influences, and entering care. Since the OCWS did not involve contacts with child participants or their case workers, subsequent research inquiries may benefit from more detailed data gathering related to a smaller sample of children. Surveys of key stakeholders in adoption and child welfare could be developed and include some of the topic areas reported on by Coyne and Russel (1990) in their study on identifying barriers to placing children for adoption in Nebraska USA. Coyne and Russel used a novel approach gathering information on barriers to adoptions both from files of 256 children who had been in care for two years or more and whose parents' rights had been terminated and from a survey of opinions of numerous knowledgeable parties such as family court judges, lawyers, members of foster care review boards, child welfare caseworkers and supervisors. It may prove productive for researchers in Ontario to explore the attitudes of child welfare social workers toward placing for adoption children with disabilities. A related area of inquiry includes the need to better understand the relation between foster children's mental health and permanency planning efforts taken on their behalf by workers.

6.2.2 Developed Theory

While we presented a systematically developed theory resulting from a qualitative methodology consistent with the analytical processes used in grounded theory (Strauss & Corbin, 1998), the present study encountered a number of obstacles which may limit findings. The main limitations encountered during our qualitative investigation concerned the relatively small number of adoption applicants included and the inability to recruit applicants who were within the early phase of adoption and the threats to the trustworthiness of our theory that these cause.

The study had fewer than the usually recommended number of participants for a grounded theory study. Strauss and Corbin (1998) were not overly prescriptive in their discussions of the number of participants needed and noted that the main indicator regarding the number of participants needed related to reaching theoretical saturation of categories and sub-categories. While they define this theoretical saturation as the point in sub-category development when no new dimensions or properties arise in analysis, they also acknowledge that there will always be gaps or less well-developed concepts, even up until the final writing stages and that the problem is "deciding when to let go" (p.158). Other researchers such as Creswell (1998) do provide a range. Creswell suggests that typically between 20-30 interviews need to be conducted to reach saturated data in grounded theory. Given the difficulty of recruiting applicants in the early phase (see comments below) and after consultation with my supervisor and advisory team, it was felt that sufficient saturation was reached: a total of 15 applicants in the middle and last phases were interviewed for this study.

It was the intention of the researchers to recruit applicants in the early phase of the decision-making process, before the influences of education or information sessions had occurred; however this proved impossible. Some agency recruiters reported making numerous attempts to engage early-phase applicants and handing out more than one hundred information sheets to new applicants but none of these applicants expressed interest in participating. Other agency recruiters suggested that their agency limited their efforts to recruit early-phase applicants to this study so as not to burden applicants with extra work. Apparently agency managers or supervisors were concerned about placing

their available children and did not want to unduly burden new applicants with whom the strength of their working relationship was unknown. After encountering these recruitment challenges for several months and, upon the advice received from agency recruiters, a decision was taken by the author to abandon the aim to include one of the original groups who were to be engaged and interviewed. This decision received the support of my supervisor. This was especially unfortunate as the perspectives of both those in the early phase of the study and those who may have later dropped out might have provided additional insights and extended our theory. The information learned may have also allowed us to propose recommendations toward improving the relative efficiency of the adoption process. Furthermore, the lack of experiences communicated from this group represents a considerable unknown effect on the theory which was developed. For this reason we are guarded about expecting that our theory can apply to the broad spectrum of applicants generally. For instance, we found that commitment and persistence were key categories within our theory. Perhaps had we involved former applicants we would find that their data confirmed the necessity of a high degree of initial commitment and shed light on specific challenges which they encountered and influenced them to drop out. It is sometimes assumed by adoption workers (author's raw data) that those who remain in the process until the late-phase matching activities represent the most committed and likely most appropriate applicants for the available children. In essence, remaining engaged in the process until the end may be viewed as a sign that these committed applicants provide the available children with the best pool of adopters whose high level of commitment may shield them from potential future disappointments and act as a protection of sorts from future adoption disruption (i.e., adoption breakdown). Such a contention may be wholly unfounded.

In contrast, the information which may be provided by applicants who later withdrew from the process could provide considerable direction to CASs regarding aspects of the application procedures which may be in great need of reform or overhaul in order to expand the pool of adopters available to Ontario's available child permanent wards. There clearly rests a duty on government and child welfare administrators to advocate for and support research on the decision-making processes of

adoption applicants, and to extend our theory, to those who may show interest in adopting but later withdraw from the process. In order to expose any obstacles to the progress of adopters through the DPA system and in order to reduce or eliminate all unnecessary and malleable impediments, the Ontario Ministry of Children and Youth Services should fund research about such applicants who subsequently withdraw. Should such a direction be embarked upon it is hoped that researchers would answer the call to focus research attention on this important and apparently neglected area. An example of a research project which would be relatively straightforward to conduct would include gathering data from focus groups of former applicants who withdrew. This information could point to possible changes needed in the adoption process or lead to the recognition of the usefulness of certain process requirements in the selection and preparation of applicants. Ultimately, such future research could confirm aspects of our theory.

To try and gain a sense of and address potential limitations, several member-checking activities were undertaken. The first activity, in which applicants were asked to comment on their interview transcripts, resulted in only one participant suggesting minor grammatical revisions. Morse (1994) cautions that confusion can be created when the passage of time or other intervening events cause participants to change their assessments of their experiences and disagree with researchers' interpretations. This raises concerns about the accuracy of applicants' recollections about both decision making at the time of the interview, and also of how the developing theory would be recognizable to these applicants months later. Recognizing Morse's cautions, much later applicants and workers were asked to comment on the emerging interpretations and theory. It was appreciated that a variety of life events and other intervening experiences had likely occurred for all our applicants in the ensuing 16-17 months from when they were last interviewed. A total of five applicants and four workers responded and their information supported our interpretations of the data though two of the applicants expressed that their own situations in the late-phase matching activities were slightly unique for differing reasons. Minor modifications in the wording to the narrative story line were made to reflect more variability regarding the adoption procedures they had experienced. In

sum, the detailed responses we received to our final member-checking activity were highly confirmatory and gave no obvious cause for concern regarding that hypothesized confusion which Morse (1994) outlined though we do not discount the possibility that some may have existed.

We presented a substantive level grounded theory of adoption decision-making with the core category, *Gaining Balance*, and sub-categories of *Commitment, Persistence* and *Evaluation.* A next step could include further applications to other groups of potential adopters such as 1) those who indicated an interest in adopting but later resigned from the process; 2) those who preferred to adopt following a course of acting as foster parents; and/or 3) those who expressly preferred the route of international adoption. As evidence demonstrates that the most predictive variable on whether a child who is in care and available for adoption would be placed for adoption was whether the foster parent wanted to adopt the child (Coyne & Russel, 1990), it would be a logical extension of this investigation to study foster parents as potential adopters.

A key question in adoption recruitment concerns the impact of applicants' knowledge and beliefs about available children on their decision-making processes. For years agency staff have wondered how best to present information about the characteristics of their available children. In order to address this area it is imperative that any future study of applicants' decision-making processes include ample description and profiles of the actual characteristics of the population of adoptable children within the jurisdiction from which applicant study participants are drawn. Awareness of these population characteristics will allow others to better assess the external validity of findings to multiple jurisdictions.

Finally, Strauss and Corbin (1998) write of the common occurrence of grounded theories being subsequently tested in future research using quantitative methods. It is conceivable that a survey could be developed and structured using our key categories and sub-categories to test applicants' identification of these as influential on their decision-making processes. This approach may be a logical next step to directly testing the validity of the theory with a similar group of applicants. While we have presented our substantive level theory, there nevertheless remains much to

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be learned about applicants' decision-making processes as they consider children with and without

disabilities in the field of DPA.

SUMMARY AND CONCLUSIONS

Child Wards and Disability

This thesis has demonstrated that children with disabilities are disproportionately represented among the population of permanent wards without access in Ontario and have experiences, such as maltreatment, and planning conducted on their behalf that are different or more frequent from the experiences and planning conducted on behalf of those without disabilities. Among those children who are permanent wards, those with disabilities represent the majority. There is considerable heterogeneity among this group with disabilities and the needs of any one child may vary greatly from those of another child. While our focus on measuring rates of diagnosed disabilities does not reflect on the success of any related accommodations to address impairments, it is well known that children with disabilities must be provided with optimal support to enable them to function at their fullest potential.

The OCWS found that children with disabling conditions had different patterns in permanency plans, which may negatively impact their life course. Regardless of disability status, children tended to be admitted to care at relatively young ages. Children with disabilities were significantly more likely to be apprehended into care than voluntarily placed into care and at older ages when compared to the other children. A variety of recommendations about the future study of children who are permanent wards and have disabilities have been proposed.

Theory of Decision-making Processes

In our analyses we identified one central category *Gaining Balance* and three main categories *Commitment, Persistence,* and *Evaluation*. These categories, nine sub-categories, and numerous associated concepts were described in detail and the explanations of their interrelations were set out using a Table and a narrative story line. The decision-making processes of adoption applicants are continuous, complex and an essential process to understand. Research from adoption and decision making informed our discussion of the interpretations of our data. This research has pointed to

possible limitations to the study of real-life decision making when participants are involved in multilayered decisions over lengthy periods of time. We have concluded that the testing and extension of our theory to other groups of adoption applicants will enhance the applicability of this substantive level theory. We have recommended that future research attention be focused on the important area of adoption decision making so that practitioners and society can ensure that indeed the best interests of children who become permanent wards with no access are paramount.

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APPENDIX I

Definitions and Background for Key Terms

A number of key terms are referred to throughout the thesis and clear definitions and descriptions of the meanings intended are described below. They are defined and described in some detail to clarify the intended meaning and provide relevant background information.

Adoption

For the purposes of this thesis, adoption refers to the procedural and legal mechanisms whereby a qualified adult or couple of adults who are formerly unrelated to a child (i.e., under age 18) who is available for adoption, take(s) over the active parenting responsibilities for that child. In Ontario a child is legally available for adoption once he/she has become legally declared a Crown ward (i.e., also referred to as a permanent ward) by a judge and all access orders to the child (and any outstanding related appeals) are terminated (Ontario Child and Family Services Act, 2000). In Canada, adoption is a provincial responsibility. In Ontario, the Ministry of Community, Family and Children's Services (OMCFCS) is responsible for reviewing adoption policies and influencing practices by funding and monitoring the work of nongovernmental child welfare agencies, as well as licensing private adoption practitioners. Domestic public adoptions are those arranged by publicly funded child welfare agencies in Ontario between Canadian citizens who are Ontarian adults and children. International and private domestic adoptions and those relatively rare cases of domestic adoptions of children from the child welfare agencies which are arranged by private licensed practitioners are excluded**.**

Adoption Applicants

The term adoption applicants will mean those adults who have formally applied to a child welfare agency to adopt a child from that agency. They may be new applicants or have completed the approval process and may even have decided to accept a child into their home on adoption probation (i.e., the minimum six month trial period before legal adoption finalization). This study will exclude applicants who have previously adopted children or have a prior relationship with the child welfare sector in the role of foster parent.

Adoption Process

This term refers to the numerous steps involved in adopting a child. Cole and Donley (1990) list eight distinct steps in the adoption process: (a) identifying children in need of adoption, (b) making them legally available for adoption, (c) preparing these waiting children, (d) preparing applicants and selecting adopters, (e) placing the children, (f) post placement services, (g) legalizing the adoption, and (h) post adoption services. Steps (d) to (f) are the steps which involve the decision-making processes by adoption applicants which are a focus if this study. During these three steps applicants are highly engaged with the adoption system (i.e., the formal agencies which arrange adoptions) and immersed in qualifying activities. Applicants also declare preferences regarding child characteristics, are prepared and, if their application is approved, required to consider the adoption of specific available children.

Prospective adoption applicants are required to apply formally to a child welfare agency and engage in an adoption home study which results in a written report. This home study is the culmination of an assessment process requiring several hours of face- to -face interviews between an adoption worker and the applicant(s), during which the worker is required to assess the applicant's current capacity to parent, motivations to adopt, and obtain permission to gather and later review pertinent archival data (e.g., criminal records). Ministry staff receive and review these home studies and either grant approval or reject applicants' applications based on eligibility criteria. If an applicant is approved, he/she progresses to considering specific children and ultimately may be matched with an available child. During an interim period of no less than six months, the matched child must reside on probation with the selected applicant(s) before legal application to finalize the adoption is made to the family court. At most Ontario child welfare agencies, the average length of adoption step (d) and the relevant portion of step (e), according to Margaret Newman, a former adoption worker, is 18 months (Margaret Newman, personal communication, August 2002). In Ontario, only rarely are approved applicants offered a subsidy to be applied against the cost of special supports for a matched

child (Burge, 2005).

In Ontario, permanent wards of the province are referred to as wards of the Crown or Crown wards. In most other provinces the term permanent ward is simply used. The legal processes which have made them permanent wards signify that the children's former parents no longer have a parenting legal role. In Ontario, current child welfare legislation dictates that only children who are Crown wards and have no legal access to their former parents are available for adoption. Therefore, at the time of his/her wardship deliberations CAS workers typically request judges to designate a child to have no access to his/her former parents (hence the use of 'no access' or 'without access') when they wish to plan an adoption for the child.

Disability

For the purposes of this thesis, disability will refer to any range of medical diagnostic labels, such as those for physical and any medical conditions or disorders including syndromes, assessed by a regulated health care provider who is qualified to deliver such diagnoses. Disability results in limitations in a child's functioning.

Child Welfare

Child welfare refers to the field of study and practice that is concerned with both the protection of children from harm and the promotion of the well-being of children. In Ontario the key government ministry responsible for funding and overseeing child welfare services is the Ministry of Children and Youth Services (formerly the Ministry of Community, Family, and Children's Services and the Ministry of Community and Social Services). Child welfare law is primarily embodied in the Child and Family Services Act (hereafter Act), which was first passed in 1984 and amended frequently thereafter (e.g., in 1992, 1993, 1994, 1996, 1999) (Ontario Child and Family Services Act, 2000). The Act outlines the various roles and responsibilities of citizens and child welfare agencies in promoting the well-being of children, including the basic criteria adoption applicants must meet and

the ways in which children can be placed for adoption (Ontario Child and Family Services Act, 2000).

Special Needs Child(ren)

In Ontario law and regulations, special needs child is an informal undefined label. Commonly this term is applied in adoption practice and research to any child in care who is any one of the following: disabled, a member of a sibling group which must be placed together in one adoptive home, or from a visible minority population. These child circumstances or characteristics are considered to distinguish special needs children as being atypical from the historical norm of desirable and adoptable characteristics. It is believed by the adoption system staff that special needs children therefore require special recruitment efforts or community supports to achieve a permanent arrangement such as adoption and an enhanced quality of life (Feuz, 1991).

APPENDIX II

Ontario Crown Wards Survey Data Form

Ontario Crown Wards without Access Study Data Form

Administration Information

_____/_____/_____'04

(Please complete on right)   *Your Initials*   *Agency*   *Today's Date*

Child's Initializing Data

#_____/_____/__M____F_/_____

(Please complete on right) *Number*   *Date of Birth*   *Gender*   *Initials*
                                         (dd/mm/yy)   (first/last)

_____

Q. # 1. What type of Crown ward status does the child have? (Check one)
  □ without / no access
  □ silent on access

Q. # 2. On what date was the child declared a Crown Ward without / or silent on access?
(dd/mm/yy)

_____

Q. # 3. What was the date the child was separated from parent(s) for this stay in care?
(dd/mm/yy)

_____

Q. # 4. What was the primary route by which the child entered care for this stay in care?

(Circle one)

1. Voluntarily relinquishment   2. CAS apprehension

Q. # 5. Which best describes the child's current placement type? (Circle one)

1. CAS Regular Foster Care
2. CAS Specialized Foster Care
3. CAS Treatment Foster Care
4. CAS Group Home
5. CAS Emergency Receiving Home

6. OPR - Group Home
7. OPR - Foster Home
8. Independent Living
9. Provisional Foster Care
10. Youth Custody Facility
11. Customary Care

12. Pre-adoptive Foster Home
13. Adoption Probationary Home
    → Note: date in Home ____
14. AWOL / Unknown
15. Other (specify): _____

Q. # 6. Is the child parented / supervised by another child welfare agency as an "other society ward"? (Circle one)

YES*   NO   UNKNOWN   ⟶   * If *YES,* stop file review on this child

Q. # 7. List all current <u>diagnosed</u> disabilities and medical conditions including behavioural and mental disorders that the child is *known* to have (i.e., diagnosed by an external professional), **and place an asterisk* in the box beside the one *primary* condition which affects the child's day to day functioning most.**

LIST of CONDITIONS   **LIST of CONDITIONS**

1. _____   4. _____
 _ ☐   ☐
2. _____   5. _____
 _ ☐   ☐
3. _____   6. _____
 _ ☐   ☐

Q. # 7a. Are eyeglasses prescribed for the child? (Circle one)   YES   NO   UNKNOWN

Q. # 7b. Are psychotropic medications prescribed for the child?   YES   NO   UNKNOWN

Q. # 8. List all <u>undiagnosed</u> disabilities and medical conditions including behavioural and mental disorders that the child is *suspected* of having (i.e., suspected by the worker or external professional) **though no formal diagnosis has yet been made.**

LIST of CONDITIONS   **LIST of CONDITIONS**

1. _____   3. _____

2. _____   4. _____

Q. # 9. Please circle all the child's *family* history items which are *known*:

1. A birth parent or sibs have a significant mental illness

2. Child was exposed to substances prenatally

3. A parent had alcohol or drug dependency

4.   A parent has serious criminal history

5. A parent had a developmental disability

6. A birth parent had HIV or AIDS

7. A birth parent has a hereditary disease
      /condition   (specify)
      _____

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Q. # 10. Answer the question '*Has the child been….?*' (Circle each of the following possible *child* experiences, which are believed to have occurred *before* entering and for *during* care. For all that apply place a checkmark in the appropriate box to indicate whether 'suspected' or formally 'verified').

Before Care	Suspected	Verified		*During Care*	Suspected	Verified
1. Sexually abused	□	□		1. Sexually abused	□	□
2. Physically abused	□	□		2. Physically abused	□	□
3. Neglected	□	□		3. Neglected	□	□
4. Abandoned	□	□		4. Witness to abuse of an	□	□
5. Witness to abuse of a	□	□		in care 'family' member		
family member						

Q. # 11. Regarding visible majority / minority status, which best describes the child? (Circle one)

1. White (Caucasian)   2. Aboriginal   3. Visible Minority   4. Unknown

Q. # 12. Does the child have a current Individual Education Plan (IEP)? (Circle one)

YES   NO   UNKNOWN

Q. # 13. What is the primary language spoken by the child? (Circle one)

1. English   2. French   3. Does not speak   4. Other (Specify)_____

Q. # 14. Has the child ever been placed on adoption probation by your agency? (Circle one)

YES   NO   UNKNOWN

Q. # 15. How many of the following has the child ever experienced? (Number for each that apply)

1. Adoption probation disruptions _____   2. Adoption breakdowns _____   3. Customary Care breakdowns _____

   Q. # 15a. Briefly state reason(s) for each disruption or breakdown? (Use extra space at end if necessary)

_____

Q. # 16. What is the child's current permanency plan? (Circle one)

1. Adoption   3. Live with Relatives   5. Mental Health Services   7. Customary Care

2. Independence   4. Developmental Services. 6. Long Term Foster / Group Care 8. Not Clear

Q. # 17. If the current plan is *not* adoption briefly note why not? (also note: if it *ever* was and what happened)?

_____

_____

<u>Continue Below Only If the *Current* Permanency Plan Is Adoption</u>

Q. # 18. If the permanency plan is now adoption, note the date plan became official?
(dd/mm/yy) _____

Q. # 19. If the plan is adoption, what has occurred or is planned to secure an adoption?
(e.g., ARE, Today's Child, referred internally to adoption department, tracing extended family,
consulting community members)

_____

_____

**Q. # 20. Whether or not this child is on an adoption probationary placement now, is there
an adoption subsidy designated for the child?** (Circle one)

YES   NO   UNKNOWN

**Q. # 21. Does the child have siblings who are Crown Wards without access for whom
adoption is also the permanency plan?** (Circle one)

YES   NO   UNKNOWN

Q. # 21a. If YES to #21, will efforts be made to place them together? (Circle one)

YES   NO   UNKNOWN

Q. #21b. If YES to #21a, how many siblings are ideally to be placed together with the child?
(Number)

_____

- Thank You -

Extra space for details only if necessary

_____

_____

APPENDIX III

Ontario Crown Wards Survey

Detailed Sampling Information

Cluster sampling afforded the best approach in trying to account for the author's sampling assumptions and control for unknown variables (Satin & Shastry, 1993). The cluster sampling strategy involved three steps: 1) acknowledging sample assumptions and making decisions about the stratification based on known and predicted variables, 2) creating uniform cluster sizes and 3) randomly selecting the created clusters of participants, informed by sample size and precision estimates.

For the present study, it was known that the 51 agencies all served CWWA and that the agencies of the OACAS were grouped into five administrative zones based on geography. The author decided that the first step in the sampling strategy was to stratify all agencies by the five OACAS zones. The second step involved stratifying agencies within each zone by their annual budget size. Next, known information regarding the previous year budget size for each agency was used to estimate a cluster size. While the Ontario agencies shared a budget of just over $950 million (an average of almost $19 million each) in 2001-2002, the wide range in budgets noted earlier raised some concerns about simply adopting the mean budget as the average cluster size. In order to inform the decision about adopting a cluster size based largely on budget size, an exploratory survey was conducted. Over one third (19 agencies) of the 51 Ontario agencies were included. These 19 represented agencies from all five zones, varying in size from very large to very small; they accounted for 40% of the total provincial budget to CASs. In the survey, agency staff were asked to share publicly available information regarding the number or estimates of the number of CWWA each served. This information was compared to known information about their budget sizes. After plotting the agencies from those serving the fewest to the most CWWA, a budget size of approximately $22.5 million for the year in question was related to, on average, approximately 49 CWWA being served. The number 49 was rounded up to 50, and $22.5 million was adopted as the budget size to correspond with the created cluster size.

Once the cluster mean budget size was adopted, all agencies were re-examined and divided or combined into cluster sizes to match, as closely as possible, the cluster definition. For

instance, an agency with a budget of $45 million was divided into two clusters. If only one cluster of that agency was randomly selected in the next stage of sample selection, then it would be requested to consent to the review of the files of only one half of its CWWA, randomly selected from a list of its CWWA. Conversely, agencies with smaller budgets were combined with nearby agencies from the same zone to arrive at a cluster approximating the average budget size; if selected than both agencies would be invited to participate with all of their CWWA included in the cluster.

Sample size and precision estimates were computed using standard precision methods for finite populations (e.g., 2000 CWWA) to determine the number of study children's files necessary for inclusion in order to most likely arrive at findings that could be generalized. The next step involved computing the proportion of the provincial child welfare budget attributed to agencies in each zone. As all created clusters were of approximately equal size, the final step involved randomly selecting clusters from each administrative zone based on the proportion of provincial child welfare budget received by that zone and the number of children required. As a precaution to high intracluster homogeneity, the figure was doubled resulting in a desired sample size of 556.

Given the proportions of provincial agency budgets per zone logic suggested that 12 cluster should be randomly selected. It was recognized that 100% participation was unlikely (i.e., since previous OACAS-sponsored research reported response rates of 70-75%) therefore a sampling rule was adopted to increase the likelihood of the contribution of data from every selected cluster. This rule stated that if, once selected and invited to participate, no agency or agencies comprising a complete cluster opted to participate then a new cluster within the same administrative zone would be randomly selected. The agency or agencies comprising that new cluster would then be invited to participate.

Participating Agencies

Following the random selection and invitation to participate of the original 17 agencies,

two agencies within different zones, each representing a complete cluster, immediately declined to participate. Consequently, the author randomly selected an alternate cluster for each affected zone. These newly selected clusters each were comprised of multiple agencies. About the same time, the author learned that there were 52 (not 51) child and family service agencies in Ontario as one selected agency had recently split into two entities. Therefore an invitation was sent to the Executive Director at the newly recognized agency.

In the end, of 52 Ontario agencies, 16 agencies out of 20 invited, participated (80%)[13]. Table III-1 summarizes the final number of clusters and selected agencies by administrative zone.

Table III-1

Clusters Created, Selected, Participating Agencies and CWWAs by Administrative Zone

Administrative Zone	Total # Agencies	# Created Clusters	# Clusters Selected	# Agencies within Selected Clusters	# Agencies Participated by zone	# CWWAs
ASNOCAS (Northern)	15	6	2	5	3	46
Central	7	14	4	5	5	96
Grand River	10	7	2	3	3	97
Southwestern	8	7	2	2	2	115
Eastern	12	7	2	5	3	75
Total	52	41	12	20	16	429

---

[13] When the two originally selected but subsequently non-participating agencies are included, the participation drops to 73% of invited agencies.

APPENDIX IV

Ontario Crown Wards Survey, Instruction Manual:

Excerpts on Disability

The following two excerpts are taken from the OCWS Instruction Manual given to reviewers to guide the coding of the disability variables.

Excerpt 1

"Q. # 7. List all current <u>diagnosed</u> disabilities and medical conditions including behavioural and mental disorders that the child is *known* to have (i.e., diagnosed by an external professional)**, and place an asterisk* in the box beside the one** *primary* **condition which affects the child's day to day functioning most."**

<u>Background:</u> This is one of the most important questions so please read the instructions carefully. The framework for a definition of Disability is borrowed from the World Health Organization. Their framework defines disability as the relationship between body functions and structures, daily activities and social participation and recognizes the role of environmental factors (e.g., such as lack of accessible buildings) as contributing to the experience of disability for people. In this question I am seeking the actual diagnostic name for every current diagnosis the child has - excluding only the most basic and very temporary medical conditions (e.g., common colds, flues, warts). *Current* refers to conditions diagnosed where no mention of a cure or change in diagnosis is found. For instance, a child who underwent eye surgery may have had a complete cure so it must be determined if the conditions persists or is resolved. When the researcher groups these disabilities and conditions together he will likely use the following broad categories: seeing, hearing, mobility, dexterity, learning, developmental delay, developmental disability, chronic conditions.

The ***diagnoses*** must be made by a professional external to the agency (e.g., Psychiatrist, Psychologist, Family Doctor, some other medical specialist)*.* Social Workers and many other professionals are not licensed to give health or mental health diagnoses. However, when in doubt include the diagnosis, the type of professional who gave it and the date of the diagnosis or original document it was noted on. Checking the school record may indicate whether a

Psychological Assessment was completed. A learning disability is indicated by a 15 point or more difference between Verbal and Performance sections on the child's WISC score.

An asterisk ***** should be placed beside the one disability or medical condition which is most frequently cited as primary to affecting the child's current day to day functioning. Notations on the file of affects on functioning may be found or inferred from certain accommodations such as assistive technologies. If a child has several diagnoses the primary one affecting them may be the one that is most broad in scope. For instance, a child with limited dexterity in one foot may be far more affected by a tic disorder as evidenced by significant levels of psychotropic medications which are taken regularly and have concerning side effects. When in doubt call the researcher and add detail to the entry on file.

Examples of commonly found ***Mental Disorders*** and ***Behavioural Disorders*** in this population may include: Attention Deficit Disorder (ADD), Attention-Deficit/ Hyperactivity Disorder (ADHD), Any disorders with Attachment in the label (Reactive Attachment Disorder), Disruptive Behaviour Disorder, Oppositional Defiance Disorder (ODD), Obsessive Compulsive Disorder (OCD), Mood Disorders (depression, bipolar disorders), Learning Disabilities (e.g., Dyslexia), Pervasive Developmental Disorders PDD, such as Autism (or Autism Spectrum Disorders) and Aspergers syndrome, Developmental Delay (indicates delays in certain aspects for children under age 8), Developmental Disability (an administrative term used in Ontario to replace the actual medical diagnosis of mental retardation and indicated by an IQ score below 75 or at or below the second percentile, along with adaptive functioning limitations), and Psychoses, such as Schizophrenia.

Examples of chronic conditions which may be formally diagnosed: asthma, severe allergies, heart condition or disease, cancer, epilepsy, cerebral palsy, Spina Bifida, Cystic Fibrosis, Muscular Dystrophy, Fetal Alcohol Syndrome (or Fetal Alcohol Effects), and sight or hearing problems.

Excerpt 2

"Q. # 8. Please list all <u>undiagnosed</u> disabilities and medical conditions including behavioural and mental disorders that the child is *suspected* of having (i.e., suspected by the worker or external professional) **though no formal diagnosis has yet been made."**

Answer as in #7 above, except here you may list all suspected conditions and use the blank space at the end of the form if necessary. Disabilities or medical conditions listed here will include those that are under formal medical investigation with no results yet conclusive. For instance some diagnoses (e.g., Autism, other Pervasive Development Disorders and Developmental Disabilities or Fetal Alcohol Syndrome, Schizophrenia) may require extensive medical or and/ or psychological testing and these tests may not be completed or conclusive at the time of the file review. As well, some such tests cannot be reliably administered to babies or young children and therefore a decision may have been taken to wait until the child is older before formally testing for a suspected syndrome, disorder or condition. Furthermore, some communities lack the professionals who are qualified to give certain diagnoses (e.g., Speech and Language Pathologists, Psychologists) and therefore no specific diagnosis may have been given. You may also include here conditions that are not under formal investigation. For instance, agency staff may believe a child exhibits signs of having a disability or a chronic condition such as Fetal Alcohol Effects or Syndrome but there have not yet been any formal investigations or the medical professional did not offer a diagnosis still suspected by staff or an external professional. Do not include conditions suspected by caregivers only.