

Ontario Association of Children's Aid Societies

# JOURNAL

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## INSIDE:

SIGNS OF SAFETY

IMMIGRATION STATUS AND YOUTH IN CARE

CASE NOTE EXCELLENCE



Ontario Association of  
Children's Aid Societies  
The voice of child welfare in Ontario

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The OACAS Journal features articles on child welfare research and practice in Ontario, highlighting projects and initiatives to improve the well-being of children, youth and families. Submissions to the OACAS Journal are reviewed anonymously by the Editorial Board and compared against a review matrix that questions the logic, research, content and discussion of the submission.

### SPECIAL MESSAGE FROM OACAS AND THE JOURNAL

As the Ontario child welfare sector continues to undergo significant change, OACAS has decided it's an ideal time to re-evaluate the purpose, content, and format of the *Journal* for future volumes. To do this effectively, production of the *Journal* will go on a short hiatus. We will not be seeking submissions during this period, and will notify the field and all subscribers when we plan to relaunch the *Journal*.

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# TABLE OF CONTENTS

## **Message from the Chief Executive Officer**

Mary Ballantyne, CEO, Ontario Association of Children Aid Societies (OACAS) .....1

## **Signs of Safety (SOS) at the Children's Aid Society of Toronto (CAST):**

### **Evaluation of Year I Implementation**

Violeta Dubov (Research Project Coordinator)  
and Nancy Andrews (Director of Intake Services), CAST ..... 2

## **Permanency for Youth in Care: Immigration Status Matters**

Anthony Fung, BA (SW) CQSW, PBDM, MA, MBA, Manager, Service Administration, CAST,  
Bryan Shone, MSW, Senior Service Manager Permanency, Peel Children's Aid Society ..... 9

## **Case Note Excellence in Child Welfare:**

### **A Pilot Study of Contemporaneousness and Quality**

Jessica A. Sartori, Ph.D., Windsor-Essex Children's Aid Society  
and Sandra Bortolin, Ph.D., Windsor-Essex Children's Aid Society ..... 15

## **Understanding the Symptomatology of ADHD in Pediatric Populations from a Biopsychosocial Perspective**

### **Part Two – The Assessment and Diagnosis of ADHD**

Sebastiano Fazzari, Ph.D., R.S.W., Sean Robb, M.A., Ph.D., and Peter Bonsu, M.D., F.R.C.P.(C). ..... 24

## **Management and Treatment of ADHD in Pediatric Populations from a Biopsychosocial Perspective:**

### **Part Three – Translating Research into Clinical Practice**

Sean Robb, M.A., Ph.D., Sebastiano Fazzari, Ph.D., R.S.W., and Peter Bonsu, M.D., F.R.C.P.(C). ..... 35

## **A Better Way Forward: Open Adoption and its Benefits for Adopted Children and Their Adoptive and Biological Parents**

Susan Doran ..... 44

## **Book Review: Child Welfare Systems and Migrant Children: A Cross Country Study of Policies and Practices**

Bruce Leslie, MSW ..... 51

## **Examining Relations Between Foster Parent and Foster Youth Ratings of Parenting Practices and Youth Psychosocial Functioning**

Julie Norman, M.A., Rosanne Menna, Ph.D., and Deborah Ellison, Ph.D ..... 54

## **The Ontario Child Abuse and Neglect Data System (OCANDS) Data Sheets 1-4**

OCANDS, OACAS, Factor-Inwentash Faculty of Social Work, University of Toronto..... 63

## MESSAGE FROM THE CHIEF EXECUTIVE OFFICER

Welcome to the fall/winter special double issue of the Ontario Association of Children's Aid Societies (OACAS) *Journal*. This issue focuses on a wide array of topics, and highlights the range of research and innovative practices that continue to be undertaken to help support the children, youth, and families of Ontario. We believe the articles presented are also reflective of the significant change agenda currently taking place in Ontario's child welfare sector.

As the field explores new and promising practice models, Nancy Andrews, Director of Intake Services, Children's Aid Society of Toronto (CAST), and Violeta Dubov, Research Project Coordinator, in partnership with the Practice Leadership Committee and the Child Welfare Institute, present "Signs of Safety (SOS) at the Children's Aid Society of Toronto (CAST): Evaluation of Year I Implementation." This article details the anticipated outcomes, methodology, main findings, and practice implications of the evaluation of the first year of SOS implementation at CAST.

The importance of recognizing key intersections between the work of child welfare with other social services and adapting new strategies to address these intersections is at the heart of the article "Permanency for Youth in Care: Immigration Status Matters." Immigration status issues have a significant impact upon outcomes for children and youth who come into contact with child welfare and this piece explores that impact and current strategies for addressing those issues.

We're also pleased to present the final two parts of a three-part series exploring the diagnosis, treatment, and clinical practices of ADHD; an article that explores Open Adoption and its implications and benefits for children and families; a fascinating book review of *Child Welfare Systems and Migrant Children: A Cross Country Study of Policies and Practices*; and "Examining Relations Between Foster Parent and Foster Youth Ratings of Parenting Practices and Youth Psychosocial Functioning."

As the Ontario child welfare sector continues to undergo significant change, OACAS has decided it's an ideal time to re-evaluate the purpose, content, and format of the *Journal* for future volumes. To do this effectively, production of the *Journal* will go on a short hiatus. We will not be seeking submissions during this period, and will notify the field and all subscribers when we plan to relaunch the *Journal*.

OACAS recognizes the important space the *Journal* occupies in child welfare, as both an outlet for child welfare professionals' work and as a source for the field of new research and study. We hope to continue to serve the field through this publication and endeavour to build upon the *Journal's* strong history.



A handwritten signature in black ink, consisting of a stylized 'M' followed by a large, circular flourish.

**Mary Ballantyne**  
Chief Executive Officer  
Ontario Association of Children's Aid Societies

# Signs of Safety (SOS) at the Children's Aid Society of Toronto (CAST): Evaluation of Year I Implementation

Violeta Dubov, Research Project Coordinator, and Nancy Andrews, Director of Intake Services, Children's Aid Society of Toronto, in partnership with the Practice Leadership Committee and the Child Welfare Institute

Signs of Safety (SOS) is a clinical framework for child protection that was developed through the 1990s by Andrew Turnell and Steve Edwards. SOS arose out of a need for a structured approach to child protection casework and the decreasing morale of child protection staff. Today, the SOS approach is increasingly practiced in numerous jurisdictions of various countries, including Australia, UK, USA, Netherlands, Japan, and Canada. SOS was formally implemented at the Children's Aid Society of Toronto (CAST) in March 2013. This article details the anticipated outcomes, methodology, main findings, and practice implications of the evaluation of the first year of SOS implementation at CAST.

## PROJECT BACKGROUND

Planning for SOS implementation commenced in 2012 with the agency's Practice Leadership Committee (PLC) getting exposure to the SOS framework and introducing it to the agency. Other practice models (e.g., Supervision Model, Family Centered Conferencing) were examined with regards to collaboration with SOS. Connected Families, an organization that has been helping agencies adopt SOS since 2008, provided consultation on implementation, clinical practice, and training. SOS was formally implemented at CAST in March 2013, and the first round of training occurred in April 2013. Turnell often notes that agency-wide implementation of a new clinical framework is a ten-year journey. Therefore, with over a year of SOS implementation at CAST now complete, the journey is yet at its infancy. To support continuous learning and development, internal resources have been put into place:

- Weekly practice enhancement sessions to promote peer SOS knowledge exchange and enhance application
- Ongoing introductory and Connected Families training, safety planning, and branch management training.

The main anticipated outcomes following the first year of implementation were:

**OUTCOME 1:** Protection and non-protection staff trained in introductory SOS

**OUTCOME 2:** Advance staff skills in SOS assessments, safety planning, and family engagement

**OUTCOME 3:** Improved family satisfaction with CAS services

**OUTCOME 4:** Improved worker job satisfaction

## METHODOLOGY

This evaluation report prepared by the Child Welfare Institute (CWI) aims to provide an overview of Year I SOS implementation at CAST by collecting input from multiple stakeholders, specifically front-line workers, PLC, Intake supervisors, and clients. A mixed-method research design was utilized to meet the objectives of the evaluation; quantitative data included training surveys, Supervisor SOS Fidelity Rating Checklist, and Parental Rating Checklist, while qualitative data included client interviews, focus groups, file reviews, and qualitative survey questions.

The main strength of this evaluation is the in-depth data collection from multiple stakeholder groups using mixed qualitative and quantitative methodology. These diverse sources and types of data increase confidence in the findings obtained. In addition, this evaluation report adds new knowledge, although preliminary, in an area where little research exists to date. With SOS becoming the leading clinical framework to child protection casework in multiple countries, more insight is needed into the implementation of SOS as well as its impact. While every effort was made to mitigate data collection limitations, there were some challenges in collecting the data:



- Conducting an evaluation at such an early phase of SOS implementation limits the sample sizes, the breadth of the analysis possible at this stage, as well as the applicability of the findings.
- Although common in evaluation research, there are challenges associated with retrospective file reviews. It is a method in harnessing or utilizing information that was not originally collected for research and evaluation purposes. Therefore, file review findings should be interpreted with caution.
- Competing and overpowering CPIN-related priorities rendered it impossible to allocate SOS implementation and evaluation the full attention it deserves.

## FINDINGS

### OUTCOME 1: PROTECTION AND NON-PROTECTION STAFF TRAINED IN INTRODUCTORY SOS

Over 350 child protection workers and supervisors received two-part SOS training in 2013, of which 34%-40% completed an evaluation survey:

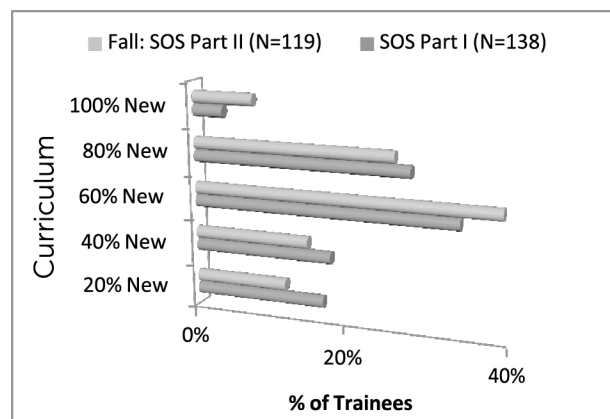


FIGURE 1. PERCENTAGE OF NEW KNOWLEDGE GAINED BY PARTICIPANTS

SOS PART I, INTRODUCTION TO SOS (N=354) was designed for all protection staff and protection supervisors and was delivered by CAST trainers. Topics covered were the philosophy behind SOS, practice principles, skillful use of authority, and partnering with

families. The use of questions was introduced as well as danger statements and tools within the SOS framework. A total of 138 trainees (40%) completed the evaluation survey.

SOS PART II, ADVANCED PRACTICE (N=355) was delivered to protection staff by Connected Families trainers, with child protection supervisors attending one additional day. Curriculum included an in-depth understanding of SOS and focused on the use of the questioning approach and various clinical tools. A total of 119 trainees (34%) completed the evaluation survey.

The majority of survey respondents (76% and higher) rated all satisfaction questions positively, while over half of participants found they gained between 60% and 100% new knowledge from the curriculum (see Figure 1). The main criticisms were repetitive content and insufficient practice-based learning. In 2014, training and skill development continued for protection staff and management while non-protection service staff were introduced to SOS that Fall.

### OUTCOME 2: ADVANCE STAFF SKILLS IN SOS ASSESSMENTS, SAFETY PLANNING & FAMILY ENGAGEMENT

Analyses contributing to these findings included:

- Supervisor SOS Fidelity Rating Checklist** (N=30), where six protection supervisors evaluated 30 of their workers using a 35-item scale assessing workers' practice skills and use of SOS. The Checklist is a component of a larger research project undertaken by SOS Fidelity Workgroup.
- Focus Groups** (N=26) were conducted with front-line workers (n=5), Practice Leads (n=9), and Intake supervisors (n=12). The focus group questions assessed CAST's current stage of SOS implementation, the benefits and challenges encountered, and recommendations with regards to moving forward.

**C. File Reviews** (N=30), where SOS Super Users (n=9), who have more advanced SOS skills, were compared to Regular Intake (n=21) on family file characteristics and evidence of SOS use in their file recordings.

**A: Supervisor SOS Fidelity Rating Checklist (N=30).** The analysis of data from six supervisors of 30 workers on their teams showed that most workers (over 80%) are highly proficient in many skills, including humility, transparency, working with strengths, focusing on and enhancing safety, and engaging with various family members while working collaboratively. Qualitative comments from supervisors indicated that SOS brought structure into the casework and helped workers engage clients, conduct thorough and balanced assessments, build collaborative and meaningful safety plans, and reflect on their own practice. However, at least half of the workers or more were not sufficiently proficient in multiple SOS-specific skills, in particular the use of "Mapping" and "Words and Pictures".

To shed further light on these results, inferential statistical analyses was performed and found significant differences where  $p < 0.05$  between the ratings of workers with less advanced and those with more advanced SOS knowledge and skill:

- A t-test comparison found that workers with more advanced knowledge in SOS were rated significantly higher on all checklist items;
- The number of workers' years of SOS practice had a significant positive correlation to the majority of rating items, indicating that as the former increased so did the frequency with which workers practiced the skills assessed by their supervisors (see Figure 2);
- The number of days workers spent in training also had a significant positive correlation to their ratings by supervisors on all 35 items (see Figure 3);

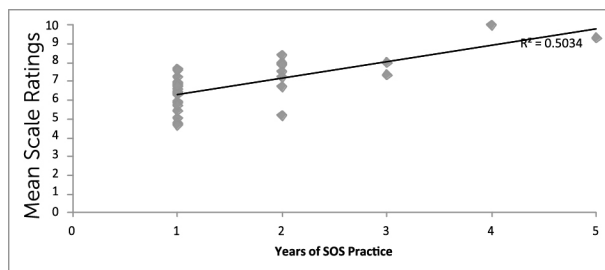


FIGURE 2. MEAN RATING SCORES OF ALL WORKERS VS. THEIR YEARS OF SOS PRACTICE

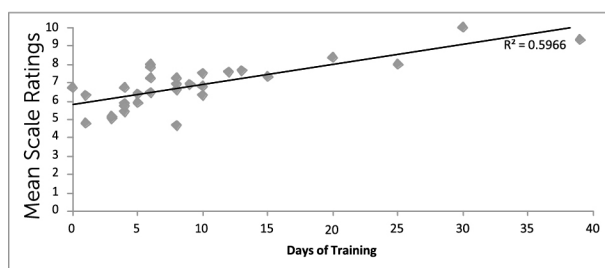


FIGURE 3. MEAN RATING SCORES OF ALL WORKERS VS. THE NUMBER OF TRAINING DAYS THEY COMPLETED.

**B: Focus Groups (N=26).** Focus groups were conducted with three different stakeholder groups between February and December of 2014 in order to get their perspective on SOS implementation and impact within the agency; front-line workers, practice leads, and supervisors were able to provide a unique perspective by virtue of their different roles within the agency. Participants were asked questions that were broadly categorized around what was going well, not going well, and needed to change.

Most participants agreed that the SOS approach has useful tools that bring structure to child welfare work, lead to more collaboration and partnership with families, and improve the practice of front-line workers by enhancing risk assessments and safety planning. With that being said, it was also recognized by focus groups participants that there is an existing gap, where some staff at front line and management levels are behind in their level of SOS knowledge and use; some of the challenges mentioned were lack of buy-in, insufficient time and opportunity given to learn SOS, split agency priorities, and inadequate integration of various models and initiative

on the agency's agenda. Table 1 summarized the findings while highlighting both common and distinct themes between the stakeholder groups.

TABLE 1. SUMMARY OF FOCUS GROUP DATA

	Front-Line Workers (n=5)	Practice Leads (n=9)	Intake Supervisors (n=12)
What's going well?	-	⬆ Highly level of skill among staff	-
	⬆ Improved parent experience through partnership/collaborative approach ⬆ Increased job satisfaction and enthusiasm for front-line workers/staff ⬆ Utility of SOS approach and tools (improved practice and risk assessment, hearing the child's perspective and bringing voice into the work)		
	-	⬆ Order, consistency & structure to the work, especially in challenging cases ⬆ Appreciative inquiry, safety goals & genograms – useful for work & supervision	
What's not going well?	-	Split agency priorities	-
	⬆ Resistance, push back and/or lack of practice at the worker level ⬆ Lack of buy in and/or insufficient leadership at the management level ⬆ A gap in learning and knowledge at the management level		
	⬆ No time to sufficiently learn or practice SOS	-	⬆ No time to sufficiently learn or practice SOS
What needs to change?	⬆ Leadership & visible support from management towards agency-wide full use of SOS ⬆ Additional training and opportunities to practice SOS for front-line workers ⬆ Management extensively trained in SOS ⬆ Agency-wide continuous culture of learning of SOS		
	⬆ Funding & resources towards SOS implementation	⬆ Better integration of agency initiatives with SOS (e.g., Supervision Model) ⬆ Showcase SOS success stories ⬆ Videotape SOS w/families	⬆ Reduced workload to allow learning & practice to occur



**C: File Reviews (N=30).** A total of 30 CAS Intake files were randomly selected for review from all files opened to Intake between April 1 and June 30 of 2014 and transferred to Ongoing Family Services. Of the 30 files reviewed, nine belonged to SOS Super Users, who are Intake workers who had additional training in SOS and were ahead in their SOS practice when compared to the agency as a whole. The remaining 21 files belonged to regular intake, Intake workers without such classification. The contents of file transfer recordings were reviewed using a File Review Tool developed by CWI in collaboration with PLC. The File Review Tool collected information in two areas:

- Family characteristics – previous CAS openings; referral source; family court involvement; verification of protection allegations; Family Risk Ratings; number of children in the family; the children's residence; and any changes in the children's caregivers and/or residence from opening of CAS file to the point of file transfer.

- Use of SOS principles – evidence of SOS practice assessed using ten questions, which sought evidence of: (1) focus on engagement of client; (2) clear communication of protection concerns; (3) statement of family strengths or protective factors; (4) use of danger and harm statements; (5) an outlined plan; (6) safety goals; (7) involvement of family's support network; (8) use of Elicit, Amplify, Reflect, Start-over (EARS) questioning style; (9) use of SOS Tools; and (10) identification of what works well for the client. Each question received one point if there was clear evidence of use of the principle within the transfer recordings, a half point if there was unclear or inconclusive evidence, and a score of zero if there was no evidence. The scored questions were added up to an overall SOS implementation score of 10 possible points (see Table 2).

TABLE 2. FILE REVIEW COMPARISON BETWEEN REGULAR INTAKE WORKERS AND SOS SUPER USERS

	Regular Intake (n=21)	SOS Super Users (n=9)
Previous file openings	76% of files previously open <i>M</i> = 2.75 ( <i>SD</i> = 2.02)	78% of files previous open <i>M</i> = 3 ( <i>SD</i> = 2.24)
Referral source	Self = 9%; Other = 91%	Self = 33%; Other = 67%
Family court involvement	14%	0%
Verification of original allegations	62% verified	56% verified
Verification of additional allegations	62% verified	67% verified
Family Risk Assessment	Moderate Risk = 52%; High Risk = 48%	Moderate Risk = 78%; High Risk = 22%
Number of children in the family	<i>M</i> = 1.90 ( <i>SD</i> = .89)	<i>M</i> = 1.56 ( <i>SD</i> = 1.13)
Children's residence	19% of children changed their residence	0% of children changed their residence
SOS implementation score	<b><i>M</i> = 4.79 (<i>SD</i> = 1.91)*</b>	<b><i>M</i> = 8.06 (<i>SD</i> = .85)*</b>

\* Statistically significant difference where  $p < .05$

Comparing SOS Super Users (N=9) to Regular Intake (N=21), there was a significance difference, where  $p < 0.01$ , in the level of implementation of key SOS principles as evident in the recordings of Intake files transferred to Ongoing Family Services, where SOS Super Users appeared to implement SOS much more often. There was no significant difference found on family variables at point of file transfer to Ongoing Family Services between Regular Intake and SOS Super Users; this is not surprising given the small sample size and the short time period that intake workers have with families. Going forward, as SOS implementation across the agency continues, it will be possible to increase the sample sizes and follow up on the outcomes of these 30 families after receiving Ongoing Family Service. This would shed more light on the difference SOS implementation makes in the lives of child welfare clients.

**File review results combined with focus group and Supervisor Fidelity Rating Checklist results imply that additional training and practice may bring intake workers up to a more advanced level of practice.**

### OUTCOME 3: IMPROVED FAMILY SATISFACTION WITH CAS SERVICES

Potential clients were selected to be contacted for a telephone interview based on the following criteria:

- Families who had an open CAST file for at least 30 days within the last six months;
- Families who were closed to CAST for at least one month;
- Families who experienced SOS as the guiding approach during the most recent file opening;
- Families with previous file openings with CAST where SOS was not the guiding approach.

Client interviews were conducted using the Parent Feedback Checklist, which is another

tool developed by the SOS Fidelity Workgroup. The tool contains 19 rating scales assessing parental experience with their most recent child protection worker. Nine client interviews were successfully completed in March 2014 and February 2015.

Most clients were highly satisfied with their worker, most frequently with the worker's ability to do what was promised, engage with children and ensure their voice was heard, approach the family with humility, and conduct a balanced assessment that includes strengths, worries, and next steps. Six clients were asked to compare this most recent worker to previous child welfare workers they had; half indicated that their most recent worker had superior skills to previous workers while the other half indicated that their most recent worker's high level of skill and support was comparable to previous workers.

It is important to note that there was high variability in the responses, in particular on an item assessing the worker's ability to help the family develop an achievable safety plan; this could attest to the complexities in the lives of child- welfare involved clients and the possibility that the use of a checklist is insufficient to thoroughly assess clients' experience, especially with such a small sample size. Nevertheless, this very preliminary evidence suggests that the use of SOS contributed to improved family experience and satisfaction with CAS services.

### OUTCOME 4: IMPROVED WORKER JOB SATISFACTION

According to a report by focus group participants as well as qualitative comments made on the Supervisor SOS Fidelity Rating Checklist, implementing SOS led to improved experience for front line staff who feel more job satisfaction and pride in their work. Despite existing challenges with the implementation process, users of the SOS framework experience improved practice, better partnership with clients, and witness the beneficial impact on the safety and functioning of children and their families.

## CONCLUSION & PRACTICE IMPLICATIONS

The Signs of Safety (SOS) approach presents a clinical framework for child protection practice that has the potential of increasing the safety of children, improving the experience of child-welfare involved families, and enhancing job quality and satisfaction of case workers. This evaluation report of SOS implementation at CAST demonstrates preliminary evidence for these positive outcomes. For example, the increased satisfaction of child welfare clients with CAST services is an important finding, despite the small sample size. This evaluation report also highlights the importance of additional learning and skill development across the agency in order to expand the positive impact SOS seems to have on workers and clients as well as sustain it over time.

Overall, the anticipated outcomes of Year I SOS implementation have been achieved, but only for pockets of front line workers and protection supervisors. Therefore, the next step in SOS implementation should focus on increasing the knowledge and skill of staff across the agency who do not have the same proficiency as SOS Super Users or Practice Leads. As for child welfare clients, as a next step it is important to investigate beyond client satisfaction and compare longitudinal outcomes, the most important being child safety, of clients who received SOS-informed service versus those who did not.

The full SOS FINAL REPORT is available on the Child Welfare Institute portal (scroll down the right-side of the Children's Aid Society of Toronto website [www.torontocas.ca](http://www.torontocas.ca); go to "Our Services", then "Research Publications.")

**Violeta Dubov**, has an MSW from the University of Toronto and is a Research Coordinator at the Child Welfare Institute and previously worked as an Intake worker with the Children's Aid Society of Toronto. She uses the combination of her program evaluation skills, love of data analysis and front-line field perspective to advocate for improving services to child-welfare involved children, youth, and families.

**Nancy Andrews** has an MSW from the University of Toronto and is the Director of Intake Services at the Children's Aid Society of Toronto. Nancy has worked in the field of child welfare for 25 years. She is the Agency lead for Signs of Safety (SOS) implementation at the Children's Aid Society of Toronto and is involved in many provincial activities related to SOS.

# Permanency for Youth in Care: Immigration Status Matters

Anthony Fung, BA (SW) CQSW, PBDM, MA, MBA, Manager, Service Administration, Children's Aid Society of Toronto,  
Bryan Shone, MSW, Senior Service Manager Permanency, Peel Children's Aid Society

## BACKGROUND

Recent experiences of OACAS member agencies, in particular Peel Children's Aid Society, Children's Aid Society of Toronto and Catholic Children's Aid Society of Toronto, demonstrate that immigration status issues have a significant impact upon outcomes for children and youth in care as well as other service areas such as kinship and adoption. Further, increased immigration to Canada and globalization, has and will continue to increase the frequency of immigration status issues for children in care.

The implications of unresolved immigration status issues for children in care are profound not only in terms of their impact while in the care of the Society but also later in life. Without documented immigration status (defined as permanent residency or Canadian citizenship) planning for permanency is problematic and the transition to adulthood is significantly affected. These challenges can include barriers to adoption and kinship caregivers, risk of deportation after aging out of care for those involved with the youth justice system, inability to obtain a Social Insurance Number (and hence employment), access to affordable post-secondary education, and other long-term outcomes.

The literature review revealed a lack of Canadian-based empirical research completed on this topic and some of the early studies were largely outdated. Even so, among the very few research projects undertaken, there was strong evidence to link immigration status, or lack thereof, as an important determinant of mental health and social well-being. Although most children in care are permitted to stay in Canada, the lengthy delays in processing their case to resolution and granted permanent residency, only accentuates their feelings of being "stuck" in immigration limbo and being uncertain about their future (Ali et al., 2003). Some research studies reinforce the

negative experiences faced by these youth leaving CAS care with unresolved immigration issues. Meagher et al., (2012) suggested having precarious status has a strong negative impact on the lives of youth and affects their access to services, education, jobs, and housing. Kamal's study (2012) has come to a similar conclusion that the lack of immigration status has significant implications to developmental impairments. It is highly associated with difficulties with identity formation and it compromised self-efficacy and peer relations as well as acculturative stress which in turn results in poorer developmental and mental health outcomes. These research findings are in line with some of the issues that were observed with youth in care with no proper documented immigration status. The case example included in this article highlights the significant challenges faced by these youth.

When children and youth come into the care of CAS, their futures are in a state of uncertainty, and even more so when there are unresolved immigration issues. They experience distinct challenges, as they do not share the same rights as other Crown wards of the Province. They will enter a life filled with uncertainty: they will be unable to access essential health, housing and social services, pursue education, gain legal employment or feel confident that they will be able to remain in Canada, a place they may have called home for some or most of their lives. In many cases, these barriers can be overcome by helping these young people obtain permanent residency and, ultimately, Canadian citizenship.

This subgroup of in-care children and youth who do not have permanent resident status or Canadian citizenship is not an easy group to identify. Not only because they do not constitute a single, uniform cohort, this is also a silent group, as most of them are less likely to speak for themselves and/or not knowing how and thus they are extremely vulnerable. Prior to coming into care, these young people

may have arrived in Canada with their parents or other relatives; some will have fled political unrest, civil war or political oppression in their home countries. While some will have been sponsored to enter the country by a Canadian guardian (but the sponsorship has since broken down), many others may have come to Canada as unaccompanied minors without legal guardians. In all cases, these children and youth have come into care because they are in need of protection due to abuse, neglect or abandonment.

The number of youth in care with unresolved immigration issues is likely to increase over time. According to Statistics Canada (2015), 260,404 permanent immigrants landed in Canada in 2014 and there is an indication that these immigration trends will continue or increase in the coming years. Canada had a foreign-born population of about 6,775,800 people in 2011 and the vast majority of the foreign-born population lived in four provinces (Statistics Canada 2015). Most of the people who arrived in Canada as immigrants chose Ontario as their destination. In spite of the fact that most new immigrants still lived in the nation's largest urban centers such as Toronto, this settlement pattern, which depicts a spatial polarization between rural and urban regions, is changing. There is a growing trend of immigration settlement in smaller cities and towns as the cost of living in the Greater Toronto Area has become less affordable.

## PROVINCIAL PROJECT REPORT

### PURPOSE

The purpose of the OACAS provincial project in 2012 was to better support CASs in resolving immigration issues for former Crown wards prior to age 21. The Immigration Issues Advisory Project was formed to provide leadership and support toward the achievement of the following four main goals:

- To understand the extent to which OACAS member agencies are knowledgeable about immigration issues and able to identify children and youth without legal immigration status;
- To determine the adequacy of available

data to address the needs and foster the progress of children and youth with unresolved immigration issues;

- To determine what resources may be needed to address barriers in resolving immigration issues for youth in care; and
- To work toward a reduction in the number of youth leaving care who lack legal immigration status in Canada.

The project supported the production of a literature review, a field-wide survey, and site visits to a number of Children's Aid Societies in order to help form a better understanding of immigration issues for children in care across the province of Ontario.

### SURVEY RESULTS

The provincial project surveyed child welfare agencies (49) across Ontario in order to gain a further understanding of best practices and provide a gap analysis of the issues agencies were facing when dealing with immigration issues. The response rate was 67% to the survey. The intent of the survey was to gather general information of practice and was not a research-based project. The field survey provided some very important findings for child welfare workers as well as child welfare organizations. The survey findings clearly indicated there are gaps in immigration knowledge and expertise across the field of child welfare in Ontario. Agencies reported the perception that immigration issues occurred infrequently, that immigration training was limited, and there was a lack of systematic data collection about the immigration status of children and youth in the care of the Society. Survey findings also suggested that, for most agencies, the unresolved immigration issues of children in care tend to be discovered on a case-by-case basis rather than identified through routinely collected data present within the child's file. Most agencies relied heavily on external resources when immigration status issues were identified for a child in care.

While one of the project goals was expressed as reducing the number of youth who age out of care with unresolved immigration issues, the general lack of relevant data being collected



by the field has made it virtually impossible to establish a baseline of youth who age out of care without legal status. Most CASs appear to have limited awareness or experience of immigration issues, basic concepts, key players or agents responsible for steps in the process of obtaining refugees status, to permanent residency and to citizenship. This is either because the incidence of occurrence is rare or because there are children being served whose immigration issues are not known to the agency.

As a result of these issues, the numbers of children and youth reported provincially were very likely under-reported. Several agencies reported seldom or never serving children with immigration issues, while some responses indicated a confounding of ethnicity and immigration status, with agencies more likely to inquire about immigration issues for children of some ethnic groups than others. The absence of routinely collected data can result in the issues remaining latent and thus not identified and it limits CASs' abilities to quantify and analyze trends. The establishment of baseline data becomes virtually impossible in identification of youth who currently age out of care without legal status issues. The issue may only become apparent after the youth has left care and dealing with services.

## KEY FINDINGS

### **1. To help Children's Aid Society workers become more aware of and better able to identify children in care with immigration issues.**

Results of the provincial survey indicated that awareness of immigration issues are limited within the vast majority of agencies across the province. The result of which makes it very difficult for workers to identify and then help to resolve immigration status issues for children in care. This may be due to the perceived infrequency and occurrence of the issues, limited training opportunities, and a general lack of systematic recording and monitoring of the immigration issues of children and youth in care. A few agencies with extensive experience with these issues were identified as being able to provide support when specific issues were identified by provincial colleagues.

However, very few organizations had ways of supporting the identification of immigration issues for children in care. Most agencies had very limited experience, either because they identified the incidence of occurrence as rare or because there were children being served whose immigration issues were not apparent to the agency.

### **2. To have reliable data to be able to document the scope of this issue.**

Sixty-eight percent of agencies reported that they did not track data on immigration status for children in care. Of the agencies that reported collecting data, the immigration issues of children in care tended to be discovered on a case-by-case basis rather than through the systematic collection of immigration status data. This may have resulted in a number of children and youth not being identified as requiring immigration support services. Often immigration status issues were only identified due to other barriers being identified by a worker (e.g. a youth not being accepted to university), rather than the immigration status issue being identified at an early stage where the impact was not as pronounced. Furthermore, some survey responses indicated a confounding of ethnicity and immigration status, with agencies more likely to inquire about immigration issues for children of some ethnic groups than of others. These findings reinforce the idea that immigration status data should be routinely collected and maintained for all children in care. Given the present state of data collection across OACAS member agencies, it is impossible to document the scope of the issue accurately.

### **3. For Children's Aid Societies to have the tools and resources to address barriers and to help children achieve legal status and Canadian citizenship.**

At present, there is a strong reliance on external resources, typically utilized on a case-by-case basis. Some agencies, most notably in the Central Zone have well developed training manuals or brochures as well as well-documented procedures and practices to address the issues. Most agencies, however, do not have this level of in-house expertise or experience. The project toolkit has been developed and distributed to all Children's

Aid Societies across the province to make resources broadly available across member agencies. In addition, the recommendation of a training and advisory team, based in an agency with expertise, based centrally at OACAS, or even within a government ministry, will be a step toward realizing this project goal.

#### **4. To have fewer children age out of the care system without legal status in Canada.**

One complication of this goal is the general lack of relevant data among CASs. It was virtually impossible to establish a baseline of youth who currently age out of care without legal status issues. Information on the frequency of this situation was not sought in the survey and may only become apparent after the youth has left care and is dealing with services. There may be an opportunity to gain relevant information from external sources such as the Office of the Provincial Advocate for Children and Youth or the Pape Adolescent Resource Centre, both of which were referred to by agencies as sources they occasionally consulted. Also relevant is the need to clarify the extent to which agencies can act on behalf of children in care when applying for citizenship. The survey and supplementary documents did not directly address this issue, although the issue appeared during site visits and deserves clarification.

## **RECOMMENDATIONS**

Based on an analysis of the survey results the principal recommendations are as follows:

- I. A priority must be placed on the early identification of children and youth with immigration issues, including the documentation of immigration status at the time of admission to care. It has been recommended that current information systems including CPIN be updated to include immigration status data collection. Doing so would foster ongoing awareness of the child or youth's progress toward achieving resolution of these issues. Through more effective tracking and reporting, agencies will be better able to determine the magnitude of the

problem, and provide effective service to children in care with immigration issues.

- II. It was recommended that Children's Aid Societies review and update their policies and procedures to include processes in helping to deal with immigration status issues for children in care. By doing so staff will be better supported to respond to immigration status in a more timely and effective manner.
- III. A project toolkit and a webinar have been developed and provided to all CASs to support staff in expanding their knowledge of immigration status issues. It was recommended that CASs support their staff in the use of these resources in order to increase worker capacity and knowledge of the immigration process for children in care.
- IV. Staff and managers are encouraged to reach out early to support services such as settlement agencies, immigration lawyers and other agencies with immigration expertise when immigration issues are identified. There are a number of requirements related to immigration issues that are beyond the capacity of individual agencies to navigate.
- V. A further recommendation was made to support a provincial Immigration Centre of Excellence as a collaborative effort of key stakeholders (e.g. OACAS, relevant local, provincial and federal government bodies, individual member agencies) to advocate for, and facilitate successful outcomes for children and youth with unresolved immigration issues. OACAS and a number of member agencies have been working on a project to move this recommendation forward. Further inter-governmental collaboration is required in order to discuss ways of providing effective, coordinated services to children in care who have been separated from their families. The lack of a coordinated response to immigration status issues

for children in care creates significant barriers to meeting a child's need for permanency and formal structures are required to explore the unique circumstances for separated children.

## KEY PRACTICE RECOMMENDATIONS

The project recommended immigration status for children in care be routinely collected by OACAS member agencies and be comparable across agencies. Further, the establishment of an Immigration Issues Advisory Team going forward as a collaborative effort of key stakeholders (e.g. OACAS, relevant local, provincial and federal government bodies, individual member agencies) to advocate for and facilitate successful outcomes for children and youth with immigration issues is critical. A webinar and an immigration resource guide have been developed and workers are encouraged to review the materials to support learning across the field and to support early identification of immigration status issues for children in care.

Children's Aid Societies are encouraged to develop policies and practices to support staff when immigration issues are identified. Further, there is a need to consider many factors related not only to the youth but possibly also to other family members who may be impacted by a youth's lack of immigration status.

## CONCLUSION

Immigration status issues for children in care present significant challenges for children and youth in care and early identification and/or intervention is required to support permanency outcomes. Resolving immigration status issues can take from five to seven years, making early intervention even more critical. Options related to adoption are not possible, since identification and immigration status documentation are required for an adoption to proceed. There are also structural documentation barriers for separated children and youth. General privileges such as OHIP coverage, driver's licenses and Social Insurance Numbers required for employment are not available to former Crown wards without

permanent residence status once they leave the care of the Society. If immigration status issues for children in care are not identified by Children's Aid Societies, the child's immigration status issues may not be resolved at all, resulting in further delays in accessing services once the need has been identified and/or the increased possibility of deportation.

However, resolving immigration status issues is not always a straightforward process. It can be a complex, time-consuming and resource-intensive process. Not only does it require agencies to have full commitment to establish practices and resolve immigration status issues, it relies on their specialized knowledge as well as their child protection expertise. Unfortunately it is a niche market and it is not easy to build such capacity for each CAS pending on different profile of the families they serve as well as on the volume of children and youth in care with unresolved immigration issues. Additional information and guidance for CASs and stakeholders can be found in the document "Immigration Status Matters: A Guide to Addressing Immigration Status Issues for Children and Youth in Care" (Dec. 2014).

A provincial effort to develop field-wide capacity and expertise is a solution to this issue that will increase overall efficiency and effectiveness in resolving immigration issues. It is the most effective way to utilize resources and is flexible in providing services to youth beyond age 18 and/or to respond to more unique circumstances beyond age 21.

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# Case Note Excellence in Child Welfare: A Pilot Study of Contemporaneousness and Quality

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## ABSTRACT

It is critical that Children's Aid Societies (CASs) maintain high quality, contemporaneous case notes in order to deliver the most effective services (Reamer, 2005) and ensure the best outcomes for clients (Cumming et al., 2007). This study explores contemporaneousness, or, timely documentation of casework (Mental Health Commission, 2001), by measuring the rate of recording contact logs within 24h of face-to-face visits for clients receiving services from a CAS in southwestern Ontario. The study also explores the quality of contact logs; supervisors completed a questionnaire to assess whether contact logs contained various elements of best practices. An *ad hoc* report of all case notes generated from the agency's database in a three-month period (N=9800) showed a contemporaneous rate of 76.6%. Similarly, contemporaneousness was found to be 77.8% in a sample of contact logs selected for supervisors to assess manually (n=655). Supervisors were asked to rate the quality of the smaller sample of contact logs; 83.5% were rated "good" or "very good" overall. Finally, contemporaneous contact logs had a significantly higher average rating of quality (M=3.14) than those that were not contemporaneous (M=2.95). This study has sparked conversations at the agency and helped to identify gaps that can be mediated for continuous improvement. The field would benefit from further research into the impact of case notes on client outcomes.

## INTRODUCTION

Children's Aid Societies (CASs), like other human services agencies, recognize that service delivery depends to an extent on maintaining excellent case notes, which are records of interactions, observations, and events pertaining to clients (AASW, 2015; Phillips & Raphael, 1992). Meticulous case notes are essential because situations can

change quickly in child welfare, which can affect service planning and delivery. Reamer (2005, p. 325) noted that case notes "help practitioners coordinate and evaluate service needs and delivery" and provide "a liability shield and risk-management tool". Indeed, case noting is a professional skill that social workers begin developing in school and on placements, as it is an integral part of their role. For these reasons, Windsor-Essex Children's Aid Society (WECAS) undertook an evaluation of a sample of case notes.

## Literature Review

Aside from best practice guidelines published by professional associations and agencies, a literature search returned very few peer-reviewed articles on the impact of case notes in human services. The literature did indicate that two important aspects of case notes are contemporaneousness (Mental Health Commission, 2001; Phillips & Raphael, 1992) and quality (Isle of Wight Safeguarding Children Board (IWSCB), no date; Mental Health Commission, 2001). In human services, contemporaneousness is a construct that refers to timely documentation of casework, specifically, documentation soon after the events occurred (Mental Health Commission, 2001). In their paper on the social worker's preparation for the court process, Phillips and Raphael (1992) state that contemporaneous case notes are likely to be more accurate as they reduce reliance on fading memory. Moreover, in her paper on the importance of record-keeping in social work practice, Blake (2010) explains that accurate case notes are critical, as they ensure current details are available to a covering caseworker. In fact, many CASs have developed policies mandating that caseworkers enter their notes within 24 hours (24h). As well, Standard 2 of the Child Protection Standards in Ontario (Ontario Ministry of Children and Youth Services, 2007) mandates recording of a referral within 24h.



In the area of quality, Cumming et al. (2007) noted that poor-quality case notes may pose a risk to service outcomes. They described the findings of a project undertaken by hospital-based social workers to minimize problems associated with documentation. The project stressed that when procedures for recording assessments, interventions, and outcomes are not followed, patients may be put at risk.

In addition, case notes are important pieces of evidence in court; information that is missing or captured unprofessionally impedes the worker's ability to recreate what has happened (Mental Health Commission, 2001). Indeed, a discussion paper released by IWSCB (no date, p. 7) indicated that a good case note communicates a meaningful "story" and provides evidence which allows the reader to understand "the child's full circumstances...and the basis for decisions made with the reasons and the outcomes intended".

Several elements of high-quality case notes are discussed in the literature. Among these, conciseness is frequently mentioned; that is, case notes should neatly summarize the important facts and events. The reader should be able to quickly read and understand the family's needs, the services provided, and the outcomes of the services (IWSCB, no date; Rycus & Hughes, 1998). Similarly, in her paper on documenting case notes in child welfare, Stephenson-Valcourt (2009-2010) explains that workers must clearly and concisely state the purpose of their visit with clients and relate the purpose directly to the presenting problems or emerging issues.

Furthermore, the information contained in the case note should be factual and accompanied by dates and clear observations, and opinions must be supported with evidence (Cameron and turtle-song, 2002; Rycus & Hughes, 1998). Stephenson-Valcourt (2009-2010, p. 165) suggests that subjective observations require elaboration; for example, when describing the well-being of children, details need to be included, such as, "the children looked healthy and well-fed without any visible bruising".

In his paper on ethics and managing risk in the field of social work, Reamer (2005) explains that in writing documentation, caseworkers must choose their words carefully; the language should be respectful, unbiased, and neutral in tone. As Cameron and turtle-song (2002, p. 288) suggest, a case note stating, "Client arrived drunk to this session and was rude, obnoxious, and uncooperative" would not be acceptable; an acceptable recording would be "Client smelled of alcohol; speech slow and deliberate in nature...". Finally, acronyms should be defined; names and other information should be written in full at least the first time to avoid confusion (IWSCB, no date).

## Purpose of the Current Study

Based on the literature review, one purpose of the current study was to investigate timely documentation of case notes at WECAS. A second purpose of this study was to assess case note quality. A third purpose was to expand the literature beyond discussion papers by providing a framework for assessing contemporaneousness and quality.

Due to a lack of empirical research in the literature, this study was exploratory. It was an attempt to begin to measure the concepts of contemporaneousness and quality, assess compliance, and develop recommendations for continuous improvement. Indeed, discussions with other CASs in Ontario indicated that this area has rarely been investigated due to the complexity and subjectivity of "quality" as well as a lack of precedents. There may be other Ontario CASs that have studied case note quality, but WECAS is grateful to Halton CAS for providing the instrument they developed for their 2013 study, which helped inform ours. It is hoped that this study will assist other CASs in monitoring their case notes as well as educating workers and supervisors in ways to maintain high-quality, contemporaneous case notes.

## METHOD

### Sample

There are various types of case notes in child

welfare. The focus in this study was case notes pertaining to face-to-face visits with clients. These are known as contact logs at WECAS and are critical pieces of information used in service delivery. Contact logs for 145 caseworkers were sampled from the database and assessed by 33 child protection supervisors across four service departments. Each of these departments (Intake, Family Services, Children's Services, and Resources) share a requirement to document contact logs within 24h in our database.

Contact logs are typed or dictated into our database (Matrix) by caseworkers working with clients involved in child protection services. They can be locked manually by the caseworker upon completion. The database also has a feature which automatically locks a case note 24h after it has been edited if the worker has not manually locked it. Only locked contact logs were included in this study.

Contact logs were sampled using two methods. First, *ad hoc* reports were developed from WECAS's database for the purpose of assessing contemporaneousness. In consultation with the Information Technology Department (IT), a report was generated for all contact logs on face-to-face visits between January 1 and March 31, 2014, regardless of when the file opened. This generated a total of 9800 contact logs across the four service departments.

Second, a sample of contact logs was selected primarily for supervisors to assess quality. Contemporaneousness was assessed using this sample as well. Thus another set of *ad hoc* contact log reports were developed. It was not possible to write a query to randomly sample contact logs in our database because queries require specific instructions to select files. The selection criterion used in this sample was the two most recent contact logs from the oldest and newest file per worker, totaling four contact logs per worker. The resulting sample was 655 files.

## Questionnaire

A questionnaire was developed in order to

capture supervisor feedback on contact log quality. Questions were developed through several sources: senior service directors at WECAS, Halton's template, and the literature review. The literature highlighted various elements of what constitutes high-quality case notes, many of which coincided with Halton's template and the view of WECAS senior directors. As described above, these include:

- conciseness (IWSCB, no date; Rycus & Hughes, 1998);
- clear purpose of visit (Stephenson-Valcourt, 2009-2010);
- factual (Cameron and turtle-song, 2002; Rycus & Hughes, 1998);
- evidence-based opinions (Stephenson-Valcourt, 2009-2010);
- respectful and unbiased language (IWSCB, no date; Reamer, 2005);
- defined acronyms (IWSCB, no date).

The questions are detailed in the Results section (Table1). Each element of quality was assessed as well as the overall quality of the contact log. Steps were taken to use the same response options for most of the individual elements (i.e., yes, somewhat, no). However, service directors felt that some elements required a definitive "yes" or "no" response. For example, the item, "The content consists primarily of facts and observations" required a yes or no answer, whereas "Where opinions are given, they are supported with stated evidence and observations" allowed for a "somewhat" response to recognize that some opinions in the contact log were supported by evidence. The overall quality question was rated on a 4-point scale of quality: 4=Very Good, 3=Good, 2=Fair, 1=Poor.

The questionnaire was piloted with 6 supervisors and 15 contact logs. Feedback was positive, and minor changes were made to the final questionnaire. Detailed instructions and examples of each element of quality were provided in the final questionnaire to help ensure some consistency in the assessments of these clearly subjective constructs. For example, when reading the contact log,

supervisors were asked to consider whether they could clearly visualize what transpired at the visit to the degree that another worker could take over the case or present it in court. They were also asked to focus on questions they had when reading the contact log. For example, did they think, "Why is the worker writing about this? This is an irrelevant detail." Or, "Where is the proof of that statement? It seems more like an assumption and there is no evidence." This helped supervisors to approach their evaluations from a common lens.

## Procedure

As stated above, two sampling processes were used in this study to examine contemporaneousness and quality. The report on the 9800 files used for contemporaneousness included the dates and times of the visit and the documentation. It automatically calculated the difference in whole hours between the date and time of the visit and the date and time the contact log was entered. Contact logs that were entered up to 24h after the visit were coded as contemporaneous. Contact logs that were entered by the end of the next working day were also assessed in a separate analysis to explore the difference in compliance. Rates of compliance were calculated by dividing the number of contact logs coded as contemporaneous by the total number of contact logs.

Second, a sample of 655 contact logs was selected for supervisors to assess quality. In order to standardize the process and promote efficiency, IT generated queries and provided spreadsheets to supervisors with the needed information, which included:

- case number;
- date and time of visit;
- date and time contact log entered;
- contact log contents.

Supervisors were assigned the contact logs of workers from other supervisors in order to control for bias, as the compliance and quality of their own workers' contact logs could be perceived as a reflection on themselves. They were assigned files within their own

departments rather than across departments because they are most familiar with their department's expectations.

The questionnaires were completed electronically by child protection supervisors via Survey Monkey, online software which allows users to build custom surveys and send them to a targeted audience (Survey Monkey Inc., 2015). This method provided a convenient means to capture the data consistently and convert it into an analyzable format.

## RESULTS

### Contemporaneousness

In this study, contemporaneousness was operationalized in two ways: first, documentation of a contact log within 24h of a face-to-face visit; second, documentation of a contact log by the end of the next day after a visit. The second method could theoretically result in documentation beyond 24h if the visit occurred in the morning of the previous day and the documentation occurred in the afternoon.

Of the 9800 contact logs generated by the agency's database, 7506 were entered within 24h for a compliance rate of 76.6%. In addition, when looking at contact log entry by the end of the next day, the rate increased to 86.7%, indicating it is possible to complete 10% more contact logs within a few extra hours.

Compliance was also calculated based on the sample of 655 contact logs rated by supervisors. Factoring in missing dates and times on the supervisor questionnaires, a total of 603 contact logs were used in the analysis. Of these, 469 were entered within 24h of the visit for a compliance rate of 77.8%. When contact log entry was examined by the end of the next day, the rate was 86.9%. The similarity of the compliance rates across the two methods was remarkable and helped to validate the results.

### Contact Log Quality.

Supervisors rated the elements of quality quite positively. Table 1 illustrates the findings for each element and shows the exact questions. Note that "NA" indicates that "somewhat" was not an option for the element.

### Supervisor ratings of contact log quality elements

Quality Element	Yes	Somewhat	No
The primary focus of the visit is either <u>stated</u> in the body of the contact log <u>OR</u> can be <u>inferred</u> from the contact log contents.	96.8%	NA	3.2%
The contact log contains clear description and “shows” with evidence rather than “tells”.	77.7%	15.6%	6.7%
The content consists <u>primarily</u> of facts and observations.	98.9%	NA	1.1%
Where opinions are given, they are supported with <u>stated</u> evidence and observations.	61.6%	34.7%	3.7%
Where there are initials or <u>uncommon</u> acronyms in the contact log, they are defined at least once (Please provide examples).	55%	NA	45%
The contact log is respectful and free of bias, discriminatory, or judgmental language (Please provide examples).	97.9%	NA	2.1%
The contact log is concise and contains only necessary detail.	88.1%	NA	11.9%

The results indicated some variation in assessments of case note quality. In particular, defining acronyms scored much lower than the other elements at 55%. Supervisors were asked to give examples of acronyms that were undefined. These included “Dr. M” and “NYE” among others. Without the full name of the doctor, a covering or new worker on a file would have difficulty locating this person in an emergency.

Most contact logs were rated as having unbiased language; however, 2.1% were rated as problematic. Two examples of biased, discriminatory, or judgmental language provided by supervisors were: “It was apparent from [her] appearance that she had a rough life” and “Dad tried to scam the government”. Although both of these statements were perceived by supervisors as biased, caseworkers seemed to believe they were acceptable statements in a case note. Language may be an area the agency needs to further explore.

At the end of the survey, supervisors were asked to rate the overall quality of the contact log. Supervisors rated 27.6% of contact logs “very good” and 55.9% “good”, for a combined total of 83.5%. They were asked to explain the reasons for their ratings of quality. A thematic analysis found some clear differences. “Very good” contact logs were described only in positive terms: “detailed and concise”, “clear”, “factual”. “Good” contact logs contained both positive and negative explanations: “clear and concise”, “good detail”, “well written”, but also “issues with spelling/grammar”, “requires more detail”, “irrelevant information”. “Fair” contact logs were

primarily negative: "lacks detail", "unclear", "poorly written". Finally "Poor" contact logs were described only in negative terms and focused on lack of information: "missing much detail", "incomplete." These supervisor explanations provided important insight into their assessments of quality and help the agency begin to develop a common definition of quality, which has been difficult to identify. These results demonstrated that there are indeed clear distinctions and a shared understanding among supervisors of what constitutes quality in assessing contact logs.

### Additional Analysis

During the course of the study, a question arose about the relation between contemporaneousness and quality. It seemed possible that contemporaneous contact logs would also have higher-quality ratings. Some caseworkers may have better skills at meeting deadlines and place more importance on the role of contact logs in delivering services. They may work to complete them as proficiently as possible and within the time allotted. Conversely, contemporaneous contact logs may result in lower quality; knowing the 24h deadline, workers may rush to complete them. In addition, our agency's auto-lock feature could increase compliance but inadvertently reduce quality. For example, it is possible that some automatically locked contact logs were still in draft form; the worker may have intended to edit it, but was not able to do so within 24h before it was auto-locked.

It also seemed possible that because the audit template required supervisors to record the dates and times of the visit and the contact log in order to identify them, this may have influenced their quality ratings. Even though supervisors were not asked to determine whether a particular contact log was recorded within 24h, it may have been apparent upon recording the dates and times, and they may have unconsciously rated contemporaneous contact logs higher in quality.

A t-test examined whether there were statistically significant differences in quality ratings depending on whether the contact log was completed on time. The analysis found that contemporaneous contact logs had a significantly higher average quality

rating ( $M=3.14$ ,  $SD=0.69$ ) than those that were not contemporaneous ( $M=2.95$ ,  $SD=0.77$ ),  $t(601)=2.69$ ,  $p=0.007$ . Additional research is required to more fully understand the impact of contemporaneousness on quality ratings. At this time it is not possible to conclude whether this was due to worker habits or an unintended consequence of supervisors having access to the dates and times the contact log was entered.

## DISCUSSION

This study explored case note excellence by examining contemporaneousness (i.e., timely documentation) and the quality of case note contents. The results were positive in both areas. The majority of the contact logs examined in this study were documented within 24h. In addition, the majority of the contact logs contained the elements of quality that are expected according to best practice. Overall quality was rated positively in the majority of contact logs.

The results of this study have helped the agency refine case note training modules and develop a best practice guide. In addition, the reports developed in our database for the purposes of this study are repeatable and can be run at any time. Moreover, these results provide a baseline for WECAS from which targets may be considered and subsequent interventions can be evaluated.

Previous discussions at the agency suggested that because quality is a subjective construct, it was important to examine how staff defined quality with regard to case notes. This study provides evidence that supervisors, who monitor workers' case notes, view case note quality in relation to completeness, organization, content, and spelling and grammar. High-quality case notes met all of these requirements; low-quality case notes not only failed to meet these requirements but were perceived to be incomplete and missing information. These findings are helpful for future education with caseworkers and supervisors to ensure that case notes meet expectations.

### Areas for Future Study

In the future, it will be important to further



understand factors affecting case note contemporaneousness and quality. There may be agency-specific processes and broader factors which impact case notes. With regard to agency-specific processes, WECAS's database automatically locks a contact log 24h after it was last edited if it has not been locked manually. Although this study focused on locked contact logs, the database does not track whether they are automatically or manually locked. It seems possible that the auto-lock feature may artificially increase compliance with documentation timelines, but decrease quality if a contact log was only partially completed when it was auto-locked. Quality may also have been affected by whether caseworkers typed case notes or used voice recognition software. While dictation software may ease input and therefore increase contemporaneousness, it may negatively affect quality. Indeed, workers have described some limitations with the voice-to-text translation, which may require keyboard editing after dictation. If the contact log was locked automatically, quality may have been compromised.

In terms of broader factors, when caseloads are high, both aspects of case notes may suffer, as the priority is placed on services over documentation. In addition, caseworkers may differ in their writing abilities and the importance they place on completing high-quality case notes on time. These factors may be difficult to control and were not investigated in this study. However, they do suggest that agencies need to consider how to identify an appropriate rate of contemporaneousness when setting targets. That is, these factors are not always controllable and an expectation of 100% may not be realistic.

Finally, combining the four departments provided a large sample for the study. Although they all share the same expectation to have their case notes documented within 24h, there may be unique practices within these departments which are not captured here. Indeed, the full agency report shows some variation between departments. Although each of these factors may pose additional questions, they also point to dynamics that supervisors and workers can work to understand together and overcome. That is, it will be important for

different departments to develop their own solutions.

## Limitations

Although the results were promising, there were some limitations with this study. The main limitation of the analysis of contemporaneousness is that only contact logs that have been recorded could be analyzed. That is, theoretically, some visits may not have a contact log at all. These would surely be recorded as not completed within 24h and in fact point to a different, possibly more worrisome, problem.

With regard to the analysis of quality, this was an exploratory study of a relatively undefined construct and there may be other ways of defining quality. Moreover, even though the questionnaire was piloted with a sample of supervisors and contact logs, and contained detailed instructions, quality is subjective and perception likely played a role. Although the feedback from supervisors helped to explain why they rated overall quality the way they did, there is still more work that can be done to understand the construct more fully.

In addition, the contact logs selected for quality assessment were not a true random sample. While using the oldest and newest file for each worker provided a reasonable cross-section, it may have introduced another variable which confounded the analysis. Nevertheless, the comparable rates of contemporaneousness between the two sets of data used here suggest that this may not have been problematic.

Finally, the unique characteristics of the WECAS database may point to a lack of generalizability to other agencies. The auto-lock feature and the ability to dictate case notes are not common across agencies. These features may have affected our findings in unique ways as described above. Conversely, the databases used by other agencies may have different features that need to be considered when completing their own studies.

## Conclusion

Case notes are critical in providing the best possible services and obtaining the best outcomes for clients (Cumming et al., 2007;

IWSCB, no date). Timely and well-written case notes are especially important if a file is transferred to another worker or if they are needed in court (Phillips & Raphael, 1992). This study provided an excellent opportunity to begin to understand the concepts of contemporaneousness and quality of case notes at a CAS in southwestern Ontario. The following quote eloquently summarizes the importance of case notes in the worker's role:

"Case recording is, and has always been, an integral tool of professional accountable practice. It will contribute most effectively to the achievement of good outcomes where staff view and value it as a positive aid to practice and as giving a "voice" to a vulnerable child rather than as a distraction from the "real" job. It is essential to regard recording as part of the real job" (IWSCB, no date, p. 8).

This study contributes to the literature on the importance of case notes in the field of human services, and in particular, the field of child welfare. While subjectivity in quality ratings may exist, this study found common elements that constitute a high quality contact log. The various elements identified here may provide a frame of reference for other agencies conducting their own studies. As compliance to Child Protection Standards presents an ever-growing demand in the field of child welfare, the importance of quality must not be downplayed; the information contained in contact logs is used to make important clinical and legal decisions, and must be as current and as accurate as possible. The field will benefit from further study of the impact of case notes on client outcomes as this study has shown it to be a promising area.

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# Understanding the Symptomatology of ADHD in Pediatric Populations from a Biopsychosocial Perspective

## Part Two — The Assessment and Diagnosis of ADHD

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The diagnosis of ADHD presents a challenge to the child, the parents, the family, the teachers, the school, and anyone else having to interact with the child in a meaningful manner. The challenge is for all the individuals involved to become more willing to come up not only with behaviors that are more productive, but also to honestly and clearly describe to the assessors a personal history from inception to the present time. Most often the diagnosis of ADHD is given to a child early in elementary school or a suspicion of the condition is existent even before the child enters school. A diagnosis does not solve the problem: it is merely the beginning of a long process that necessitates, at the very least, the following:

- The child has to learn new ways of moving his/her brain from the creative state to the logical, problem-solving state.
- The parents and teachers must be willing to change their behavior patterns, parenting styles, and teaching styles in order to come up with different outcomes.
- The parents and teachers need to provide enough structure, express love and confidence, become more accepting, and get the required support from each other and from professionals when the need arises.

Everyone enjoys being successful. ADHD individuals are not different from everyone else when it comes to their desire to be successful. As evidenced by our clinical practice, ADHD individuals want to succeed. ADHD children become stressed when they fail, just like other children. As soon as the anxiety arises, ADHD children want to dismiss it quickly. Often these children become impulsive, and in their attempt to dispel the anxiety, they cause the situation to become explosive and emotionally charged with angry outbursts. ADHD children are notorious for not completing homework.

Parents of ADHD children, on the other hand, want their child to complete the homework and they believe that if they are going to provide some extra help the child then will become motivated to do so. The parents need to understand that the child's motivation may be totally different. The child may use the opportunity to obtain a higher level of self-esteem and takes advantage of the parents' need to have the child succeed by having the parents do the work for him/her. The child is merely overcompensating for his/her lack of success at school by finding a way to "win" at it. Children with ADHD live with frustration constantly. As a result, they need to find ways not to be defeated by it.

Everyone, including ADHD individuals, is driven by some very basic human needs, such as survival, love, trust, being effective, having a sense of identity, self-esteem, intimacy, being creative, and being part of something greater than ourselves or spirituality. Our mental health and wellbeing is contingent to the degree that we satisfactorily meet these needs. When these efforts are impeded by ADHD or other circumstances, the individual will resort to other methods to obtain the desired outcomes, sometimes even through destructive means. Some individuals engage in risky behaviors like binge eating, driving too fast, or dieting excessively in order to fulfill the need for self-determination. Failure to achieve our desired goals can lead us into a state of depression. The desire to have even a small success is so great that destructive means can be quite appealing.

Human behavior has purpose even when it does not seem so. There is a reason why we behave the way we do. In other words, there is a payoff or a gain: attention, solitude, avoidance of tasks or people. Having control over our lives is perhaps one of the strongest motivating forces of human behavior. If a child observes that others gain control by being angry or hostile, that child may adopt the same approach in order to get his/her way. Children

turn towards their parents, as primary models, to learn how to seek control over others. While ADHD can be a formidable obstacle for a child who seeks to fulfill the basic human need of power and control, children can be quite resilient and adaptable and can learn to use ADHD to their advantage. The child can use the ADHD diagnosis as a license to act out even more or to act out in a silly manner or rebel in order to achieve a sense of identity. Each child responds to the diagnosis of ADHD differently. However, it is highly dependent on how easy or difficult it is for the child to meet his/her basic human needs. For some individuals, achieving a payoff is of the utmost importance and if they cannot meet these payoffs in a positive manner, they will resort to destructive behaviors to achieve their goal. When this occurs, it may take professional intervention or a major crisis to break the destructive pattern. It is important that neither the child nor the family hide behind the diagnosis of ADHD as an excuse for all the problems the child may be having.

## THE BRAIN AND ADHD

In the last twenty years or so, the label of ADHD in scientific circles is understood to be a neurological disorder. As far as brain symptoms are concerned when compared to seizures or paralysis, this disorder (ADHD) is relatively mild. The individual diagnosed with ADHD functions normally in most of his/her daily activities and may even have age-appropriate skills. Does having a diagnosis of ADHD mean that the brain is performing at lowered ranges or, if you will, that the brain is under active?

In scientific circles, it is accepted practice to speak about the brain as having four measurable ranges of electrical activity. These ranges or states are called Beta, Alpha, Theta, and Delta and usually are measured using electroencephalography.

At the Beta state, the highest range of brain activity, the output range measures greater than 13 hertz or cycles per second. This is the output that occurs during most of the day when the individual is engaged in problem-solving activities or is actively thinking. On the other hand, when the brain is in a calm or relaxed state it is said to be in Alpha and the output range is 8 to 12 hertz per second. At this

level, the individual is experiencing a sense of tranquility.

The Theta State is also called a trance state, similar to the time when individuals are about to enter a sleep state. Often it is referred to as a "twilight" zone and the range of output is 4 to 8 hertz per second. The hypnotic state usually occurs at this range. At this level, realities have a tendency to blur and imageries and dream states are created. Creativity is highest at this level simply because rationality and objectivity are cast aside and do not impede the individual. Individuals entering this state usually report that they did not want to leave it.

The Delta state is the level of sleep. The output range is 0.5 to 4 hertz per second. This is not the state that is related to ADHD issues. In individuals with ADHD, the brain is functioning in the Alpha and Theta ranges most of the time, even when the brain should be operating in the higher ranges, such as when the individual is at school or at work trying to solve problems.

To understand the world of the ADHD individual one must imagine driving with a high-performance vehicle into a garage and putting the vehicle high on a hoist. Then while the vehicle is on the hoist, the engine is started, the shift gear is placed on drive, and the accelerator is pressed. The engine is revved, but the vehicle goes nowhere. Another metaphor would be to get set to run a one hundred yard dash with one hundred pounds weights attached at the feet and then throwing a temper tantrum because he/she knows they will not win. The ADHD individual becomes very easily frustrated and acts out simply because he/she is placed in a situation where the brain should be at the Beta state, but instead is vacationing at the Theta and Alpha ranges. In addition, the ADHD individual becomes frustrated because he/she is unable to self-regulate when it is required to do so (i.e., when extremely frustrated by not being successful at an activity or assignment; Keune et al., 2015; White, 1999) and does not have the executive function capacities to develop a solution or compensatory strategies to solve the challenge. This process begins a vicious cycle. ADHD individuals solve the challenge by misbehaving, so that their arousal can be increased via others disciplining them and



providing them with an adrenaline rush (i.e., increased norepinephrine). These individuals are not hyperactive because their brains are in high gear, but rather because their brains operate in low gear and can't shift into high gear. Since the methods of shifting their brains into high gear are not successful, the ADHD individuals engage in high-risk behaviors to stimulate or activate their brains (Keune et al., 2015; White, 1999). These individuals will do whatever they can to create an excited state. Often they create stressful situations so that their adrenal glands get into the act and, in so doing, stimulate the brain activity into higher levels by releasing a number of stress hormones (i.e. norepinephrine and cortisol; McEwen & Sapolsky, 1995).

Most individuals can attest that they have witnessed children enjoying immensely activities such as running and playing. Children with ADHD tend to love these activities even more. They tend to crave exciting activities because these are the perfect ingredients to stimulate their brains into moving out of Theta and Alpha levels and stepping into Beta. It is not uncommon to see individuals eating sweets because the sugar offers a quick fix (Amen, 2001). Other individuals jump-start their brains with a large cup of coffee (Grady, 1986; Smith, 2002).

As a way of attempting to capture the world of the ADHD individuals from their internal perspective, let us imagine two children in school. Child number one is not an ADHD individual; therefore, when the teacher asks the children to figure out the area of the square drawn on the board, having been taught the process, this child is able to figure out the steps. Child number two, however, is an ADHD individual, and this child's internal dialogue takes on a totally different path. The run-on sentences that follow are done on purpose to better represent what the child with ADHD goes through every time he/she is asked to perform a task. The square might remind the child of a soccer field where the day before a game was played and he/she starts wondering where all the people in attendance came from; one of them was wearing a cool T-shirt with the picture of Mickey Mouse. The child then starts thinking about a commercial that was seen on TV the night before during which a

loud bang was heard coming from the garage where a large hammer fell off the counter and broke a large container of oil spilling all over the walls and creating a mess for the parents to clean up. This in turn may remind the child that the parents were upset because a friend came calling at the door and he/she left while the parents could have used an extra pair of hands, which in turn remind the child that the hand was hurt while jumping over the toys in the driveway and so looks at the hand to see what hurts while at the same time noticing that the teacher is staring at him/her and thinking that he/she missed again for the hundredth time what was going on in class. The second child with ADHD is meandering in an imaginative state, but this creative state is internally forced upon him/her at the wrong time. The child needs, instead, to focus and learn precise steps required to solve a specific problem. If this child misses a step, anxiety arises; tries to re-focus and perhaps regain some of the ground he/she has lost, but meets with failure because the brain is still stuck in theta, a free-associative state. The inability of the ADHD individual to control his/her mental tracking explains why this individual is forgetful, unable to concentrate, easily distracted, and quickly bored. Since most people do not experience difficulty focusing, teachers and others can quickly assume that someone who is easily distracted must be inattentive, uncaring, lazy, and undisciplined. The ADHD individual is not necessarily someone who has serious dysfunction because he/she is easily distracted but the system may not be appreciative of the creative gifts that he/she offers.

## ETIOLOGICAL FACTORS

As with any condition, no single etiological factor causes the development of ADHD symptomatology in children/adolescents/adults. The literature identifies that neurobiological/neuropsychological, genetic, and environmental factors interact in a way that requires all of these indicators to be taken into consideration when dealing with a child/adolescent or adult with ADHD.

## NEUROBIOLOGICAL FACTORS

Research examining the volume of different parts of the brain through structural

neuroimaging (i.e., magnetic resonance imaging [MRI]) illustrates that children and adolescents have reduced total brain volume relative to non-clinical control subjects and these reductions persist into adulthood (Castellanos et al., 2002). More specifically, reductions in areas such as the right caudate nucleus (implicated in learning/memory and regulatory control of cortical activity), cerebellar vermis and splenium of the corpus callosum (responsible for the posterior portion of inter-hemisphere communication) as well as prefrontal cortex regions (important for attention and executive functions) have been consistently found in ADHD subjects (Valera et al., 2007). In addition, diffusion tensor magnetic resonance imaging has shown white matter alterations in both the prefrontal cortex and cerebellum. Many of these structures mentioned play a role in regulation of cortical activation (i.e., how much brain activity is taking place), as well as modulation and allocation of attentional resources (Tripp & Wickens, 2009).

Functional neuroimaging studies (i.e., positron emission tomography [PET] and functional magnetic resonance imaging [fMRI]) have illustrated under-activation in parts of the prefrontal cortex and fronto-parietal networks important in regulation and allocation of attention (Tripp & Wickens, 2009). This suggests that these parts of the brain are under-activated, and therefore individuals with ADHD may illustrate difficulties focusing their attention on activities that require a great deal of top-down cortical control (i.e., tasks that appear very boring or are of very little interest, such as homework or a school assignment, etc.). Conversely, tasks that do not require this top-down cortical control and that are innately stimulating (i.e., a video game, a movie, etc.) do not require these additional attentional resources and therefore a child with ADHD will have no difficulty focusing on these activities for long periods of time (even potentially hyperfocusing), as these individuals have difficulty pulling themselves away from tasks that are highly stimulating (Hersen, Thomas, & Ammerman, 2006).

The neurotransmitter dopamine, which has been implicated in the reward/pleasure sensations (i.e., in the nucleus accumbens) as well as initiation and regulation of

movement (i.e., basal ganglia; Parkinson's disease, etc.) also plays a considerable role in modulating activity of the prefrontal cortex. Dopamine, in addition to the neurotransmitter norepinephrine, regulates the attentional networks within the brain (Kolb & Wishaw, 2009). These findings explain why most stimulant medications (i.e., amphetamine-based stimulants like Ritalin, Concerta, Vyvanse, etc.) that elevate dopaminergic activity in the prefrontal cortex reduce ADHD symptoms. While the use of stimulants may seem counter-intuitive, these medications serve to activate and promote excitation in areas of the brain that appear to be underaroused in ADHD samples relative to non-clinical samples.

In addition to the alterations of attention and executive function, it is well documented that children, adolescents, and adults with ADHD have altered motivational processing, particularly in the context of reward or reinforcement (Nigg et al., 2005). Individuals with ADHD, particularly those experiencing hyperactivity/impulsivity symptomatology, often make choices involving more immediate rewards, rather than delayed gratification, even when it is at significant cost to themselves (Tripp & Wickens, 2009).

The preceding mechanisms may be explained by the altered processing of the nucleus accumbens, which is a part of the brain that has been highly implicated in reward response. For individuals with ADHD hyperactivity/impulsivity subtype, much of the literature suggests that perhaps they receive greater reward information from the nucleus accumbens in anticipation of immediate reward relative to delayed reward; thus, these decisions appear more enticing despite their long-term costs (i.e., less gains; Tripp & Wickens, 2009).

## GENETIC FACTORS

It has been well established within the literature that ADHD has a strong familial genetic contribution involving multiple genes (Faraone & Mick, 2010). Twin studies suggest that the genetic concordance rate is between 0.6 and 0.9 (Biederman et al., 1999). While no single gene has been identified to account for the heritability of ADHD, genes that have been implicated are involved in the dopaminergic

and noradrenergic systems, respectively (Biederman & Spencer, 1999; Tripp & Wickens, 2009). This coincides with the structural and functional neuroanatomical literature implicating frontostriatal (executive function, emotional and behavioral regulation, etc.) and attention networks in the brain as playing a considerable role in the symptomatology of ADHD (Tripp & Wickens, 2009).

More specifically, genes that code for the dopamine transporter (i.e., DAT1 polymorphism) have been shown to account for a small, but consistent amount of the genetic variance of ADHD (Madras, Miller, & Fischman, 2002; Tripp & Wickens, 2009). The dopamine transporter is responsible for the amount of dopamine turnover (i.e., how quickly dopamine is recycled once it is released in the gap between two neurons [synaptic cleft]). The more dopamine transporters that are present in the synaptic cleft, the more quickly dopamine is taken up and has less opportunity to activate post-synaptic neurons. Higher transport densities have been associated with ADHD and this may play a role in under-activation of frontostriatal and attention networks implicated in the pathophysiology of symptoms (Dougherty, Bonab, Spencer, Rauch, Madras, & Fischman, 1999; Madras, Miller, & Fischman, 2002).

Furthermore, genes that code for dopamine D4 and D5 receptors have also been implicated in the genetic association of the disorder. Lower D4 and D5 receptor densities and altered affinity may lead to reduced activation of post-synaptic neurons, which may also contribute to hypo-activation of frontostriatal networks (Tripp & Wickens, 2009). It is known that ADHD has been associated with alterations to SNAP-25 gene (coding for protein structure that holds and controls the release of synaptic vesicles containing neurotransmitters within the neuron), and this gene is important in regulating how many synaptic vesicles containing neurotransmitter are released at a given time. Alterations to these genes may result in fewer vesicles being released with neurotransmitter, and therefore result in less dopaminergic or noradrenergic activity, leading to this under-arousal previously described (Tripp & Wickens, 2009). In summary, the

alteration in genes D4 and D5 and SNAP-25 gene provide a genetic basis for ADHD, both from historical and scientific data, involving a neurotransmitter alteration in childhood (e.g., dopamine, norepinephrine, and serotonin).

## ENVIRONMENTAL FACTORS

Although not exclusively related to ADHD, it has been well documented that lead, phthalates, bisphenol A (BPA), polycyclic aromatic hydrocarbons (PAHs), and polyfluoroalkyl chemical (PFC) exposure have all been associated with heightened risk for symptomatology (Polanska, Jurewicz, & Hanke, 2013; Tripp & Wickens, 2009). While the causal pathways are not well understood, it is known that these interact with a host of genetic risk factors that contribute to the development of ADHD symptoms. Moreover, the literature suggests that exposure to prenatal smoking or prenatal maternal alcohol consumption coupled with the genetic susceptibility to ADHD, puts one at a much greater risk for the development of symptoms than either factor alone (Kahn et al., 2003).

## SEX DIFFERENCES IN ADHD

Within the research literature, a significant difference is noted in the disproportionate number of males to females diagnosed with ADHD (Bauermeister, et. al, 2007; Gaub & Carlson, 1997; Gershon, 2002). The male to female ratio is 2.28 to 1 (Ramtekkar, Reiersen, Todorov, Todd, 2011). This noted difference is due to a multitude of factors such as:

- Low clinical index of suspicion for girls;
- Better coping strategies on the part of the girls when compared to boys;
- Anxiety and depression common comorbidities in female patients can lead to a missed or misdiagnosis; and
- Unique issues related to hormonal effects on ADHD expression and treatment response by females (Ramtekkar, Reiersen, Todorov, Todd, 2011).

## DIFFERENTIAL DIAGNOSES (AMERICAN PSYCHIATRIC ASSOCIATION, 2013)

Given the complexity of ADHD symptoms and the overlapping symptomatology with other disorders (i.e., attention impairments are a common symptoms of a plethora of neuropsychiatric disorders), it is important that other etiologies for attention symptoms be ruled out. It would be wise for the clinician to utilize not only symptoms checklists, but also properly normed scientific standardized instruments to evaluate not only reported symptoms and behavior, but also indices of neurocognitive performance.

What follows is a quick reference list for common disorders that mimic or have overlapping symptomatology (American Psychiatric Association, 2013):

- **Bipolar Disorder**—this disorder is episodic in nature; does not have some of the symptoms of ADHD; is usually seen after the age of twelve; and has additional symptoms, i.e., decreased need for sleep, grandiosity, and significant changes in mood and appetite.
- **Conduct Disorder**—Individuals with this disorder understand the rules, but choose not to follow them; they may also lack empathy, may be callous, lack remorse or guilt, are unconcerned about performance, and may be shallow or deficient in affect. Conversely, those with ADHD tend to struggle with rules not because they do not want to follow them but because they are unable to do so due to behavioral dysfunctions and challenges to inhibition of more dominant stimuli.
- **Oppositional Defiant Disorder (ODD)**—Individuals with this disorder may resist work or school tasks because they resist conforming to other's demands. This is different from ADHD because those with this disorder have difficulty sustaining mental effort, may forget or may have not understood

the instructions given, and are impulsive, which prevents them from completing a task. ODD individuals do not want to conform, while ADHD individuals are neurologically unable to do so. It is important to note that ODD is also a neurodevelopmental disorder, hence individuals with it may not be able to behave otherwise. It is also important to note that both disorders can co- exist.

- **Learning problems**—Individuals with learning problems may appear inattentive due to frustrations or limited ability in specific academic domains, whereas ADHD individuals illustrate inattentive symptoms in more than just academic environments.
- **Autism Spectrum Disorder**—Individuals with this disorder have the following symptoms in common with ADHD individuals: inattention, social dysfunction, and difficulty managing behaviors. However, in Autism Spectrum Disorder, the social dysfunction is due to indifference to facial and tonal communication cues. They may display tantrums because of an inability to tolerate a change from their expected course of events, while ADHD individuals may misbehave during major transitions because of impulsivity or poor self-control.
- **Anxiety**—Individuals with anxiety disorders are inattentive due to worry and rumination, whereas ADHD individuals are inattentive due to their attraction to external stimuli, and new and exciting activities.
- **Reactive Attachment Disorder**—Individuals with this disorder show social disinhibition, but not the other symptoms of ADHD.
- **Depressive Disorders**—Individuals with this disorder have difficulty with concentration during depressive episodes only; whereas with ADHD individuals the difficulty seems to be more pervasive.

- Substance use disorders—Differentiating ADHD from these disorders requires clear evidence of ADHD symptoms prior to engaging in substance misuse.
- Personality Disorders—Unless one is able to obtain a thorough clinical history, it may be difficult to differentiate ADHD from personality disorders (i.e., narcissistic and borderline personality disorders, etc.); however, ADHD is not characterized by fear of abandonment, self-injury, narcissism or other distinctly evident personality traits.
- Psychotic disorders—ADHD cannot be diagnosed during a psychotic episode.
- Brain injury—Individuals having a brain injury may have behaviors similar to ADHD individuals. It is important to ask about head injuries during the clinical interview.
- Medication-induced symptoms of ADHD. One must monitor side effects of medication, such as asthma medication and stimulants, which may mimic symptoms of ADHD.

## COMORBIDITY

It is strongly recommended that when ADHD is present, the clinician (i.e., family doctors, pediatricians, psychologists, psychiatrists, etc.) ought to evaluate the possibility of other problems that occur with it, but sometimes are diagnosed as ADHD. It is important that everyone in the treatment team be aware of comorbidities, as these are commonly missed. It is wise for the clinician to closely evaluate emotional and adjustment problems that can be the result of ADHD or can occur with ADHD (American Psychiatric Association, 2013):

- Adjustment Disorders
- Family Problems
- Behavioral Problems Not Related to ADHD
- Depressive Disorders
- Bipolar Disorders
- Anxiety Disorders
- Obsessive-Compulsive Disorders
- Tourette's Syndrome
- Physical, Sexual, and Emotional Abuse
- Medical factors such as gestational problems, birth traumas, head trauma, seizure disorders, thyroid diseases, lead exposure, severe allergies to toxins or food, asthma medications
- Learning disabilities.

Many of the aforementioned difficulties can mimic symptoms of ADHD. The key to arriving at a proper diagnosis is history taking. ADHD symptoms tend to remain constant over a long period of time, whereas depression, anxiety, and bipolar disorder, for example, tend to fluctuate (Amen, 2001). It is not uncommon for ADHD individuals to also experience significant anxiety from underachievement and depression; to experience being demoralized as a result of failure, and to also experience bipolar symptoms such as restlessness, excessive talkativeness, racing thoughts, hyperactivity, and impulsivity. On the other hand, ADHD individuals tend not to experience the manic highs of the bipolar disorder (Amen, 2001; American Psychiatric Association, 2013).

## ASSESSMENT METHOD

The undersigned work together as a team in conducting an assessment. The team approach, in our professional view, is the best approach for chronic illnesses, and ADHD is a chronic illness. We look at gathering very specific information with respect to the following:

- Inattention
- Hyperactivity
- Impulsivity
- Information pertaining to related disorders, such as:
  - a. ODD
  - b. Learning problems
  - c. Communications
  - d. Conduct problems,
  - e. Anxiety problems,
  - f. Mood problems,
  - g. Developmental problems,
  - h. Problems in reality perception,
  - i. Substance use,



- j. Sleep problems, and
- k. Eating problems.

Our diagnostic information is a summary of the results of the following process:

- a. Symptoms checklists,
- b. Standardized instruments,
- c. Semi-structured clinical interviews,
- d. Medical examination
- e. Collateral information from both teachers and parents.

One of the major challenges with respect to diagnostics is that there is no set criteria for structural or functional diagnosis of ADHD based on neuroimaging, given that while we can find group differences that account for these symptoms, there is too much variability at the individual level to provide conclusive diagnostic evidence. Our diagnostic information is a summary of the results of the following process:

- f. Semi-structured interview of the individual
- g. Symptoms checklists,
- h. Standardized instruments,
  - a. Neurocognitive measures
    - at the minimum we would recommend performance measures of executive function
  - b. Personality measures
- i. Medical examination
  - a. A complete history of the individual
    - it is important to rule out substance-induced inattentive symptoms
  - b. Medication – rule out being overmedicated for hypothyroidism (e.g., synthroid, altroxin) or asthma (e.g., bronchodilators)
  - c. Microarray analysis for specific genes associated with ADHD
  - d. Chromosomal abnormalities (e.g., Fragile X syndrome with intellectual deficits)
  - e. Chemical analysis for lead, magnesium or other chemical poisoning linked to ADHD.
  - f. Screening for allergies – children with allergies tend to behave in a fashion that is suggestive of

hyperactivity when in reality this psychomotor agitation is due to the sensations of itchiness.

- j. Collateral information from teachers, parents and other professionals.

Referrals are accepted from parents, teachers and other school officials, social workers, counselors, child and youth workers, and physicians. Our aim is to be efficient, thorough, and expeditious.

## CONCLUSION

Identifying the etiology of reported attention and concentration challenges by individuals is of significant importance when trying to diagnose and treat these symptoms. It is clear from the literature that there are many different “ways” for the nervous system to reach a state of impaired or altered attention. While investigation of these symptoms is complex and time consuming, the improvements for treatment efficacy and efficiency are unparalleled.

*Part Three will address the treatment of ADHD.*

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# Management and Treatment of ADHD in Pediatric Populations from a Biopsychosocial Perspective

## Part Three — Translating Research into Clinical Practice

Sean Robb, M.A., Ph.D. Candidate, Sebastiano Fazzari, Ph.D., R.S.W., and Peter Bonsu, M.D., F.R.C.P.(C).

*This article is a conclusion to a three-part series that provides an up-to-date approach to understanding the symptomatology, assessment and treatment of ADHD from a biopsychosocial perspective. This third article will provide a brief summary of the authors' modality on evidence-based treatment approaches for ADHD.*

The undersigned are of the view that optimum treatment consists of a combination of the following:

- Medication
- Neurobehavioral techniques
- Nutritional regime
- Vitamin supplements
- Exercise routine.

Many parents tend to have an aversion to medication. Medication has been studied thoroughly and has been found to be very effective in the treatment of ADHD (Hart, Radua, Nakao, Mataix-Cols, & Rubia, 2013; Schachter, King, Langford, & Moher, 2001). In fact, their effect size (the statistical approach to measuring the magnitude of treatment effect) is some of the largest values in all of psychiatry (Faraone, 2009). Nonetheless, the undersigned believe that medication alone is not enough. Medication does help the ADHD individual, which pleases teachers mostly and parents at least occasionally. The undersigned are strong advocates for counseling and psychotherapy to address the emotional and social aspects of the disorder. It is wise for the ADHD individual to learn to combat negative thoughts in order to reduce depressive symptoms and isolation. The proper combination of medications, nutrition, exercise, and psychotherapy is the ultimate goal for effectively helping the ADHD individual.

### MEDICATION

Let us take a look at pharmacological agents first. Pharmacological treatments do help at least some individuals with ADHD (Hart et al.,

2013; Schachter et al., 2001). If an individual is diabetic we would not have any difficulty with the prescription and administration of insulin to make the life of the individual easier. The ADHD individual is no different (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011; Cunningham, Kim, & Schachar, 1999). Sometimes medications get a bad treatment from the public and from professionals alike. Acknowledgement of impact, instead, ought to be given to medications for the great difference they make in improving the lives of those with ADHD. On the other hand, it is also true that proponents of pharmacological treatments tend to sing their praises much too easily and at times to the exclusion of other forms of treatment. It is important that, whether we are parents, teachers, or treatment professionals, we do not give the individual with ADHD the impression that medications are solely responsible for good behavior and that they do not need to put forth effort and a positive attitude. The individual with ADHD is required to be an active participant—regardless of the age of the person—in the treatment process and, as such, must learn new behaviors and new ways to diminish or eliminate undesirable behaviors with the help of professionals and parents (Cunningham, Kim, & Schachar, 1999; Sprich, Burbridge, Lerner & Safren, 2015).

All pharmacological treatment follows the principles of medical treatment and as such there are specific considerations in the selection of medication for the treatment of ADHD, such as: age and individual variation, duration of effect, the speed of action of the medication, subtypes of ADHD, comorbid symptoms profile, comorbid psychiatric disorder, history of earlier medication use, attitudes towards medication use, affordability, medical problems and other medications, associated features similar to medication side effects, combining stimulants with other medications, and physician's attitude towards ADHD medications (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011).



In most of the cases, the ADHD individual will respond to an approved ADHD medication at the first trial. Those who do not respond to one stimulant may respond to another, for example, methylphenidate versus amphetamine salts classes of medication (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011; Cunningham et al., 1999; Hart et al., 2013; Schachter et al., 2001). The same may be true for the side effects. An individual may tolerate one more than the other for common side effects like loss of appetite, sleep suppression, headaches, etc. (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011; Correll, Kratochvil, & March, 2011; Findling, Ginsberg, Jain, & Gao, 2009; Fredriksen, Halmøy, Faraone, & Haavik, 2013; Santosh, Sattar, & Canagaratnam, 2011). It seems that the treatment response percentage increases when more than one medication is tried (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011; Cunningham et al., 1999).

The treating physician ought to consider a family history of prior positive medical treatment as well as negative experience with a specific medication (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011). A positive response to a specific treatment in a family member could increase positive expectations for this treatment while the contrary can occur for a negative outcome, although, unfortunately, minimal research data has been able to support these aspects. Given that there is no current evidence for how to choose which class of psychostimulants one ought to trial, this approach serves as an alternative to randomization, even if the effect is purely expectancy-related. There is, however, emerging evidence that those who do respond to the amphetamine class of psychostimulants have larger treatment effects relative to those who have success with methylphenidate. This is proposed to be the result of the mechanism of action associated with amphetamine-based medications, whereby they are thought to release greater concentrations of dopamine (Faraone & Buitelaar, 2010). In addition to the stimulant medication, one can also add non-stimulant medications (e.g., Strattera, Intuniv, Clonidine), either as an alone therapy or as an add-on medication. These medications work as noradrenergic agonists

to potentiate the effects of the stimulant medications. The latter has more evidence for its superior efficacy (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011).

It is important that all individuals with ADHD and their families be educated with respect to the medication. The choice of medication ought to follow the principles of informed consent. Misinformation about the short-term or long-term side effects, along with elevated parental anxiety associated with the increased challenges of parenting a child with ADHD and the misperception of having "caused" ADHD, often leads parents to feel that ADHD medications should not be utilized. On the other hand, excessive expectations with respect to improvement through the use of medication may lead to disappointment. Parents of ADHD children need to access reliable and valid sources of information along with participation in support groups (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011). It is also important for the physician to gather information with respect to parents who are at risk of diversion, such as the risk for substance abuse. In such cases, children should not be given short-acting stimulants and parents should be educated about the risks of diversion of medication to friends (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011; Molina & Pelham, 2003).

In a perfect world, everyone should have access to optimum treatment. Unfortunately, this is not the case. If individuals do not have extended health insurance, they may not be able to afford some medications, which can be quite expensive. Most medications, however, are covered by third-party insurers in Ontario.

All medications may cause some side effects. Usually, most side effects improve after two or three weeks of continuous use (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011). Tics, sleep problems, reduced appetite/very low body weight, headaches, gastrointestinal problems or dysphoria may be aggravated by ADHD medications, although some of these symptoms may actually improve with the ADHD medication. The patient ought to be informed at the beginning how to tell if they are getting too much medication, e.g. feeling

too "wired," too irritable, or too serious during the time the medication should be active (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011). If any symptoms of the preceding triad or if the individual is dysthymic at the time when the medication is expected to wear off, it is likely that the symptoms are not due to excessive high dose, but from rebound, where the medication is wearing off too fast and the individual is "crashing" (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011; Feldman, Meyers, & Quenzer, 1997).

If the treating physician determines that a second medication is needed, it would be wise to begin the process with an ADHD medication that is known to combine safely with the second medication (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011). As an example, for an individual with ADHD who is also dealing with severe anxiety, a psychostimulant could be combined with an antidepressant (Majewicz-Hefley, & Carlson, 2007). Since there are also exceptions and limitations to what was just stated, it is imperative that a physician seeks out reliable sources of information and that he/she continues to upgrade their clinical skills. Each individual is a unique human being and should be treated as such whenever medications and/or other forms of treatment are considered (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011; Feldman, Meyers, & Quenzer, 1997).

It would be wise for the ADHD individual to eliminate if possible or to greatly reduce potentially neurotoxic substances, such as illicit drugs and alcohol, from his/her life. If the ADHD individual has an addiction to these substances, it is imperative that he/she seeks treatment for the addiction in order to effectively treat ADHD. It seems that caffeine and nicotine have been shown to decrease overall blood flow to the brain (Cameron, Modell, & Hariharan, 1990; Skinhoj, Olesen, & Paulson, 1973). Although the neurocognitive consequences of this reduced cerebral blood flow have not been thoroughly explored in research, lower blood flow has been typically associated with poorer executive function (Noël, et al., 2002; Starkstein et al., 1996).

Consequently, these substances may intensify ADHD symptoms over time, even if in the short run they are associated with attenuated symptomatology (Leon, 2000; Prediger, Pamplona, Fernandes, & Takahashi, 2005). In addition, it is imperative that if possible all medications that contribute to ADHD symptoms (Thyroxin, Meperidine, Warfarin, Phenobarbital, Phenytoin, etc.) be eliminated as well.

## NEUROBEHAVIORAL TECHNIQUES

Anyone who has a child with ADHD knows that being a good parent may not be good enough. The child with ADHD presents arduous challenges that make the greatest of parents or teachers feel quite inadequate. As human beings we have to come to the realization that we—ADHD and without ADHD—are worthy but imperfect. If we as parents cannot accept ourselves and our children as being less than perfect, then we build unnecessary resentments, which can be sensed by our children who, in turn, may develop an inadequate level of self-esteem. Low levels of self-esteem may not allow our children to be happy, successful, and well-adjusted individuals. The first order of business for us as parents is not only to accept ourselves, but also accept our children, and the rest of the world that may be dealing with us and with them. Everyone needs love and acceptance. These are the most basic human needs and, as such, are the sine qua non to develop the necessary confidence in order to build our abilities. ADHD individuals are not inferior to others. As a matter of fact, they are quite intelligent, possess abundant energy, and are incredibly creative, at least at levels that compare to non-ADHD children, if not more creative (Cramond, 1994; Healey, & Rucklidge, 2006; 2008). As a result, they need to be loved and accepted unconditionally for the individuals that they are and not for what we as parents would like them to be. The ADHD individual is no different than someone with asthma or diabetes. The person with asthma needs help to breathe; the diabetic needs insulin; the ADHD person needs to have the learning environment regulated, both at school and at home (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011).

Second, it is important for the ADHD individual to take good care of his/her head. Due to individuals with ADHD having an impulsive nature, it is more likely that they will suffer head injuries. A head injury can cause mild forms of ADHD to become very severe (Gerring et al., 1998; Keenan, Hall, & Marshall, 2008). It is imperative that the ADHD individuals avoid all possible activities where there is a risk for head injuries. If these individuals ride bikes, go skiing, or rollerblading, or snowboarding, it is important that they be made to wear a good helmet.

Third, we now live in a world where individuals enjoy playing video and computer games. It is better to reduce the amount of time the ADHD individual spends watching or playing these video games. Two hours a day is more than enough time to enjoy these types of activities and these can be utilized as a great incentive or reward for other activities (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011; Lawlis, 2004).

In neurobehavior approaches, which have been shown to be highly efficacious (Fabiano, Pelham, Coles, Gnagy, Chronis-Tuscano, & O'Connor, 2009), positive and negative reinforcement are used to increase and promote desired behaviors, while punishment and cost-benefit analysis are used to decrease unwanted behaviors. Punishment, however, has been shown in ADHD populations to have minimal impact on changing their subsequent behavior. As a result, they may appear as if they are very risky in their decision-making, as they do not anticipate punishment or negative consequences. As a result, changing their behavior should be predominately focused on reward, as individuals with ADHD are highly sensitive to rewards (Humphreys & Lee, 2011; Luman, Tripp, & Scheres, 2010). The recommended behavioral strategies would be focused predominately on positive reinforcement (i.e., giving a reward for good behavior) and negative punishment (i.e., removing a reward for bad behavior – e.g., disengagement of the parent when the ADHD individual does an undesirable behavior, etc.). Differential positive reinforcement (i.e., using positive reinforcement when the desired behavior is observed and not responding to any unwanted behaviors), is one of the most

effective tools for changing behavior in this population. Positive punishment is likely to produce the opposite effect, as it significantly impacts self-esteem and well-being. There is no need to apply physical or verbal abuse to re-direct unwanted behavior. If the child is being cruel to people or animals, it may be appropriate to use negative punishment, such as a loss of privileges or a time out, but not physical or verbal abuse. Abuse only teaches the child to be resentful and then how to be an abuser (Marcenko, Kemp, & Larson, 2000). The above are examples of some of the effective strategies that can be used, but there are others that could be used as well, such as: redirecting, cueing strategies (e.g., direct, indirect, verbal, non-verbal), Central Auditory Processing (CAP) testing, restructuring the environment, active ignoring, etc.

Discipline defines age-appropriate goals and behaviors and then applies a systematic reward each time a small achievement is attained until the desired behavior becomes a routine. The reward of positive behavior is what assists the child to become a productive, successful individual. Success breeds motivation. As parents and/or professionals we would be wise to use positive rewards rather than overusing punishment, which tends to increase fear and shame (Braswell, & Bloomquist, 1991).

Fourth, neurofeedback is a type of treatment where electrodes are placed on the scalp to measure the electrical activity in the brain. This information is then provided to the individual being treated so that areas of increased and decreased activity can be recognized. This type of treatment is based on the principle that if one knows what activity is occurring in a specific body function then one can learn to optimize that activity. Early random-control trials have illustrated its therapeutic efficacy, and current evidence suggests that this is an effective treatment for ADHD (Arns, M, de Ridder, Strehl, Breteler, & Coenen, 2009; Wangler, et al., 2011).

Fifth, the undersigned know too well that ADHD individuals tend to have sleep disturbances. Many of them have difficulty falling asleep at night and then have even more serious difficulty waking up in the morning. If the ADHD individual becomes sleep deprived,

the ADHD symptoms will worsen because the deprivation leads to decreased brain activity. For the brain to function properly, it needs an adequate amount of sleep. In addition, stimulant medication may increase the difficulty of falling asleep (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011; Ebert & Berger, 1998; Owens, 2005). The most common sleep problem co-morbid with ADHD is delayed sleep phase syndrome (DSPS) or also referred to as phase shifted sleep, a disorder in which individuals go to bed late and then want to sleep longer in the morning. ADHD individuals often complain that they cannot shut off their minds, so they resist going to bed because they do not feel sleepy. In addition, there is some mixed literature with respect to ADHD and an increased risk of other sleep disorders, including obstructive sleep apnea, and while the consensus is still out, this is an important area for clinicians to consider, as sleep problems can contribute to neurocognitive challenges (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011; Owens, 2005). It is highly recommended that ADHD individuals should always be screened for sleep disorders. The acronym BEARS is useful for this purpose: Bedtime resistance, Excessive daytime sleepiness, Awakenings, Regularity, Snoring (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011; Owens, & Dalzell, 2005). Most sleep problems can be diagnosed clinically and treated effectively with significant improvement in quality of life. It is important to remember, though, that effective treatment of sleep problems does not usually treat or "cure" ADHD (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011). ADHD individuals would be very wise to learn effective strategies (i.e., sleep hygiene, etc.) for going to sleep and for waking up in the morning on a regular routine (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011).

## NUTRITIONAL REGIMEN

Food plays a very important role in life. It plays an even bigger role for the individual with ADHD. Generally speaking, these individuals would be wise to put themselves on a high-protein, low-carbohydrate diet. The undersigned realize that this type of diet

goes against what most people eat in North America. ADHD individuals need to do most of the work and it is important that they learn to make good decisions, even if often it is difficult for them to do so. Studies on the nutritional status of children with ADHD show deficits in zinc, serum ferritin, and general omega-3 fatty acids (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011). However, the clinical implications of these deficits are unclear at this time. Strategies to encourage good nutrition and dietary intake ought to be provided by the physician. Children with ADHD may not sit for long meals and may need to snack when the medication wears off (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2011). Healthy snacks are very beneficial and should be available to the child. It is also important to remember that reliable randomized control trials demonstrating the impact of improved diet on ADHD are not available at the present time (Heilskov Rytter et al., 2015; Nigg, Lewis, Edinger, & Falk, 2012; Sonuga-Barke et al., 2013). Common sense, though, dictates that sound sleep and nutrition would improve the overall health and well-being of the individual and thus indirectly benefit behavior and attention.

The undersigned believe that the ADHD individual needs to reduce his/her sugar intake. Sugars with high glycemic levels tend to be more destructive when it comes to emotional and cognitive functions, since these types of sugars flood the body with glucose. It is better for the ADHD individual to substitute starches—pastas and potatoes—for the simple, natural sugars (Lawlis, 2004), such as sugars from fruits, honey, and cane sugar.

## EXERCISE REGIMEN

While physical exercise, generally speaking, does some good for everyone, it is especially beneficial for the ADHD individual. A good physical exercise tends to boost blood flow to the brain and increase cortical activity (Archer, & Kostrzewa, 2012). A fast walk for thirty to forty-five minutes a day will actually be all that is needed. Obviously, one can choose the exercise of one's choice, as long as it is intense enough to raise one's heart rate (Archer, & Kostrzewa, 2012).



## VITAMIN SUPPLEMENTS

Contrary to some popular belief, vitamins and other supplements are not cures for ADHD symptoms (Lawlis, 2004). However, vitamins and supplements help to manage or reduce the ADHD symptoms. The creation of a healthy diet is by far the greatest first step in the treatment of ADHD (Lawlis, 2004). It is the responsibility of the ADHD individual to control his/her symptoms through natural means. There are no quick fixes and, even more importantly, no magic pills.

## CONCLUSION

The treatment of ADHD ought to begin at home, not at school or at the therapist or pediatrician's office. The family needs to invest time, energy, effort, and love in the treatment of ADHD. If the family is unwilling to invest time, energy, effort, and love, then there is very little that others can do, including teachers and doctors.

ADHD does not affect the individual solely: it affects the entire family. The demands the ADHD individual places on a family can expose even the subtlest flaws of the family structure. On the other hand, it can also provide the very foundation for building stronger bonds. For most parents, handling a child's behavioral problems is to search one's own memory banks for the experiences one has had. At least one of the undersigned grew up in an environment where the behaviors displayed by the ADHD individual were not tolerated at all and were dealt with very swiftly with what is now considered abusive parenting, even if back then it was considered good parenting. The truth is that ADHD is a mystery for many parents and it is foreign to their realm of experiences. Guilt and anger become quite prominent feelings in the home. These feelings can cause havoc even in the most loving homes. Unfortunately, the divorce rate among families with ADHD children is three times higher than that of the general population (Wymbs, Pelham Jr, Molina, Gnagy, Wilson, & Greenhouse, 2008). Love, determination, and dedication are essential elements in combating ADHD. Taking control of the healing process rests in the hands of the parents and the family.

For the success and happiness of the ADHD child, assuming responsibility and making a commitment to positive action is a requirement for the parents and for those involved in the lives of the ADHD individuals. Fortunately, effective treatments have been established and are presently available to those who are willing to undertake the challenge.

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# A Better Way Forward: Open Adoption and its Benefits for Adopted Children and their Adoptive and Biological Parents

Susan Doran

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Despite the beliefs of many people to the contrary, adopted children who are placed into an open adoption where contact with their biological families is maintained have a far better chance of thriving and enjoying continued mental health than those whose contacts with their birth families are cut off. Open adoption leads to more positive outcomes for adopted children than closed adoption, as it results in better overall adjustment, attachment, and identity development; ready access to historical and medical information; and greater feelings of security and well-being for adopted children and their adoptive and biological parents. In this paper, the advantages of open adoption will be demonstrated by a careful analysis of scholarly material and other evidence, in order to illustrate that, generally, open adoption is in children's best interests.

The implications of openness in adoption remain a subject of great debate, and in fact are among the most controversial issues in the adoption arena (Mail & March, 2005a). Although most people think of open adoption as a new phenomenon, in actuality it was common practice in North American adoptions until the 1930s (Siegel & Smith, 2012). The intent of moving to absolute confidentiality in adoption at this time was to shield unmarried mothers and adopted children from the "stigma of illegitimacy" (Ge et al., 2008, p. 529) and to protect the privacy of all parties involved in hopes of affecting a clean break from the past.

Openness in adoption refers to "the level of contact taking place between adoptive and birth family members" (Von Korff, Grotevant, & McRoy, 2006, p. 531). While there is no communication at all in confidential (closed) adoptions, the level of openness in open adoption arrangements can vary dramatically, ranging from an occasional exchange of letters or photographs mediated through a third party (such as an adoption agency) to regular

ongoing personal visits among the adoptive and birth families and the adopted child (Von Korff et al., 2006).

In the decades immediately following the advent of closed adoption, it was not unusual for children to grow up unaware of their adopted status, or for births to be registered in such a way that the names of the adoptive parents were substituted for the birth parents' names (Brodzinsky, 2005). Many adoptees from this era have since come forward, "voicing their displeasure that essential parts of their history were kept secret, including the basic medical and social histories of their birth parents" (Lifton, 1979, as cited in Jones, 2004, p. 4).

Having no bridge to their past left many adoptees wrestling with issues around who they were and where they belonged in the world (Jones, 2004). Adoption was "shrouded in shame and secrecy," but is now "metamorphosing into a radically new process ... helping us redefine our understanding of family," says American adoption researcher Susan Wolfgram (2008, p. 133).

Since the 1970s, there has been a movement towards greater openness and flexibility in societal practices around parenting, with the result that open adoption has made enormous inroads and—in one form or another—is now considered to be standard adoption practice by many adoption agencies (Wolfgram, 2008).

Society's increasingly accepting attitudes towards issues such as single parenthood and abortion accelerated the shift to open adoption; as healthy white infants became less and less available, birth parents (mainly mothers) felt empowered to begin to exercise more authority with adoption practitioners, insisting on remaining involved in their children's lives (Wolfgram, 2008). Prospective adoptive couples "were faced with a choice of traditional closed adoption and waiting for

a number of years, or opting for contact with the birth family and most likely receiving their infant within a year; many chose the latter," explains Wolfgram (2008, p. 134). No matter how open the adoption, of course, it is the adoptive parents who are the child's legal guardians (Jones, 2004).

Here in Ontario, there are some relatively new regulations and recommendations in effect that allow for a variety of openness arrangements—in fact, adoption openness can now be court ordered if it is felt to be in a child's best interests (Plunkett, 2010). As in other jurisdictions, in Ontario this legislation is underpinned by attachment research, which has revealed that openness in adoption tends to promote attachment security (Plunkett, 2010). It is now well known, for instance, that after too much loss, children may lose the capacity to form close relationships, and that their early bonds to significant caregivers—usually parents, but in effect anyone with whom the child has extremely close ties—must therefore be treated with great sensitivity, and if at all possible, preserved in order for children to attach securely in other relationships (Plunkett, 2010). "When applying these research results to adoption practice, it should be recognized that a well thought out openness arrangement can promote an adopted child's capacity to form and maintain attachments with their adoptive family," states Ontario Association of Children's Aid Societies (OACAS) writer/advocate Ross Plunkett (2010, p. 2). "Openness agreements have a demonstrated track record of being beneficial to an adopted child's long term outcomes," Plunkett (2010, p. 4) confirms.

As social practice becomes increasingly holistic, there is an abundance of research available that challenges the basic principles of confidential adoption and points to open adoption as a superior and more compassionate and open-minded option (Brodzinsky, 2005; Siegel & Smith, 2012; Wolfgram, 2008). Research has shown that open adoption can have many other benefits for adoptees besides those revolving around attachment security; these include promoting positive identity formation, self-esteem, and better overall psychological adjustment than closed adoptions, with the result that an

extensive range of intrapersonal, interpersonal and developmental processes are positively impacted, notes American researcher David Brodzinsky (2005).

Open adoption "will reduce the child's sense of rejection and loss by fostering a more empathetic understanding of the circumstances surrounding relinquishment, which in turn should support more positive self-esteem and fewer adjustment difficulties states Brodzinsky (2005, p. 147). It appears that children in open arrangements, having birth relatives in their lives, tend to realize that they were not unloved or abandoned, and this helps minimize or neutralize feelings of rejection, allowing the adoptee to develop a better sense of self (Jones, 2004). For example, researchers describe one commonly- expressed sentiment among adopted children who are in contact with their birth mothers as being, "I know now that she didn't give me up because of anything I did wrong, but because she cared" (Brodzinsky, 2005, p. 150). In addition, the often traumatic need to search and reunite with birth relatives is no longer necessary (Jones, 2004)—a benefit of open adoption frequently overlooked by researchers.

Identity formation is a key aspect of development that becomes increasingly important as children reach adolescence, and this is especially true of those who are adopted, as they may struggle more than adolescents in the general population with identity issues (Grotevant, Perry, & McRoy, 2005). It is important that if at all possible adoptees are given opportunities to determine "how they are alike and different from both the biological and adoptive families," states Plunkett (2010, p. 3). Research shows that openness helps in this area, as well as in adoption stability, by providing adoptees with "accurate information about their birth parents, which allows them, amongst other things, to understand and assess the reasons why their birth parents were unable to parent them" (Plunkett, 2010, p. 3). Being better informed and more equipped to answer their child's questions about birth relatives, adoptive parents are then able to do a better job of helping their adopted child assimilate his/her history into a healthy identity, notes Plunkett (2010).



Establishment of adoptee identity is also aided in open adoption by "first-hand knowledge of biological, medical, and genetic history" (Jones, 2004, p. 13). As medicine advances, such information is vastly increasing in importance and relevance, point out Canadian adoption researchers Charlene Miall and Karen March (2005a). They executed a relatively large, Canada-wide, random-sample telephone survey (with 706 telephone respondents and 82 qualitative in-home interviews) examining public support for evolving adoption practices. Their subjects were largely white, middle class, well educated (52 per cent had a post-secondary education) and over the age of 30. Miall and March (2005a) explained that any generalization of their results would need to factor in the specificity of this demographic, but added that it is, in fact, typical of volunteer samples and "shares characteristics with the traditional adoptive parent profile," and as such is a fair representation of "the community stakeholders in adoption" (p. 386).

The Miall/March (2005a) survey revealed access to updated health, medical, and genetic information to be the most frequently cited benefit of open adoption. Adoptees with contact to birth relatives have ongoing access to this information, as well as to information about their adoption, birth relatives, and family histories. In contrast, adoptees in closed arrangements are usually in the medically-precarious situation of having to make do with outdated information that has been "frozen in time" since placement (Grotevant et al., 2008, p. 89).

By virtually all expert accounts, the problems "created by denying adoptees information about their biological histories are abundant" (Jones, 2004, p. 11). It seems clear from the research that in open adoptions, adoptees are not only better able to manage their feelings of loss, they also tend to remain more in touch with their biological, cultural, and racial roots (Jones, 2004). It also appears they may exhibit fewer behavioural issues than adoptees in closed arrangements (Von Korff et al., 2006). It is widely believed that adoptees in open arrangements will be confused by the differing value systems of their birth and adoptive families, and that this may lead to them exhibiting more behavioural and emotional

issues than adoptees in closed arrangements (Jones, 2004; Miall & March, 2005b). Recent studies indicate that, in fact, the reverse seems to be more accurate, as it is adopted adolescents in closed arrangements who actually self-report more aggression, defiance and other "externalizing behaviours" (Von Korff et al., 2006, p. 534), with a greater proportion of adoptees in closed adoptions scoring in the clinical range. These behavioural issues are confirmed by the adolescents' adoptive parents as well (Von Korff et al., 2006). Thus, adoptive parents in open adoption arrangements may find themselves facing less challenging behaviours from their child. There is also strong evidence that—contrary to popular belief—adoptive parents benefit from openness in many other ways as well.

Opponents of open adoption argue that the birth and adoptive families may wind up in a mutually unsatisfying and unsustainable relationship (Jones, 2004). There are also concerns that ongoing contact between the two families will result in "greater insecurity in the adoptive parents and undermine their sense of control and entitlement to their child," states Brodzinsky (2005, p. 152). However, research has shown that maintaining contact with their child's biological family can help adoptive parents to view the birth relatives and the adopted child more empathetically and realistically, thus reducing the adoptive parents' anxieties, insecurities, and fears of the unknown—including worry that the birth family will want the child back or that having both families in his/her life will make it difficult for the child to bond to the adoptive family (Brodzinsky, 2005; Jones, 2004). This helps to promote security and bonding within the adoptive family, and strengthens the adoptive parents' feelings of entitlement as legitimate parents to their adopted child (Brodzinsky, 2005; Plunkett, 2010). In turn, this can lead to better communication and rapport between the child and the adoptive parents, "not only affecting the adjustment of the adopted child but also influencing feelings of closeness to the adopted parents as well as feelings of satisfaction with the adoption, even into adulthood," Brodzinsky states (2005, p. 153). There has to be a balance initially though, "between preserving significant attachments and ensuring enough time between visits to

allow the child to develop their attachment to the adoptive family," cautions Plunkett (2010, p. 12).

Although it is common for adoptive parents to enter into openness arrangements with concerns about issues such as potential conflict with their child's birth family or over-involvement of birth relatives in the child's life, there is a great deal of evidence that once the openness arrangement is in place, the majority of adoptive parents are satisfied with it and say they actually would be happy to have more contact with their child's birth relatives (Grotevant et al., 2008). Many adoptive parents come to view open adoption as more compassionate than closed adoption, and make statements along the lines of there now being "more family to love their children" (Jones, 2004, p. 13). Thus, it appears that perceptions that the birth relatives will be camping out on the adoptive family's doorstep tend to be more fiction than fact. Boundaries between the two families must be negotiated—open adoption can be a dance (Brodzinsky, 2005)—but studies to date suggest that birth relatives in these situations tend to accept their role and the adoptive family's parental authority (Jones, 2004). A number of studies have also indicated that the adoptive parents who opt for open adoption arrangements tend to be those who have a more secure parenting style than the adoptive families who prefer closed arrangements (Brodzinsky, 2005; Grotevant et al., 2005).

Concerns that open adoption may cause adopted children to have conflicting loyalties between their birth and adoptive parents is another commonly perceived potential issue with open adoption (Jones, 2004; Miall and March, 2005b). Although there is no denying that adoptees in both open and closed arrangements may feel conflicting loyalties to their biological and adoptive families, recent research seems to indicate that these effects are lessened or eliminated in open adoption arrangements due to their more open and inclusive dynamic (Siegel & Smith, 2012). In the well-known Minnesota—Texas Adoption Research Project (MTARP), adolescents who were in contact with their birth mothers made it clear that they "could want a deeper relationship with birth mothers while also being content with their adoptive families; they did not feel they were having to choose one family

over another," explain the MTARP researchers (Grotevant et al., 2005, p. 174).

The MTRAP findings also revealed that adolescents in open arrangements considered the main advantages they obtained from ongoing contact with their birth mothers to be the provision of additional supports; the opportunity to better understand themselves and their backgrounds; and the opportunity to meet other birth relatives (Grotevant et al., 2005).

To date, many of the studies on open adoption have focused on information provided by the adults in these arrangements (Grotevant et al., 2005), but research centering on interviews with adoptees themselves is accumulating, the ongoing MTARP findings being a prominent example. An important American longitudinal project focusing on interviews on post-adoption contact and its consequences, MTARP has followed hundreds of adoptees and their families in a wide spectrum of arrangements from confidential/closed to open/fully disclosed, from the time the adopted children were infants right through to adolescence (Grotevant et al., 2008). The results point strongly to the benefits of open adoption over closed—adolescents and their family networks in fully open adoptions reported the highest levels of satisfaction with their arrangements, while those without contact reported the lowest (Grotevant et al., 2008). Moreover, according to the findings:

Adolescents having no contact were more likely to want contact to increase in future rather than stay the same. Many adolescents (55.2 %) already having contact wanted it to increase in the future. Less than 1 % (0.7 %) of the participants across the contact groups wanted to see the level of contact decrease. (Grotevant et al., 2008, p. 89)

In the initial waves, MTARP participants included 720 individuals—the mean age of the adopted adolescents was 15.7.

Another important American longitudinal study around adoption is the Early Growth and Development Study (EGDS). Aware that "previous studies have shown that the degree of openness is associated with satisfaction with the adoption process" (Ge et al., 2008,

p. 533) and using this as their hypothesis, the EGDS researchers collected data on open adoption satisfaction among adoptees and their birth and adoptive families and "examined descriptive statistics of the study variables" (Ge et al., 2008, p. 534). They concluded that there is indeed a significant positive correlation "between openness in the adoption process and post-placement adjustment," not just for adoptees but for their adoptive and birth relatives as well (Ge et al., 2008, p. 536).

Nevertheless, where birth relatives are concerned, critics of open adoption express concerns that openness arrangements may complicate and prolong their grief process (Ge et al., 2008; Jones, 2004). However what research there is in this area (generally interviews with birth mothers) indicates that both the adoptive parents and the birth relatives tend to be empowered by the choices, flexibility, and open exchange of information implicit in open adoption, and are generally more satisfied and express greater well-being when the adoption process is open (Ge et al., 2008; Jones, 2004). Although profound feelings of loss attend both types of arrangement, it appears that birth mothers involved in open adoptions are usually "better able to accept their decision and resolve their grief," according to Krista Jones (2004, p. 66), a Canadian researcher who devised a questionnaire for birth mothers which indicates that those involved in open adoptions tend to feel a greater sense of control around the relinquishment of their child, which aids in their grief resolution. Jones' research sampling was small, involving only 15 birth mothers. However, she also executed an extensive summary of past research on how open and closed adoption impact birth mothers, and compared that information with her own qualitative and quantitative findings (Jones, 2004).

Using these methods Jones (2004) also came to the conclusion that open adoption appears to offer birth mothers greater peace of mind than closed adoption, as it fulfills a well-documented wish for continued contact with their child and knowledge of his/her circumstances and well-being. Contrary to public opinion in decades past, research indicates that the vast majority of birth mothers

never stop caring about their adopted child, and those who enter into closed adoption arrangements continue to hold out the hope that one day they will reunite (Jones, 2004). The fact that it was birth mothers who led the push for open adoption over 40 years ago makes a good case for it being a development that many of them embrace today.

Of course, each adoption is unique and requires individual assessment regarding openness needs and levels (Brodzinsky, 2005). In child protection adoptions, notes Plunkett (2010, p. 12), meeting the "significant special needs" of the children involved may have to take "priority over other considerations, including openness." This does not necessarily mean that contact with birth relatives is ruled out if there are serious protection issues to consider—for instance, when a child has been abused by biological relatives. Even in such cases, "contact may still be beneficial," notes Plunkett (2010), "but it will need to be a safe experience for the child" (p. 1), so it may have to be indirect or at arm's length. Hard as it may be for some people to understand, in protection cases or situations where the child has insecure attachments to his/her birth family, contact may still be preferable to "having to reconcile questions about identity and worth in the face of perceived abandonment," Plunkett (2010, p. 6) explains. These are difficult decisions, and practitioners are advised to avoid a one-size-fits-all approach to openness arrangements, he and other researchers advise (Grotevant et al., 2005; Miall & March, 2005b; Plunkett, 2010).

Two decades ago, lawyer Ruth Appell (2010) was having a challenging time implementing any sort of approach at all to openness arrangements. She was battling a system that still largely viewed adoption "as a rebirth that severs and erases all ties" (Appell, 2010, p. 16). She describes her years in the American court system, representing foster children and their families "whose legal ties had been or were on the precipice of being terminated" (Appell, 2010, p. 12). The children remained "deeply connected to their parents, even when they were resigned to never again live with them," Appell recalls (2010, p. 12). She explains that she worked hard to negotiate (at the time unenforceable) open adoption

agreements between birth and prospective adoptive parents, in hopes "that the process itself would communicate the vitality of these connections to the child welfare system and the families who would adopt our clients" (Appell, 2010, p. 13). When Appell's peers asked why she bothered, she replied that "adoptees are happier when they have direct contact with their birth parents" (2010, p. 35). As this paper attests, research in the area of adoption does appear to bear this out.

Despite the abundance of positive research on open adoption and the legislation resulting from that research however, the field has a long way to go to catch up (Plunkett, 2010). Many experts attribute this to factors such as lack of training in the child welfare sector and the widespread aforementioned misconceptions and myths about open adoption and its supposed potential negative impact on the adjustment security of adoptees and their biological and adoptive families (Miall & March, 2005b; Plunkett 2010). Adoption practitioners should be aware that their preconceptions about open adoption may not represent the best interests of the children in their care (Miall & March, 2005b).

Advocates of open adoption everywhere would no doubt concur. "Greater education and training, along with ongoing research into how different kinds of open adoption journeys affect their participants, can help to guide and improve policy, practice—and lives," says Adam Perlman (2012, Conclusion section, para. 2), Executive Director of the Evan B. Donaldson Adoption Institute, an American organization that recently released results it had obtained from a comprehensive survey incorporating findings on open adoption from 100 adoption programs in the United States (Siegel & Smith, 2012).

"Research and practice illuminate the wide variety of ways in which open adoption can succeed, and underscore that it can benefit everyone involved," Perlman continues (2012, Conclusion section, para. 1). Perlman concludes:

Putting an end to secrecy in adoption does not erase the grief or loss embedded in the experience; it does, however, empower

participants by providing them with information and access so that they can face and deal with facts instead of fantasies. (2012, Conclusion section, para. 2)

The evidence that open adoption has preferred outcomes not just for adoptees, but also for their adoptive and birth families, is undeniably abundant. Study after study has confirmed that maintaining some form of contact with their biological family not only helps keep adopted children in touch with their medical and family histories, but also has a positive impact on their well-being and on such important aspects of their development such as attachment security and identity formation. Research has revealed that when adoptions are more open, adoption satisfaction is higher for adoptive and biological parents as well.

For many years adoption policy makers and practitioners have been promoting the importance of child permanency outcomes and maintaining family connections (Wolfgram, 2008). Open adoption speaks to both, and has the advantage of being a strength-based practice that points the way forward to a future that embraces our culturally evolving concepts of family. As various adoption researchers have suggested, a perceptual shift towards more openness in adoption is essential, as the time has come for adoptive families to be viewed less as a self-contained entity that has added a child, and more like an "adoptive kinship network" in which the adopted child "permanently connects families of birth and rearing" (Grotevant et al., 2008, p. 91).

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# Book Review:

## *Child Welfare Systems and Migrant Children: A Cross Country Study of Policies and Practices*

(Eds.) Skivenes, M., Ravinder, B., Kriz, K. & Poso, T. Oxford University Press. New York, 2015.

Bruce Leslie, MSW

Migrant families have recently been receiving much public attention and media coverage and this new book provides timely insights into some of the present and historic challenges for migrant children and their families, especially with regard to child welfare services. Historically, colonialism, slavery, economics, imperialism, globalization, and trade liberalization, have led to people populating new countries.

In contemporary times, whether as a consequence of economic inequalities, wars or conflict, there have been movements of people across transnational borders in unprecedented numbers. (p. 7)

This book was developed by the authors as part of a research study aimed at examining Norwegian child welfare service in relation to other countries, representing three predominant approaches to implementing child welfare services. Eleven countries participated—Canada, USA, England, Norway, Italy, Spain, Estonia, Austria, Finland, Australia, and the Netherlands. Almost all the country authors in this book highlight that their populations are almost all immigrant based except for indigenous people, the percentage of the population presently foreign born varying from 26.8% (Australia) to 4.6% (Finland), with Canada in the middle at 19.9%.

The authors state that the aim of this book is “to examine where, why and how migrant children are represented in the child welfare systems in these countries.”

Country authors were directed to address the five main areas in the chapters outlined below, which most followed.

1. Law and policy: What platform is created by the law and public policy for working with migrant children and their families at risk of child abuse and

neglect? What problems and solutions are identified through laws and policies?

2. Organization of child welfare systems: How do child welfare systems at the agency level interpret and implement laws and policies into practice guidelines? To what degree are agencies specialised to work with migrant families and their children?
3. Training of frontline workers: Who delivers the services and what training and education do they receive? Are there specialised approaches like culturally sensitive and anti-oppressive practices?
4. Migrant children in child welfare systems: To what extent are migrant children involved in child welfare systems? Are migrant families and their children involved to a greater or lesser extent than in the general populations? What risks and problems do these children endure and are they similar or different compared to those experienced by non-immigrant children?
5. Frontline practices examined using a survey: What does the practice in each country look like? What experiences do workers have in working with migrant families? Each country was asked to include frontline child welfare workers in a survey using vignettes assessing perceived risk, perceptions of the problem, and what they would do about the problem.

The issue of migrant children is becoming a critical issue globally. Even countries like Finland that have not seen many migrant children are now experiencing a growing influx.

... research evidence...across the globe is growing and suggests the need to take into account the effects of immigration status, the impact of migration and acculturation, families, socioeconomic situation, and the need for comprehensive cultural assessments of children and families. (p. 6)

The editors identify that there is no universally accepted definition of "migrant" and includes the following statuses in different countries - documented, undocumented, international adoptee, displaced person, child trafficking, refugee, foreigners, born outside destination country, born in destination country. Within the countries included in the book, there are various characteristics and statuses given different unique groups identified as "migrants", influenced by national policies and child welfare ideologies and system approaches. The book editors...." understand 'migrants' as people who move across national boundaries for whatever reason." (p. 1)

The editors recognise that more is known about child welfare systems in England, Canada, USA, the Netherlands, Norway, and Finland through existing English writings and the chapter authors' descriptions for the other countries provide a beginning outline of their systems. For this book the child welfare systems in these countries have been grouped according to characteristics identified by Gilbert et al. (2011) that range from "child protection systems" to "family service systems". A "child protection system" is characterised by a relative high threshold for intervention, with a focus on preventing and stopping serious risk that can harm the child's health and safety. The "family service system" aims to promote a healthy childhood and prevent serious risk and harm and the state provides services to the child and family at an early stage of a risk situation to prevent its development into a situation of serious risk and harm for the child. Skivenes et al. (2015) describe the major differences between these two systems in their underlying ideologies and the way that they address children at risk.

Family service systems are concerned with the provision of services to families and are based on a therapeutic idea of rehabilitation

and people's ability to revise and improve lifestyle and behaviour. Thus, the basic notion is that the child welfare system should provide services to prevent more serious harm and thus prevent out-of-home placements. The threshold for intervention is low. The child protection systems, on the other hand, are not built around service provision to prevent possible harm but to intervene when there is serious risk of harm for a child. It follows that the threshold for intervention is high, and the goal is to provide services for a possible reunification. (Skivenes et al.,2015)

This classification was used with the addition of a separate category for Latino countries about which, the editor's report, less is known. Although this classification was used by the editors they acknowledged that the distinctions between the systems can become blurred and systems evolve. The table below shows the countries grouped by child welfare system.

Eleven Countries		
Family service child welfare systems in social democratic welfare states	Family service child welfare systems with-in conservative Latino countries	Child protection-oriented child welfare systems that operate within liberal welfare states
Finland Norway Netherlands Norway	Spain Italy	United States of America Canada England Australia Estonia

Although large variations in which countries are destinations for immigrants appears to have many influences that have changed over the years, many country authors indicate the numbers of migrant families and children are growing and the need for awareness and sensitivity to their situations is becoming more of a priority for services like child welfare. Increasing numbers of immigrants in some

countries is leading to national policy changes. The specifics of child welfare services in these countries appear only distantly influenced by such global normative structures as the United Nations Convention on the Rights of the Child. All countries have federally mandated and locally delivered services. National legislation and policies are created within the different countries to direct and guide services and practices, provincially and locally, to support the welfare of children. Variations are evident nationally, provincially and locally, within and between countries.

The legislation and policies have practice objectives and related training is developed for front line workers with principles and skills designed to facilitate implementation. Research has found that however good-intentioned such policies are and thorough the training, they need to be considered in relation to worker perspectives and their context.

The key to the discrepancy between political intention and administrative action appears to lie in the potential for the exercise of informal discretion (sic, at the frontline). (Blackmore, 2001)

The editors sought to explore and address this potential implementation gap between high-level and street-level bureaucrats through the use of a frontline survey. This survey was completed in nine countries, by 900 workers, and provided some grounded descriptions of practices with these migrant families. A common finding, regardless of child welfare system, was that the percentage of immigrant families and children involved with child welfare services is higher than the percentage in the general population. Frequently identified challenges, barriers and issues for migrant families were economics, housing, language, interpretation, schooling, credentials, support networks, losses, cultural clashes, different parenting expectations, legal status, racial biases, social exclusion, compatibility of immigration and child welfare policies.

Workers' increased ability to communicate in the same language as the migrants was noted as a particularly crucial and achievable practice. These families present unique characteristics needing specialised practices and policies.

The workers surveyed reported various levels of familiarity with providing services to these families, mostly related to the percentage of such families in their jurisdictions, although almost all reported that they had responsibility for the welfare of the migrant children, regardless of their status. On reviewing the responses to the survey questions, some variations were identified in the assessment of risks, and the chosen intervention of placement did not always seem to correspond to a higher level of risk. Variations did not appear to align with any of the three child welfare systems. This book provides some insightful perspectives into the variations in practices and policies at the intersection of child welfare services and migrant children and family experience. It allows a broader understanding of differences and similarities across countries experiencing a growing global phenomenon, and illuminates choices.

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# Examining Relations Between Foster Parent and Foster Youth Ratings of Parenting Practices and Youth Psychosocial Functioning

Julie Norman, M.A., Rosanne Menna, Ph.D., and Deborah Ellison, Ph.D.

## INTRODUCTION

Children in foster care represent a population at high risk for psychological maladjustment. Estimates of the prevalence of mental health concerns in this population range between 30% and 80% (Garland, Hough, Landsverk, et al., 2000; Kerker & Dore, 2006; Marquis & Flynn, 2009; McMillen, Zima, Scott, et al., 2005), and children in foster care are between 3 and 10 times more likely to receive a mental health diagnosis than children in community samples (Harman, Childs, & Kelleher, 2000; McMillen et al., 2005). The types of problems evidenced by youth in foster care are varied, and include ADHD; internalizing problems, such as anxiety disorders; and externalizing problems, such as disruptive behavior disorders (Burge, 2007). Given the high vulnerability of this population to mental health problems, research concerning psychosocial adjustment among youth in foster care is of particular importance.

### Measuring Psychosocial Adjustment of Youth in Foster Care

To investigate the prevalence of mental health problems and the quality of psychosocial adjustment among youth in foster care, many researchers make use of questionnaires that are completed by a foster parent and/or by the youth (Gil Llarío, Ceccato, Manes, & Arnal, 2013; Marquis & Flynn, 2009; Tarren-Sweeney, Hazell, & Carr, 2004). In the Ontario child welfare system, the Assessment and Action Record (AAR-C2; Flynn & Ghazal, 2001; Flynn, Ghazal, & Legault, 2006) is an instrument used to assess the quality of care children are receiving, as well as the progress in a child's development over time. The AAR-C2 involves an assessment that incorporates multiple perspectives, including that of the child, the foster parent or person most knowledgeable about the child, and the child welfare worker. Information obtained from questionnaires and instruments like the AAR-C2 has great relevance for much-needed research concerning the mental health of youth in foster care, and can be influential in making

decisions regarding the youth's well-being while in care (i.e., provision of mental health or educational services). In order to give this information the appropriate weight in decision-making processes related to youth care, the degree of concordance between foster parent report and the reports of other raters should be investigated.

### Agreement Between Foster Parent and Foster Youth Ratings

Particularly among adolescents, it becomes important to consider the concordance between foster parent report and the report of the youth themselves. In general, inter-rater agreement between parents and children has been found to differ across areas of functioning. Youth in community samples tend to report more internalizing and externalizing problems than their parents, while youth in clinically referred samples tend to report fewer externalizing and more internalizing symptoms than their parents do (Smith, 2007). It may be particularly important to consider the perspective of the youth as they gain independence through pre-teen and adolescent years, as parents and foster parents may no longer be privy to some indicators of maladjustment. There is evidence among biological parents and children that as youth grow older, their reports generally become less consistent with parents' reports (Smith, 2007).

Although foster parent ratings are one of the most common sources used in the assessment of functioning of youth in foster care, there is no data available concerning the typical rate of agreement between reports of foster parents and youth in their care. Research concerning agreement between foster parents and other adults present in the lives of foster youth suggests that foster parents may view youth in their care as having more problems than others observe. For example, Gil Llarío and colleagues (2013) found that foster parents rated youth in their care as having more externalizing problems and attention problems, and poorer social and

adaptive skills, than youths' teachers reported. It may be that inter-rater agreement between foster parents and teachers is better for some areas of youth functioning, for example, the identification of externalizing problems, but poorer in others, such as internalizing problems (Tarren-Sweeney, Hazell, & Carr, 2004). In contrast, some earlier research suggests that foster parents may underreport mental health problems among children in their care (Halfon, Mendonca, & Berkowitz, 1995). To the authors' knowledge, there are currently no studies that directly investigate the agreement between foster parent and foster youth reports of youth well-being.

## Present Study

Given the lack of research reporting on the agreement between foster parent and foster youth reports of youth well-being, this study sought to explore the agreement between foster parent and foster youth reports of psychological functioning on the AAR-C2 (Flynn, Ghazal, & Legault, 2006). The purpose of this study was two-fold. First, we sought to determine the inter-rater agreement between foster parent and foster youth reports of home environment and of youth psychological functioning. We anticipated that foster parent and foster youth reports of nurturance, prosocial behavior, and internalizing problems would be significantly related to one another. Second, we sought to explore how foster parent and foster youth ratings of home environment (i.e., nurturance, relationship quality with caregiver) predicted the ratings of foster youth psychological functioning. These analyses were largely exploratory, but we anticipated that better ratings of the home environment (i.e., higher nurturance, better relationship quality with caregiver) would predict better youth functioning.

## METHODS

### Participants

Data were collected at two time points: the first wave of data was collected between June 1, 2008, and May 31, 2009, and the second wave of data was collected between June 1, 2009, and May 31, 2010. The two sets of data were combined to create a cross-sectional dataset.

Participants were 174 adolescents (88 male, 86 female) who were involved with Children's Aid Societies in southwestern Ontario. The participants were between 12 and 15 years of age ( $M = 12.92$ ,  $SD = 1.60$ ) at the time of data collection, and all were classified as Crown wards. Youth lived with, on average, approximately two other youth in the home ( $M = 2.43$ ,  $SD = 2.20$ ) and two adults in the home ( $M = 1.86$ ,  $SD = 1.18$ ). These youth had lived in foster care for, on average, six years ( $M = 6.12$ ,  $SD = 2.92$ ). This set of participants was selected because their age meant that both foster parent and youth reports concerning the home environment and youth outcomes were collected, which facilitated the investigation of congruence between parent and youth reports.

### Procedures

The Assessment and Action Record (AAR-C2; Flynn & Ghazal, 2001) is an instrument designed to help accomplish the objectives of the Looking After Children: Good Parenting, Good Outcomes (LAC) approach (Parker, Ward, Jackson, Aldgate, & Wedge, 1991) to foster care that was implemented across Ontario in 2007. The AAR-C2 (Flynn & Ghazal, 2001) is completed annually with each foster youth and his/her primary caregiver. Administration typically takes the form of a conversational interview between the youth's child welfare worker, the youth, and the caregiver.

### Measures

The 2006 edition of the AAR-C2 was used for this study (AAR-C2-2006; Flynn, Ghazal, & Legault, 2006). All demographic variables, measures of parenting, and youth outcome variables were obtained from the various scales included within the AAR-C2-2006. These comprised the demographic variables of gender, age, number of other youth in the foster home, number of adults in the foster home, and number of years in the foster care system. Measures of parenting and environment included parent report of parental nurturance (8 items,  $\alpha = .99$ ), as well as a youth report of parental nurturance (7 items,  $\alpha = .96$ ) and of relationship quality with the female caregiver (2 items,  $\alpha = .91$ ). Higher scores on each of these scales are indicative



of a more positive environment for the child (i.e., higher levels of parental nurturance, better quality parent–child relationship). Measures of youth outcome included parent report of youth prosocial behaviour (5 items,  $\alpha = .79$ ) and internalizing problems (5 items,  $\alpha = .76$ ), as well as youth report of peer relationships (2 items,  $\alpha = .70$ ), prosocial behaviour (3 items,  $\alpha = .75$ ), internalizing problems (8 items,  $\alpha = .82$ ), and externalizing problems (3 items,  $\alpha = .82$ ). Higher scores on each of these scales are indicative of greater frequency of positive social behavior (in the case of peer relations/prosocial behavior scales) or higher levels of psychological symptoms (in the case of internalizing/externalizing behavior scales).

## Analyses

First, bivariate correlations were computed between parent and youth reports of nurturance, prosocial behaviour, and internalizing problems. Subsequently, for each youth adjustment/outcome variable that was correlated with one or more parenting/environmental variables, these variables were entered into a forced-entry regression analysis to determine predictors of youth adjustment.

## RESULTS

Multiple imputation was performed to address missing data. In the original dataset, only one variable had complete data (youth age), and data was missing from parenting and youth outcome variables at rates ranging from 3% to 27%. Thus, five imputations of data for parenting and youth outcome variables were created. Results reported from this point forward reflect pooled estimates based on the five imputed datasets.

The measures of parenting and home environment, including the parent- and youth-ratings of parental nurturance and the youth-report of parent–child relationship quality, were not significantly related to any of the demographic variables (Table 1). However, age was negatively correlated with parent- and youth-reported prosocial behavior, and with youth-reported externalizing problems. Number of youth in the home was significantly associated with poorer youth-reported peer relations, with greater parent- and youth-

reported internalizing problems, and greater youth-reported externalizing problems. Number of adults in the home was positively associated with parent-reported prosocial behavior in foster youth. These demographic variables were entered as predictors in the regression analyses for each youth outcome variable with which they were associated.

Table 1

*Correlations between Measures of Parenting and Youth Outcomes and Demographic Variables*

Measure	Gender	Age	Youth in home	Adults in home	Years in care
Nurturance (Parent)	.071	.050	-.099	-.015	.072
Nurturance (Youth)	.113	-.059	-.101	-.019	.024
Parent-Child Relationship (Youth)	.130	.094	-.043	.019	.114
Peer Relations (Youth)	.016	-.051	-.261**	-.046	.001
Prosocial Behavior (Parent)	.113	-.201**	-.090	.159*	-.077
Prosocial Behavior (Youth)	.087	-.177*	-.024	.092	-.099
Internalizing Problems (Parent)	-.020	-.012	.228**	-.068	.023
Internalizing Problems (Youth)	.112	.009	.347**	-.130	-.061
Externalizing Problems (Youth)	.017	-.183*	.247**	-.078	-.065

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

## Agreement Between Foster Parent and Foster Youth Ratings

Higher parent-ratings of nurturance were associated with higher youth-ratings of nurturance, and higher parent-ratings of prosocial behavior were related to higher youth-ratings of prosocial behavior. Higher parent-ratings of internalizing problems were associated with higher youth-ratings of internalizing problems (Table 2).

Table 2

*Correlations Between Parent and Youth Reports of Parenting and Youth Adjustment Variables*

	1	2	3
PARENT REPORT			
1. Nurturance	.827**		
2. Prosocial Behavior		.574**	
3. Internalizing Problems			.665**

\*\*p<.01

**Predictors of Foster Youth Functioning**

Each outcome was predicted only from the demographic and parenting variables with which it was significantly associated (Table 3).

Table 3

**Regression Analyses with Youth Outcome Variables**

Outcome Variable	Predictor Variables	$\beta^1$	t	R <sup>2</sup> change (SE) <sup>1</sup>	F <sup>2</sup>
<b>Peer relations (Youth)</b>	Other Youths in Home	-.21	-3.08**	.36 (.84)	F <sub>4,150</sub> =21.23***
	Nurturance (Parent)	.50	3.91***		
	Nurturance (Youth)	.02	.89		
	Parent-Child Relationship (Youth)	.03	.75		
<b>Prosocial behavior (Parent)</b>	Other Youths in Home	-.18	-2.33*	.06 (2.33)	F <sub>2,163</sub> =4.97**
	Adults in Home	.16	2.03*		
<b>Prosocial behavior (Youth)</b>	Age	-.18	-2.27*	.032 (1.67)	F <sub>1,172</sub> =5.62*
<b>Internalizing problems (Parent)</b>	Other Youth in Home	.23	2.98**	.052 (2.32)	F <sub>1,162</sub> =8.89**
<b>Internalizing problems (Youth)</b>	Other Youth in Home	.33	4.33***	.15 (3.20)	F <sub>2,161</sub> =14.16***
	Nurturance (Youth)	-.17	-2.20*		
<b>Externalizing problems (Youth)</b>	Age	-.20	-2.62**	.10 (1.38)	F <sub>2,161</sub> =8.97**
	Other Youth in Home	.27	3.45**		

<sup>1</sup>Denotes statistics that have been computed by pooling estimates from each of five imputed datasets.

Peer relations. For the youth report of peer relations, the results indicated that fewer other youth in the home (b = -.21, t = -3.08, p<.01) and higher parent ratings of nurturance (b = .50, t = 3.91, p<.001) were predictive of higher youth ratings of peer relations.

Prosocial behavior. Parent report of youths' prosocial behavior was predicted by the number of other youths and adults in the home, with higher prosocial behavior being associated with fewer other youth in the home (b = -.18, t = -2.33, p<.05) and a greater

number of adults in the home (b = .16, t = 2.03, p<.05). For the youth report of prosocial behavior, younger age (b = -.18, t = -2.27, p<.05) was predictive of higher youth ratings of prosocial behavior.

Internalizing problems. A greater number of other youths in the home (b = .23, t = 2.98, p<.01) was predictive of higher parent ratings of youth internalizing problems. The number of other youths in the home and the youth report of nurturance were significant predictors of the youth report of internalizing problems, with a greater number of other youths in the home (b = .33, t = 4.33, p<.001) and lower youth ratings of parental nurturance (b = -.17, t = -2.20, p<.05) being predictive of higher youth ratings of internalizing problems.

Externalizing problems. The youth report of externalizing problems was predicted by age and number of other youth in the home, where younger age (b = -0.20, t = -2.62, p<0.01) and a greater number of other youths in the home (b = 0.27, t = 3.45, p<0.01) were associated with higher youth ratings of externalizing problems.

## DISCUSSION

### Foster Parent and Foster Youth Ratings

In the present study, foster parent and foster youth ratings of the foster parenting environment and of youth psychosocial functioning were highly concordant, suggesting that foster parents and youth in their care tend to agree on the nature of the home environment and on the youth's level of psychosocial functioning. Specifically, using the subscales included in the AAR-C2-2006, foster parents and foster youth ratings of the quality of parental nurturance and the youth's level of socioemotional functioning are similar. Notably, congruence between foster parent and foster youth ratings was higher for the parental nurturance variables than for the reports of prosocial behavior and internalizing problems. This finding may reflect that parent and youth reports become more congruent in rating behaviors that both parties are regularly privy to. Research supports that parent and youth ratings of behaviors that are not readily or easily observed by parents are often discrepant. Smith (2007) found that

parent and youth ratings of internalizing and externalizing behaviors were discrepant in both community and clinically referred samples. For example, parents may underestimate the level of youth internalizing symptoms because such symptoms are not always obvious to observers. Therefore, results in the present study may reflect that foster parents and foster youth have relatively equal opportunity to make observations about the nature of the parent–child relationship and the foster parents' behavior, but foster parents struggle to provide accurate ratings of youth behaviors that are not observable in the home or in regular parent–child interactions.

### Age of Foster Youth

The age of foster youth was found to predict two types of youth outcomes. First, older age predicted increased youth reports of engaging in prosocial behavior. Additionally, older age also predicted decreased youth reports of externalizing behavior. Together, these findings may be related to characteristics of the present sample, such as the Crown ward status of all children in the present study. Given that all children in the present sample were Crown wards, it is likely that some degree of stability has been achieved in their current home environment, relative to their experiences prior to becoming a permanent ward or entering the child welfare system. Therefore, their psychosocial adjustment may improve with age as they adjust to a more stable and nurturing home environment, accounting for the increased prosocial behavior and decreased externalizing behavior reported by older youth. However, these findings are based on cross-sectional data only, so these hypotheses can only be considered speculative at this time. Future research may consider looking at these variables longitudinally among Crown wards.

### The Home Environment and Foster Youth Psychosocial Functioning

Measures of the home environment were significantly related to the youth's psychosocial functioning. A greater number of other youth in the foster home was predictive of higher parent- and youth-ratings of internalizing problems and poorer prosocial behaviour, as well as higher youth-ratings of externalizing

problems. In particular, the number of other youth in the foster home was consistently predictive of more negative social, emotional, and behavioral outcomes among foster youth. This is consistent with other work suggesting that foster youth who live with a greater number of other children incur more compromised developmental outcomes, including behavioural problems (Harden & Whittaker, 2011).

Higher foster parent and foster youth ratings of parental nurturance were predictive of better social and emotional functioning, highlighting the importance of a nurturing, responsive relationship for this population of youth. These findings are consistent with general parenting literature that has identified the importance of a nurturant parenting style for developing social competence and peer relationships in parent–child dyads (Berlin, Cassidy, & Appleyard, 2008; Dozier, Higley, Albus, & Nutter, 2002; Engels, Dekovic, & Meeus, 2002). Notably, the youth's perception of parental nurturance also predicted the youth report of internalizing problems, where greater perception of nurturance was associated with lower report of internalizing problems. This is consistent with literature that supports the critical role of a caring, nurturing home environment for the development of a variety of developmental competencies (Grolnick & Farkas, 2002). Nurturance is essential in teaching children how to regulate their emotions (Thompson & Meyer, 2007), a skill which is linked with lower incidence of internalizing problems (Grolnick & Farkas, 2002).

The foster parents' report of prosocial behaviour was predicted by indicators of the quality of the home environment, as a greater number of other youth in the home was associated with poorer prosocial behaviour, while a greater number of adults in the foster home was related to a higher level of prosocial behaviour. This is consistent with research that has identified the negative outcomes of living with a greater number of other foster children (Chamberlain et al., 2006; Barth, Weigensberg, Fisher, Fetrow, & Green, 2008; Harden & Whittaker, 2011). Harden and Whittaker (2011) also identified that provision of greater emotional support predicted decreased behavioural problems and better social skills,

which may represent one way in which the number of adults in the foster home impacts foster youths' prosocial behaviour and peer relationships. That is, with more adults in the home, there may be a greater likelihood that each foster child will receive an adequate level of emotional support, contributing to their social development.

### Policy Implications for Child Welfare

The concordance between foster parent and foster youth reports of youth psychosocial functioning on select scales of the AAR-C2-2006 used in the present study suggests that this measure elicits ratings of related constructs, even though scale items differ between scales intended for foster parents and scales intended for foster youth. These data support the utility of the AAR-C2 instrument in measuring elements of the home environment and of foster youth functioning. However, results also reflect that foster parents may have relatively greater difficulty providing accurate ratings of youth behaviors that are not readily observable in the home or in general parent-child interaction, such as internalizing and externalizing symptoms. These findings highlight the importance of obtaining behavioral ratings for foster youth from multiple sources, including the youth themselves, foster parents, and from adults who interact with the youth in different settings, such as the classroom.

Results also suggest that the number of youth in the foster home has an important impact on foster youth outcomes. In the present study, a greater number of other youth in the foster home predicted more negative outcomes in every area of foster youth development assessed, including peer relations, prosocial behaviour, internalizing problems, and externalizing problems. This suggests that the number of children in a foster home is a critical factor in determining the quality of the foster care environment. Indeed, these findings are consistent with previous research, which has identified that a greater number of children in the foster home is associated with a host of negative effects for foster youth, including more compromised cognitive, language, behavioral, and social outcomes, greater likelihood of placement disruption, and greater

likelihood of re-entering foster care following a return to the biological family (Chamberlain et al., 2006; Barth, Weigensberg, Fisher, Fetrow, & Green, 2008; Harden & Whittaker, 2011).

The mechanism through which this effect operates may be similar to that observed in large biological families, where children from larger families generally receive less attention from parents than children from smaller families (Furman & Lanthier, 2002). As children in foster care often enter the child welfare system with pre-existing psychosocial problems (Lawrence, Carlson, & Egeland, 2006), they represent a particularly high-needs population, for whom the provision of parental nurturance and support will be essential in improving socioemotional functioning. Receiving little attention from foster parents who are preoccupied with many other children in the home may leave these youth especially vulnerable to development of a variety of more serious social, emotional, and behavioral problems. Given these findings, child welfare organizations may wish to consider limiting the number of children placed in each foster home as a potential mechanism for improving the home environment and developmental context of youth in foster care. Similarly, a greater number of adults in the foster home was predictive of higher ratings of youth prosocial behavior, which suggests that increasing the ratio of foster parents to foster youth in each home may also serve a protective function.

This ratio of adults to children in the home may also operate in combination with the sociological mechanisms of normalization and opportunity to contribute to poorer behavioral outcomes among foster youth. Research supports that most children in the child welfare system exhibit significant externalizing problems (Kerker & Dore, 2006; Marquis & Flynn, 2009; McMillen, Zima, Scott, et al., 2005). Research concerning peer influence on delinquency suggests that the normative influence of one's peer group plays a significant role in level of disruptive behavior (Haynie and Osgood, 2005). In the child welfare setting, this effect may operate through the foster siblings that youth reside with. As a child observes other youth in the home engage in externalizing and disruptive behavior, these behaviors may become more

acceptable in the eyes of other youth in the home. In the context of the present study's findings, a greater number of other youth in the home might magnify this effect. In addition, research has identified that youths' interpersonal relationships also contribute to providing opportunities for disruptive behavior. In particular, unstructured peer time with low availability of authority figures is associated with more frequent engagement in disruptive or delinquent behavior (Osgood, 1996). This effect may operate in combination with the low ratio of adults to youth in a foster home to produce greater levels of externalizing problems with a greater number of youth in the home. For example, having several children in a foster home, each with pre-existing behavioral difficulties, in combination with little adult supervision due to a low caregiver–youth ratio may result in a large amount of unstructured socialization in the home. Given findings from the present study support a relation between a greater number of youth in the home and increased externalizing problems in foster youth, child welfare organizations may wish to limit the effects of normalization and opportunity by, for example, increasing youth participation in structured socialization activities.

## LIMITATIONS

Generalization of the findings from the present study may be limited by the specificity of the sample. The present study used a sample of youth in foster care in southwestern Ontario, all of whom were classified as Crown wards. Greater variability in findings may be observed when foster youth whose guardianship is impermanent are included in the sample, or when the sample is broadened to include different communities across Ontario. In addition, data for the present study came from measures included in the AAR-C2-2006 (Flynn, Ghazal, & Legault, 2006). Some of the AAR-C2-2006 scales meant to assess parenting, home environment, and youth outcome contained few items and had poor internal consistency, which limited the scales and variables that were able to be included in the current study. Further research should be conducted using the revised versions of the AAR-C2 measure, which have been updated to include different scales and items, such

that a greater variety of parenting, home environment, and youth outcome variables can be studied. On a related note, the variable reflecting the number of years in foster care was constructed from data on the youth's age at the time of data collection and the youth's age at first entry into the child welfare system. Therefore, this variable constitutes a rough estimate of the child's time in the child welfare system, but does not account for factors including number of times the child returned to live with their family of origin. As such, caution should be taken when making conclusions regarding the relationship between years in care and youth outcome based on this data. In the present study, there was no significant relationship between our estimate of the youth's time in the child welfare system and any of the negative developmental outcomes assessed, suggesting that prolonged time spent in foster care may not be as detrimental as previously thought for the socioemotional functioning of foster youth. However, this should be investigated more thoroughly in future research. Finally, the nature of the AAR-C2 instrument is such that the data is obtained through an interview with the foster youth, the foster parent, and the child welfare worker present. Future research may wish to obtain parent and youth reports of variables separately, or in a written, self-report format, to reduce any influence of social desirability on parent and youth responses.

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# The Ontario Child Abuse and Neglect Data System (OCANDS) Data Sheet 1

## Service Recurrence Performance Indicators in Ontario Children's Aid Societies: Contextual Considerations

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Barbara Fallon, Joanne Filippelli, Tara Black, Bryn King, Anna Ekins, and Brenda Moody

### Introduction

Children's Aid Societies (CASs) collect information about the families and children they serve, including population demographics, service utilization statistics, and data about the functioning of children and families. The Ontario Child Abuse and Neglect Data System (OCANDS) is the first data system in Ontario to longitudinally track families throughout their involvement with the child welfare system. OCANDS was created as a data extraction and mapping tool to provide CASs with a mechanism to develop a better understanding of the services for children and their families, to track intervention outcomes, and to ultimately improve the quality of care.

OCANDS was contracted by the Ontario Association of Children's Aid Societies (OACAS) to standardize agency-level data and to calculate service performance indicators (SPIs). This information sheet has two purposes: first to present aggregate data collected from a majority of agencies in Ontario on recurrence, and secondly to describe the reasons why we would expect variation between agencies serving diverse communities and other considerations in examining agency variation.

### Methodology

Service Performance Indicator #4 measures recurrence of verified recurrence in the 12-month period after a case is closed at the investigation stage. Service Performance Indicator #5 measures recurrence of verified investigation in the 12-month period after a case is closed from the ongoing services stage.

### Findings

#### Verified service recurrence by fiscal year

As Tables 1 and 2 indicate, the rate of service recurrence for cases closed at investigation (i.e. SPI-4) and ongoing services (SPI-5) over the last four fiscal years indicates that recurrence rates are stable. Just over 15 percent of investigations that were closed recurred within 12 months in

2013/2014. Approximately 19 percent of investigations that were closed after receiving ongoing services recurred within 12 months in 2013/2014.

**Table 1:**  
**Service Recurrence SPI-4: 12-month: Investigations closed\***

		2010/2011	2011/2012	2012/2013	2013/2014
12 months	Verified Recurrence	16.48%	16.30%	15.61%	15.40%
Sample size	Number of agencies	32	32	33	30

**Table 2:**  
**Service Recurrence SPI-5: 12-month: Closed at ongoing services\***

		2010/2011	2011/2012	2012/2013	2013/2014
12 months	Verified Recurrence	19.63%	19.38%	18.82%	18.73%
Sample size	Number of agencies	32	32	33	30

\*Data as of February 28, 2016

## Potential sources of variation between organizations

While not presented in this Information Sheet, there is substantial variation in service recurrence rates ranging from a low of 9 percent to high of 32 percent. We have identified two sources of variation, which should be considered when assessing differences between agencies: (1) socio-demographic factors of the population of the community; and, (2) characteristics of the investigations in each agency.

### Socio-demographic factors of population

Child welfare agencies in Ontario serve diverse populations. Socio-demographic differences are risk factors that go beyond the mandate of child welfare including poverty rates and the proportion of Aboriginal families, many of whom live in particularly difficult conditions. Parents with fewer financial resources are faced with greater difficulties in providing safe environments, adequate clothing and nutrition, appropriate child care, and other assets, all of which foster healthy child development (Sinha et al., 2011). Parents with low income may also have more negative life experiences and fewer coping resources than others, and as a result they may be more vulnerable to mental health and substance use issues, which may in turn impact parenting (Kessler & Cleary, 1980; Mcleod & Kessler, 1990; Ross & Roberts, 1999). Research has established strong links between poverty and child maltreatment, particularly for child neglect (Drake & Pandey, 1996; Sedlak & Broadhurst, 1996).

Ontario recurrence data reflect the complex relationship between poverty and child maltreatment. Analyses conducted utilizing 2006 census data found that the rate of recurrence for closed investigations (SPI-4) by agency was significantly associated with several socio-economic factors of the agencies catchment area: income, the proportion of Aboriginal population, and the proportion of lone parent families. Higher recurrence rates were associated with agencies serving a higher proportion of individuals with lower income, a greater proportion of the Aboriginal population, and a greater proportion of lone parent families.

There is also variation in the rate of investigation across agencies in the province. Rates of investigation range from 26.10 per thousand children (just over 2.5 % of children in the census area are investigated by the agency) to 100.91 per thousand children (almost 11% of children in the census area are investigated by the agency). Not surprisingly, higher rates of investigation are strongly correlated with higher recurrence rates, and the presence of socio-economic risk factors in the area served by the agency.

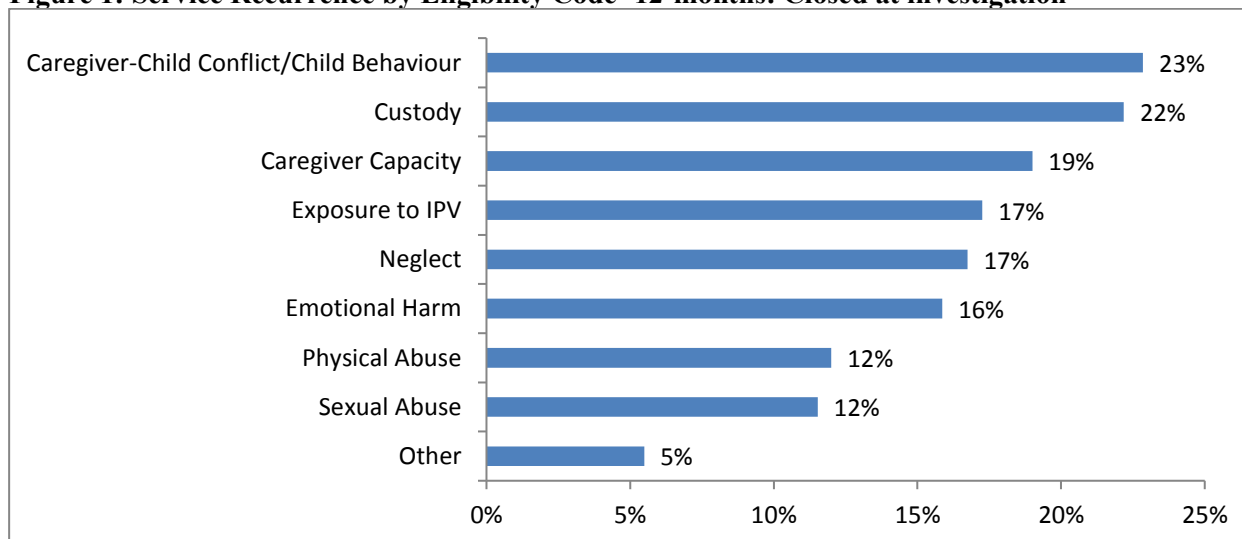
## Investigation characteristics

### *Investigation by eligibility code*

In Ontario, cases are screened with the aid of an *Eligibility Spectrum* to help determine whether an investigation is warranted. Evidence gathered from OCANDS suggests that there are differences in recurrence patterns (SPI-4) by Eligibility Code. Investigations involve the assessment of a broad range of child maltreatment, family functioning and well-being issues. Trocmé, Kyte, Sinha, and Fallon (2014) proposed a framework for understanding children and families identified to the child protection system; those in need of urgent protection which include investigations in which there is an acute threat to child safety (e.g., sexual abuse, physical abuse) and chronic need investigations where child development and well-being are at risk as a result of ongoing family challenges (e.g., caregiver capacity).

When we apply this understanding to recurrence data (Figure 1), caregiver concerns, particularly *Caregiver-Child Conflict/ Child Behaviour* and *Caregiver Capacity* are among the types of investigations closed with the highest proportion of recurrence. Complex and chronic family issues (e.g., caregiver mental health, addictions, child-caregiver relationship issues) may be more difficult for the child welfare system address in isolation. Investigations involving urgent protection issues have much lower rates of recurrence than those that reflect chronic need.

**Figure 1: Service Recurrence by Eligibility Code- 12-months: Closed at investigation**



Source: OCANDS SPI-4 (2012-2013 data, n=33 agencies)



### Methodological considerations of service recurrence

For both SPIs, verified recurrence describes cases where a verified investigation occurred in the 12-month period following the case closure. **It is important to note that the rate of recurrence is not equivalent to the rate of re-victimization.** A verification decision can mean that the family requires service, *or* the child was in fact victimized. Moreover, the verification of the presence of risk factors does not necessarily mean that a maltreatment incident occurred.

The basic calculations of SPIs should be considered when exploring variations in recurrence rates across the province. For instance, the calculation of service recurrence can be simplified as  $\% \text{ recurrence} = (X/Y) \times 100$ , where Y= all cases closed at investigation during the time frame, and X=cases from the denominator that were reopened within x months of case closure where the allegations of maltreatment were verified. Thus, any changes in smaller numerators (X) or smaller denominators (Y) over time may appear more dramatic as they will translate into large changes in subsequent calculations of recurrence percentages.

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# The Ontario Child Abuse and Neglect Data System (OCANDS) Data Sheet 2

## Service Performance Indicator 10 (Time to Discharge) in Ontario Children's Aid Societies: Contextual Considerations

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Barbara Fallon , Joanne Filippelli, Tara Black, Bryn King, and Anna Ekins

### Introduction

Children's Aid Societies (CASs) collect information about the families and children they serve, including population demographics, service utilization statistics, and data about the functioning of children and families. The Ontario Child Abuse and Neglect Data System (OCANDS) is the first data system in Ontario to longitudinally track families throughout their involvement with the child welfare system. OCANDS was created as a data extraction and mapping tool to provide CASs with a mechanism to develop a better understanding of the services for children and their families, to track intervention outcomes, and to ultimately improve the quality of care.

OCANDS was contracted by the Ontario Association of Children's Aid Societies (OACAS) to standardize agency-level data and to calculate service performance indicators (SPIs). This information sheet details the provincial aggregate data for service performance indicator (SPI) 10. The following results are as of February 2016 and are based on fiscal year.

### Methodology

SPI #10 measures the percentage of children discharged from care at intervals within a 36 month period. That is, for a cohort of children entering care each fiscal year, this SPI tracks how long it takes for them to be discharged from care. **It should be noted that the reason for discharge are varied** and includes events like family reunification and adoption, as well as aging out of care and transfers to another child protection agency. SPI 10 measures time to *discharge*, which is currently being used as a proxy for *permanency* in the Ontario child welfare system. The basic calculations of this SPI can be simplified as  $SPI\ 10 = X/Y \times 100$ , where Y= total number of children admitted in the fiscal year and X= number of children discharged.

## Findings

The data presented in Table 1 depicts the number of children entering care and those who are subsequently discharged in the 12 months, 24 months, and 36 month period following admission.

**Table 1: SPI 10: Percentage of Children Discharged within 12, 24, and 36 months\***

Time	2010/2011	2011/2012	2012/2013	2013/2014
<b>12 months</b>	61.09%	62.87%	61.67%	61.75%
<b>24 months</b>	76.41%	76.78%	77.18%	--
<b>36 months</b>	85.09%	85.38%	--	--

-- Data are not yet calculable.

\*Data for 31 agencies as of February 2016.

## Variation

Table 1 provides aggregate data on SPI 10. There is little variation for the years reported: regardless of the fiscal year, approximately 62% of children who entered care in a given fiscal year are discharged by 12 months; approximately 76% of children are discharged by 24 months; and, by 36 months, approximately 85% of children who were entered care were discharged.

Although not shown in this table, there is substantial variation between agencies across the province. One consideration is that agencies with fewer children in care are susceptible to comparisons with agencies that have larger numbers of children in care. The reason for this, is that one or two children can substantially change the discharge rate. For example, in one small agency could have 7 out of 10 children (70%) discharged in one year compared to 6 out of 11 (55%) in the following year.

## Context

### *Rate of Placement in Out-Of-Home Care*

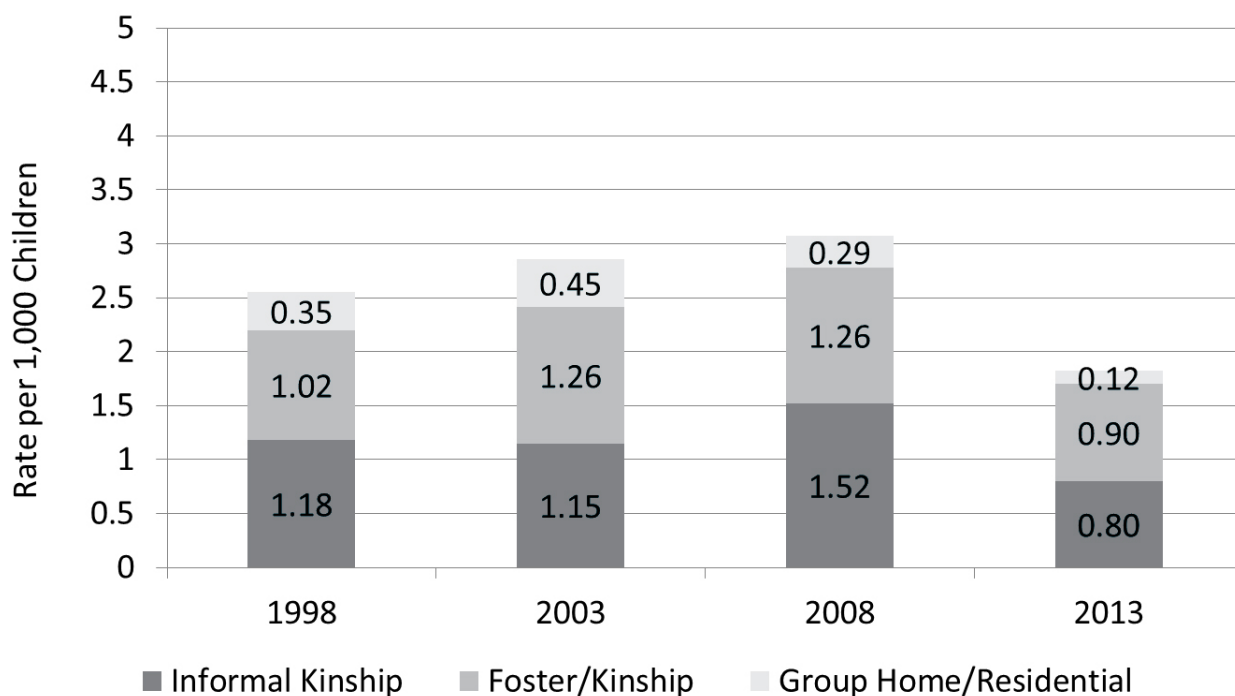
The Ontario Incidence Study of Reported Child Abuse and Neglect, 2013 (OIS-2013) is the fifth provincial study to examine the incidence of reported child maltreatment, and the characteristics of children and families investigated by child welfare authorities in Ontario. The OIS-2013 used a multi-stage sampling design to select a representative sample of 17 child welfare agencies in Ontario and then to select a sample of cases within these agencies. Information was collected directly from child protection workers on a representative sample of 5,265 child protection investigations conducted during a three-month sampling period in 2013. This sample was weighted to reflect provincial annual estimates. After two weighting procedures were applied to the data, the estimated number of maltreatment-related investigations (i.e., maltreatment and risk-only investigations) conducted in Ontario in 2013 was 125,281.

Information from the OIS-2013 can be used to estimate the proportion of children who are placed in out of home care at the conclusion of an investigation. In 2013, **there were no placements in 97 percent of the investigations** (an estimated 121,020 investigations). Three percent of investigations resulted in a change of residence for the child: one percent to informal

kinship care (an estimated 1,874 investigations or 0.80 investigations per 1,000 children); two percent to foster care (an estimated 2,105 investigations or 0.90 investigations per 1,000 children); and less than one percent to residential secure treatment or group homes (an estimated 282 investigations or 0.12 investigations per 1,000 children).

As shown in Figure 1, there generally has been little change in placement rates (as measured during the investigation) across four cycles of the OIS, other than a non-statistically significant increase between 2003 and 2008 in informal placements of children with relatives, and a statistically significant decrease in informal placements from 2008 to 2013.<sup>1</sup>

**Figure 1: Incidence of Primary Form of Formal & Informal Out-of-Home Placements: OIS-98, 03, 08 & 13**



<sup>1</sup> Fallon, B., Van Wert, M., Trocmé, N., MacLaurin, B., Sinha, V., Lefebvre, R., et al. (2015). *Ontario Incidence Study of Reported Child Abuse and Neglect 2013: Major Findings*. Child Welfare Research Portal.

# The Ontario Child Abuse and Neglect Data System (OCANDS) Data Sheet 3

## Validation of the Ontario Family Risk Assessment Instrument for Child Maltreatment Recurrence: Overall Recurrence

Aron Shlonsky, Barbara Lee, Tara Black, Mara Sanfelici and Barbara Fallon

**Ontario Child Abuse and Neglect Data System (OCANDS)** is a provincial level database composed of the various child welfare agencies' administrative data, enabling Ontario's child welfare agencies to generate timely and relevant evidence. OCANDS can be used to answer a vast array of questions that are key to understanding the pathways of children and families through the Ontario child protection system. This information sheet showcases one of the analyses that were conducted as part of the prospective validation and recalibration of the Ontario Family Risk Assessment validation.

An objective of child protection services (CPS) is to prevent the recurrence of child maltreatment. Risk assessment instruments have consistently been deployed across North America since the early 1990s in efforts to predict which children are at greatest risk of recurrence, and this information has been used to assist caseworkers in their decision-making about the type and intensity of service delivery.

Over the years, research about CPS and from a range of other disciplines have found that actuarial or statistically-driven instruments are generally better predictors of recurrence than other approaches such as clinical expertise or consensus-based instruments. What is less clear is whether actuarial tools, designed and delivered in one jurisdiction, will predict as well in other jurisdictions (e.g. California's structured decision making tools are now used in Ontario).

This study uses data from the Ontario Child Abuse and Neglect Data System (OCANDS) to evaluate the predictive ca-

capacity of the Ontario Family Risk Assessment (OFRA) and to test whether the risk assessment tool was able to predict maltreatment recurrence.

### Methodology

All families investigated for child maltreatment from January 1, 2008 to December 31, 2010 (N= 33,385) from consenting agencies, were tracked in OCANDS for 12 months to determine whether families experienced a recurrence of child maltreatment event (new report, new investigation, new verified investigation). The sample does not include institutional or maltreatment by unrelated caregivers. Families where one or more children were placed in out-of-home care during the investigation were excluded from the analysis because children placed in foster care are at far lower risk of being maltreated by their family of origin.



## Findings

Figure 1 illustrates the risk levels for all child maltreatment investigations that had an opening between January 1, 2008 to December 31, 2010.

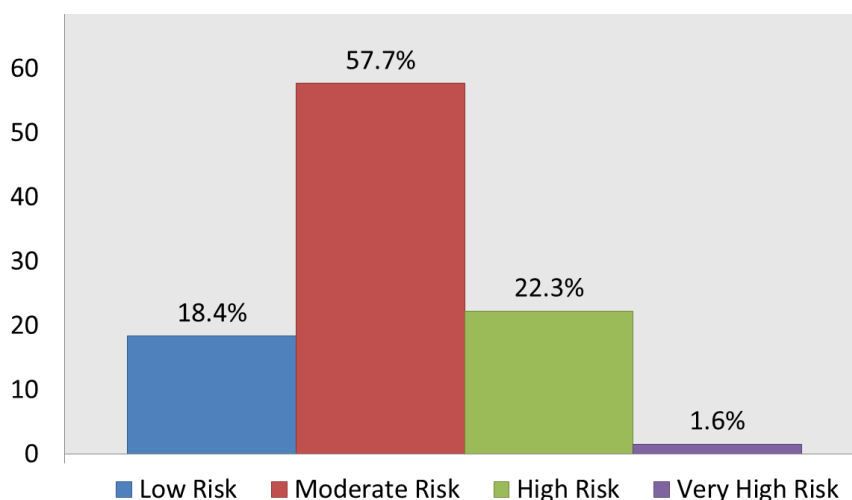
More than half of all initial risk assessments for recurrence of maltreatment fell into the moderate risk category (57.7%, n=19,271); 18.4% (n=6,136) were low, 22.3% (n=7,451) were high risk, and 1.6% (n=527) were very high risk.

Table 1 illustrates the (T1) initial risk levels for all child maltreatment investigations that had a (T2) recurrence (report, investigation, verified investigation) at 12 months after the closure of an investigation.

When looking at new reports, escalating risk of new report was observed with 18% of cases initially rated as low risk had a new report, 29% rated as moderate had a new report, 38% rated at high risk, and 34% rated as very high had a new report at T2.

When looking at new investigations, escalating risk of new investigation was observed with 14% of cases initially rated as low risk had a new report, 23% rated as moderate had a new investigation, 32% rated at high risk, and 32% rated as very high had a new investigation at T2.

**Figure 1. Risk Levels for All Child Maltreatment Investigations (Time 1, n=33,385)**



**Table 1. Initial Risk Level (T1) for All Child Maltreatment Recurrences (T2)**

T1 Risk Levels	T2 Recurrence					
	Report		Investigation		Verified	
	f	%	f	%	f	%
<b>Low</b>	1096	17.9	847	13.8	356	5.8
<b>Moderate</b>	5668	29.4	4429	23.0	2223	11.5
<b>High</b>	2820	37.8	2376	31.9	1422	19.1
<b>Very High</b>	181	34.3	168	31.9	136	25.8
<b>Total</b>	<b>9765</b>	<b>29.4</b>	<b>7820</b>	<b>23.6</b>	<b>4137</b>	<b>12.5</b>

When looking at new verified investigations, escalating risk of verified investigations was observed with 6% of cases initially rated as low risk had a verified investigation, 12% rated as moderate had a verified investigation, 19% rated at high risk had a verified investigation, and 26% rated as very high had a verified investigation at T2.

## **Conclusion**

The risk assessment instrument was generally able to distinguish between low, moderate and high levels of risk of recurrence across the three recurrence types (i.e., new report, investigation, and verified investigation). While the re-report rate in the very high category (34%) was somewhat lower than the high risk category (38%), this may be a function of the small number of initial investigations rated as very high risk and the fact that very high risk cases are more likely to enter care during an investigation and are therefore not part of this analysis.

The overall predictive capacity of the OFRA is moderately well as there is adequate differentiation of the percent of cases that recurred with low, moderate and high risk ratings. However the 4-level classification system (low, moderate, high, very high) is not working very well in the 'very high' range. Few cases get categorized as very high risk. A 3-level model with a combined high and very high risk level is proposed as an initial step in the calibration process.

# The Ontario Child Abuse and Neglect Data System (OCANDS) Data Sheet 4

## Risk and Response: A mixed methods approach to enhance decision-making in child welfare

Barbara Lee and Aron Shlonsky

**Ontario Child Abuse and Neglect Data System (OCANDS)** is a provincial level database composed of the various child welfare agencies' administrative data, enabling Ontario's child welfare agencies to generate timely and relevant evidence. OCANDS can be used to answer a vast array of questions that are key to understanding the pathways of children and families through the Ontario child protection system. This information sheet showcases one of the analyses that were conducted as part of the prospective validation and recalibration of the Ontario Family Risk Assessment validation.

### Background

In an effort to move to a more customized approach to child welfare, Ontario implemented a differential response strategy in 2007. This decision-making framework for child protection services includes assessment tools for each critical juncture of services (i.e., report, investigation, and reunification) and contains an actuarial risk assessment (the Ontario Family Risk Assessment – OFRA) tool used classify risk and to predict the recurrence of maltreatment.

In 2011, as part of the larger prospective validation and recalibration of the OFRA, Shlonsky (2011) and colleagues investigated the narrative sections of electronic case record reviews in an effort to better understand the circumstances surrounding child maltreatment investigations in Ontario, how these related to casework decisions, and whether the risk assessment tool could be improved by adding new items that were more sensitive to the Ontario child welfare context.

### Methodology

This validation study used the OFRA and administrative child welfare data to model the likelihood of subsequent report, investigations, and confirmed (verified) investigations. The study comprised of a random sample of 206 families investigated for child maltreatment between January 1, 2008 – February 28, 2008.

All narrative components of both the new decision-making system and client case file were analyzed for content and linked with key child welfare outcomes. Child maltreatment recurrence (new report, new investigation, and verified investigation at 18 months), was explored with respect to the risk factors already contained in the OFRA, and the new risk and services factors discovered in the qualitative analysis. This triangulation of the emerging themes helps to examine their utility for risk assessment and to explore their explanatory power and theoretical cogency with respect to investigative and longer-term child welfare outcomes.

## Findings

Seventeen new unique risk factors were identified in the administrative child welfare data, but are not a part of the existing Ontario Family Risk Assessment tool. These new unique risk factors were used to model the likelihood of sub-

sequent report, investigation, and verified investigation.

The definitions of each of the unique risk factors are detailed in Table 1 along with their initial occurrence (T1) and percent of recurrence after initial case closure (T2) for each factor.

**Table 1. Recurrence for Identified Unique Risk Factors at 18-months**

Unique Risk Factors	T1	Recurrence T2		
	Invest %	Report %	Invest %	Verified %
<b>Caregiver Physical Health Issues</b> Medical condition(s) that affects caregiving	51.94	2.91	2.91	1.94
<b>Financial Issues</b> Family identified as struggling to make ends meet	34.95	10.19	9.22	5.34
<b>Administrative Case Concerns</b> Practice or documentation issues	19.90	6.31	6.31	3.40
<b>Limited Support</b> Caregiver with limited family, friends, or community support	17.48	4.37	3.40	1.94
<b>Caregiver Criminal Activity</b> Criminal activity or police involvement (excluding DV)	13.59	3.40	2.43	2.43
<b>Lack of Contact or Uncooperative Caregiver(s)</b> Identified challenges during investigation	11.65	3.40	2.91	2.43
<b>Teen Pregnancy</b> Historical or current teen parent	7.28	0.49	0.49	0.49
<b>Child Bullying</b> Child perpetrator or victim of bullying	6.31	1.94	1.94	1.46
<b>Malicious Referrals</b> Spiteful or vengeful referral	6.31	2.91	2.43	0.49
<b>Traumatic Event or Loss</b> Stressful event or trauma within the last four years	5.83	0.00	0.00	0.00
<b>Use of Women's Shelter</b> Historical or current shelter use	5.83	1.46	1.46	1.46
<b>Lack of parenting role model</b> Caregiver without a positive parental figure during childhood	5.34	1.46	1.46	0.97
<b>Unfamiliar with Criminal Code</b> Use of inappropriate physical punishment techniques	4.85	1.46	1.46	0.49
<b>Communication difficulty</b> Caregiver and child communication issues	3.88	0.49	0.49	0.49
<b>Limited Caregiver Education</b> Limited formal education and/or illiteracy (not including ESL)	2.91	0.97	0.97	0.49
<b>Marital Issues</b> Reported extramarital affair(s)	2.91	1.46	0.49	0.00
<b>Transiency</b> Frequent moves and unstable housing situations	2.43	0.49	0.49	0.49

Caregiver physical health issues are the most frequent unique risk factor, identified in almost 52 percent of child protection cases (T1). Caregiver physical health issues include cases where one or more caregivers had medical condition(s) that affects their caregiving ability. Among the cases with identified caregiver physical health issues (T1), 2.91% had a report recurrence, 2.91% had an investigation recurrence, and 1.94% had a verified investigation recurrence (T2).

Financial issues are the second most frequent unique risk factor, identified in almost 35 percent of child protection cases (T1). This includes cases involving single parents, caregivers identified with gambling addiction issues, families struggling to make ends meet or dependent on Ontario Works or other subsidies for sustenance. Among the cases with identified financial issues, 10.19% had a report recurrence, 9.22% had an investigation recurrence, and 5.34% had a verified investigation recurrence (T2).

Administrative case concerns were the third most frequent unique risk factor, identified in almost 20 percent of child protection cases (T1). This includes concerns regarding CAS procedures, the way the file was handled, incorrect documentation (e.g. where the child protection worker used the override function incorrectly by lowering the risk rating, and the content of the narratives varied between files). Among the cases with identified administrative case concerns, 6.31% had a report recurrence, 6.31% had an investigation recurrence, and 3.40% had verified investigation recurrence (T2).

## Implications and Conclusion

Although unique risk factors were identified in the initial investigation and recurrence of child maltreatment, the identification of the unique risk factors were not statistically significant. Some possibilities in understanding the findings are: 1) The existing risk assessment tool is capturing the most salient factors that predict future risk of maltreatment, and there are no additional unique risk factors derived from child protection case files that are beyond the existing risk assessment tool; 2) Child welfare case documentation is sparse and not capturing the risk of future maltreatment.

The findings necessitates greater clarity of why and how case documentation is occurring (e.g. for case planning, for compliance) and what can be implemented to assist with ensuring that pertinent circumstances are represented in case files. This is particularly important considering administrative case concerns were the third most frequent unique risk factor in the initial investigations, and second most frequent unique risk factor noted in child maltreatment recurrences.

## References

Shlonsky, A., Shin, T., & Wong, B., Sawh, P., Lee, B., Eisner, A., Tan, J. (2011). Prospective validation of the new Ontario decision support system: Phase IV final report. Prepared for The Ministry of Children and Youth Services. Toronto, ON: University of Toronto.





## Ontario Association of Children's Aid Societies

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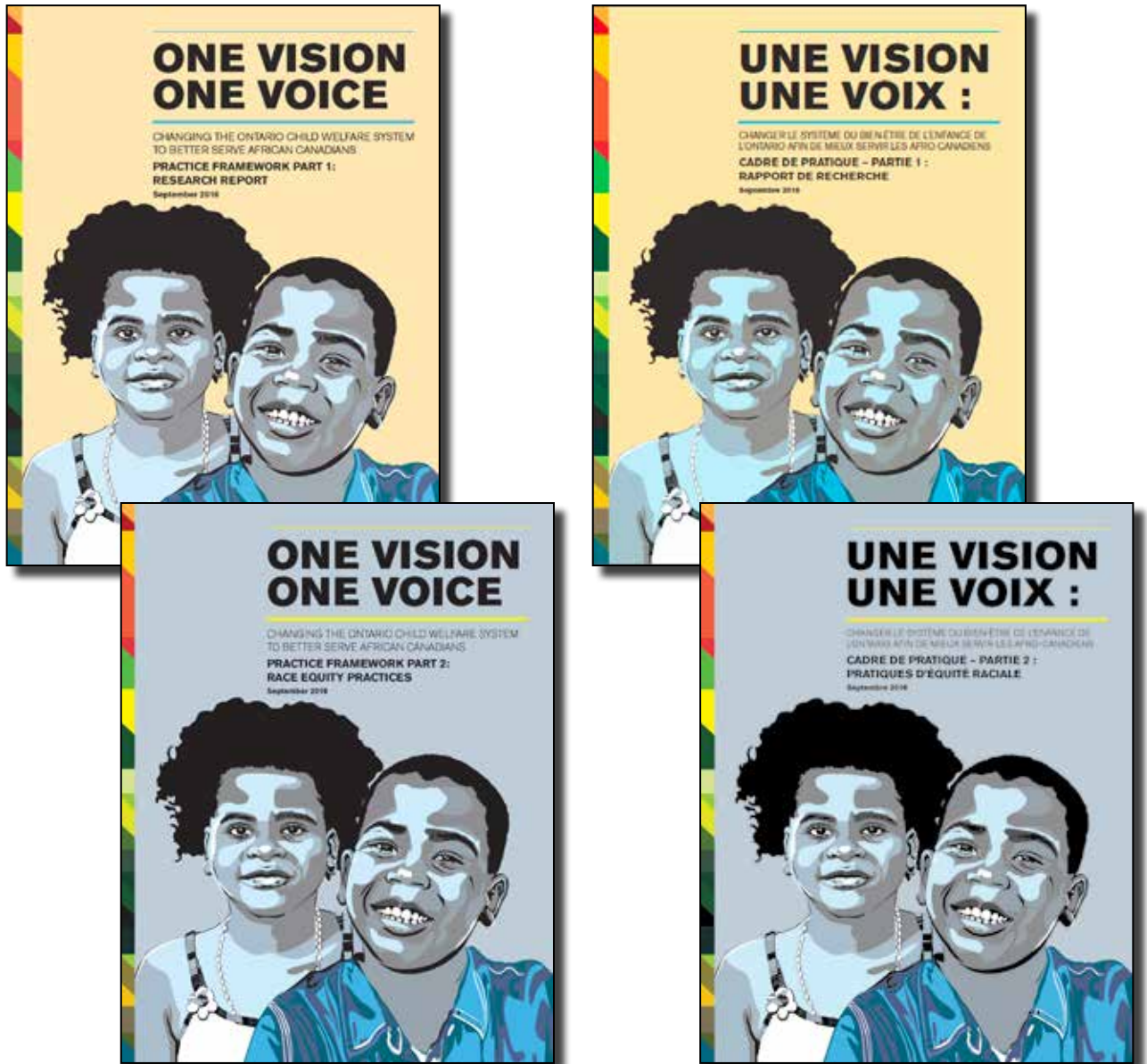
The voice of child welfare in Ontario

### **SPECIAL MESSAGE FROM OACAS AND THE JOURNAL**

As the Ontario child welfare sector continues to undergo significant change, OACAS has decided it's an ideal time to re-evaluate the purpose, content, and format of the *Journal* for future volumes. To do this effectively, production of the *Journal* will go on a short hiatus. We will not be seeking submissions during this period, and will notify the field and all subscribers when we plan to relaunch the *Journal*.

# ONE VISION ONE VOICE

## Changing the Ontario Child Welfare System to Better Serve African Canadians



This two-volume Practice Framework calls for reforms to the child welfare system to address systemic racism and to reduce the over-representation of Black children in care. These reforms include the collection of race-based data, mandatory training for child welfare professionals that addresses anti-Black racism, and culturally appropriate services and programming for Black children, youth and families.

Copies can be downloaded from our website, [www.oacas.org/one-vision-one-voice/](http://www.oacas.org/one-vision-one-voice/) and printed copies can be purchased at cost from <http://oacas.myshopify.com/>.