ADOPTION QUESTIONNAIRE REFERENCE GUIDE

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Introduction

This guide is designed to help you fill out the adoption questionnaire as accurately and completely as possible. It presents **basic** information and a brief description of the special needs found in each section of the questionnaire. You are encouraged to do further research on topics pertaining to the special needs of a child you are considering for adoption.

The questionnaire is the first step of the adoption application process with the Ministry of Children and Family Development. It gives you an opportunity to identify the background factors and special needs of the child or children you wish to adopt and it helps the social worker determine when to begin an adoption home study based on the information provided in the questionnaire.

The *Adoption Act* of British Columbia governs the placement of children with adoptive families. Children are registered for adoption through the Ministry of Children and Family Development either by the voluntary consent of their birth parents or through a continuing custody order. Children registered for adoption may have some of the special needs identified below.

Children with Special Needs

Infants to 18 years of age.

- children who are part of a sibling group of two, three or more;
- children whose genetic background includes schizophrenia or mood disorders;
- children diagnosed with a mental disability or Down's Syndrome or whose genetic background suggests a risk of mental disability;
- children whose future development cannot be predicted because of prenatal or birth trauma or other factors (i.e. use of drugs and alcohol during pregnancy);
- children diagnosed with Alcohol-Related Neurodevelopmental Disorder, Neonatal Abstinence Syndrome, Fetal Alcohol Syndrome or Partial Fetal Alcohol Syndrome;
- children who have intellectual and/or physical developmental delays;
- children who have medical or mental health diagnoses or are at risk for developing them;
- children who have or who are at risk of developing learning disabilities;
- children who have experienced physical, sexual and/or emotional abuse or neglect;
- children who exhibit significant emotional and/or behavioural problems.

Children registered for adoption may have multiple special needs related to any of the above factors.

It is highly recommended that applicants who are planning to adopt a child or children with special needs familiarize themselves through education and preparation by:

- Consulting with their social worker, physicians, geneticists, child and family therapists.
- Contacting adoption resources such as the Adoptive Families Association of BC, the Society for Special Needs Adoptive Parents, and the FAS/FAE Support Network.

SECTION A

Type of Application

1. Check if you are applying to adopt a child or children who are registered for adoption in the Province of British Columbia.
2. Check if you are seeking to adopt a child or children for which you have been providing foster care.
3. Check if you are applying to adopt a specific child or children in foster care.

SECTION B

Age of Child/Children

Children registered for adoption are “matched” with adoptive parents’ requests as specified on the adoption questionnaire.

Indicate in years (from 0-18), the age of the child/children you wish to adopt. Please do not use words such as newborn, infant, any age, adolescent, 2 years younger than our youngest, etc.

SECTION C

Gender of Child

If you have a definite preference for a male or female child, check only one category. Check “either” if you would accept either a male or female child.

SECTION D

Number of Children

Adoptive applicants who wish to adopt one child, twins or sibling groups can check any or all of the categories listed.

SECTION E

Accepted Religious Background of Child Sought

This section identifies the religious background of the children who are registered for adoption. Consideration of a child's religious heritage is important in the adoption process. If a birth parent is planning adoption, or if it is determined to be in the best interests of a child, adoptive applicants of the same racial and/or cultural background of children are actively sought.

SECTION F

Accepted Languages of Child Sought

This section allows you to identify the languages spoken by a child in care. If you have the ability to speak specific languages, and would consider parenting a child who speaks these languages, please identify them. Recognition of a child's specific language needs is important in the adoption process.

SECTION G

Ethno-Cultural Background of Child Sought

This section identifies the ethno-cultural background of the children who are registered for adoption. Check all of the choices you wish to consider. The preservation of a child's racial, ethnic and cultural heritage is important in the adoption process and adoptive applicants of the same racial and/or cultural background of children are actively sought.

Note: An aboriginal child is a child who:

- *is registered or eligible to be registered under the Indian Act (Canada);*
- *has a biological parent who is registered under the Indian Act;*
- *is a Nisga'a child;*
- *is under twelve years of age and has a biological parent who is of aboriginal ancestry and considers himself or herself to be aboriginal; or*
- *is twelve years of age or older, of aboriginal ancestry and considers himself or herself to be aboriginal.*

SECTION H

Child Conceived as a Result of:

1. INCEST
   This refers to a child conceived within a relationship between two people who are blood-related such as father and daughter. While a child conceived from an incestuous relationship will have a higher than normal chance of being affected by a genetic disorder, it is important to stress that the child may also be perfectly healthy. If genetic concerns do exist, they may not be identifiable at birth. A genetic assessment can be done, but it is not possible to rule out all risks. As adopting parents, you need to be aware of your feelings and attitudes about incest.

2. SEXUAL ASSAULT
   Even when the birth father is known, information about him is generally quite limited. This means that important genetic information will not be available. As adopting parents you need to be aware of your feelings concerning sexual assault as this may affect your feelings about or attitude towards the child.

SECTION I

Premature Birth

1. HIGH RISK
   An infant who has one or more of the following characteristics:
   - several weeks premature;
   - birth weight under four pounds (2.5kg);
   - requires extensive medical intervention that includes life supports and a lengthy hospital stay; and
   - has a family history that indicates risks of physical or intellectual developmental delays or illness.

2. LOW RISK
   An infant who has one or more of the following characteristics:
   - less than one month premature;
   - birth weight over four pounds (2.5kg);
   - did not experience infant trauma or illness such as convulsions or respiratory problems;

- is feeding well; and
- has a family history that does not indicate a risk of physical or intellectual developmental delays or illnesses.

To facilitate bonding, adopting parents are usually asked to become involved with the infant's care if the infant will be in hospital for a long time.

SECTION J

Risks Identified at Birth

1. ANOXIA/HYPOXIA
   Anoxia occurs when there is an **absence** of oxygen supply to an organ's tissues even though there is adequate blood flow to that tissue. Hypoxia is similar but it is the **decrease** of oxygen supply to an organ's tissues even though there is adequate blood flow to that tissue. These two terms are often used interchangeably to describe a condition that occurs when there is a diminished supply of oxygen to an organ's (e.g., brain) tissues. This can increase the risk for health complications.

2. LOW BIRTH WEIGHT
   Low birth weight is used to describe new-borns that weigh less than three pounds four ounces. The primary cause of low birth weight is premature birth. A baby with low birth weight may be at increased risk for health complications. They may have a more difficult time eating, gaining weight and fighting infection. They also have more difficulty staying warm due to their low amount of body fat. Most low birth weight babies need specialized care in hospital until they gain weight and are well enough to go home.

SECTION K

Genetic Factors and Risks

The human body is composed of billions of cells with each having a nucleus that contains chromosomes. Each human cell normally has 46 chromosomes. Chromosomes are composed of genes. In fact, our bodies have over 100,000 chromosomes that control the body's appearance and functioning. Genes are the basic units of inheritance

that transmit traits from parent to child during conception. Everyone has genes that have the potential to cause illness or disabilities in their children.

The implications of, and risks related to genetic conditions can have a major impact on the lives of adopted children and their adoptive families. It is important for adoptive parents to obtain as much information as possible about the medical, social and psychological history of the child they adopt. Genetic family histories can help potential adoptive parents make informed decisions about their ability to parent a child who has certain genetic concerns or risks, and to anticipate the child's special needs.

Information about a genetic condition can initiate appropriate assessment and treatment that can improve the quality and length of a child's life. Genetic research has made many advances in our knowledge about genetic disorders and in developing services that are beneficial to children and families affected by or at risk for genetic disorders.

"Genetic Disorders" refer to a wide range of conditions with diverse causes. More than 4,000 inherited diseases have been identified. In general, genetic disorders are described as permanent, complex and lifelong familial conditions. The terms genetic and inherited are not necessarily interchangeable terms. Although all inherited disorders are genetic, not all genetic disorders are inherited. Birth defects can be caused by environmental conditions such as chemicals and other contaminants.

There are four types of genetic disorders: single gene, chromosomal, multifactorial and environmental agents.

- Single gene disorders are associated with a single defective gene, i.e. cystic fibrosis, neurofibromatosis, sickle cell disease and haemophilia.

- Chromosomal disorders occur as a result of a change in the number or structure of chromosomes i.e. miscarriages, infertility, Down's syndrome.

- Multifactorial disorders are caused by the interaction of specific genes with environmental factors. Height and weight are everyday examples of multifactorial inheritance. Common examples of multifactorial disorders include Spina Bifida, cleft lip or palate, club foot, diabetes mellitus, congenital heart disease, some cancers and mental disabilities. Some psychiatric conditions such as schizophrenia may be related to multifactorial inheritance.

- Certain genetic disorders are caused by specific environmental agents that are potentially harmful when exposure occurs during prenatal development. Examples include sexually transmitted diseases, infections, maternal biochemical factors and nuclear radiation.

Section K on the Adoption Questionnaire identifies six conditions that have genetic components.

Mood Disorder and Schizophrenia can be found in this section. Information about allergies, asthma, diabetes and epilepsy can be found in Section M. Mental disability is described in Section K.

1. ALLERGIES – Refer to Section P

2. ASTHMA – Refer to Section P

3. DIABETES – Refer to Section P

4. EPILEPSY/SEIZURES – Refer to Section P

5. MENTAL DISABILITY – Refer to Section N

6. MOOD DISORDER
   Mood Disorder is a general category that includes disorders whose primary symptom is a clinically depressed or elevated mood or a combination of both. Mood disorders characterized solely by depressed mood are Major Depression and the milder Dysthymic Disorder. Those that are characterized by elevated moods (usually in combination with depressed moods) are known as Bipolar Disorder and the milder Cyclothymic Disorder.

The primary feature of Major Depression is a severe depressed mood or an inability to enjoy things that once were pleasurable. In children and adolescents, irritability is often present. Other symptoms of Major Depression can include loss of appetite, unintentional weight gain or loss, difficulty sleeping or excessive sleep, lack of energy or fatigue, feelings of guilt or worthlessness, difficulty concentrating or making decisions, increase in agitated (e.g., pacing, restlessness) physical movement, reduction in (e.g., slowed speech or body movements) physical movement and suicidal thoughts, plan or attempts.

Studies suggest that the risk for Major Depression in the adult population is between 5 and 25%. Women have a higher risk of developing this disorder than men. Family members of individuals with Major Depression have an increased risk of 1.5 to 3 times that of the general population. Although Major Depression can begin at any age, the average age of onset is in the mid-20's. Approximately two-thirds of those with Major Depression fully recover.

Bipolar Disorder, often referred to as manic depression, is characterized by extreme mood fluctuations. The highs are called manic episodes where the individual experiences an elevated euphoric or irritable mood. During a manic episode the individual is hyperactive, distractible, and the need for sleep decreases. The lows are like that of Major Depression. These mood swings are usually interspersed with periods of "normal" mood. Severe episodes are sometimes accompanied by hallucinations or delusions (refer to section K, #6).

The prevalence of Bipolar Disorder is estimated to be between 0.4 and 1.6%. Parents, children or siblings of a person with Bipolar Disorder have 4 to 25 times the risk of developing Bipolar Disorder or Major Depression than the general population. The average age of onset is the early 20's. Bipolar Disorder tends to be a recurrent disorder. The majority of individuals with Bipolar Disorder do tend to experience a significant reduction in symptoms between episodes.

7. SCHIZOPHRENIA

Schizophrenia is a thought disorder that interferes with an

individual's ability to think clearly and to discern what is real from what is not. It can be a severe chronic condition that can negatively impact a person personally, socially and economically. Deterioration in daily functioning may be seen in the areas of employment, personal relationships and self-care. Some of the characteristic symptoms of Schizophrenia include the following:

Delusions: False beliefs based on a misinterpretation of experience or perception. These beliefs are maintained in spite of clear evidence that they are not true. An example is the belief that the newscaster on the television is speaking directly to the individual.

Hallucinations: The experience of a sensory perception that is not actually there. The most common are auditory hallucinations such as hearing voices not heard by others.

Disorganized speech: The speech difficulty must be severe enough to significantly impair communication. Examples of this include difficulty staying on track and changing topics or going off on tangents that are unrelated to the conversation. In severe cases speech may be so disorganized that it is incoherent or not understandable to others.

Disorganized or catatonic behavior: Disorganized behavior can be exhibited in a variety of ways. Some examples are unpredictable shouting and swearing or dressing in an unusual way. Catatonic behaviors include a significant decrease in response to ones environment, resisting instructions or attempts to be moved and excessive activity.

Negative symptoms: These are characteristics that are generally present for everyone, but for a person with schizophrenia they may be absent. This includes flat affect or a severe decrease in emotional expressiveness. A person with Schizophrenia may speak in a monotonous voice and may not show normal emotion. Social withdrawal and decreased motivation are also common symptoms.

Schizophrenia can occur at any age, but the typical age of onset is late adolescence to mid-30's. Although the essential

features of Schizophrenia are the same for children it is more difficult to diagnose because features such as disorganized speech and disorganized behavior are exhibited in a number of other disorders with childhood onset (eg. Pervasive Development Disorders, ADHD). Schizophrenia affects both men and women in relatively equal numbers but tends to develop earlier in men than women.

The onset of this disorder varies. Although it may appear abruptly for some, for the majority the onset of Schizophrenia is characterized by a slow and gradual development of various symptoms that may include poor hygiene, social isolation and unusual behavior. Eventually some of the characteristic symptoms described above differentiate the disturbance as Schizophrenia. The course and prognosis for Schizophrenia is variable. Some people experience phases of active symptomology with periods of remission and others are chronically ill. Of the group that are chronically ill, some maintain a relatively stable course while others get progressively worse. The goal of treatment is usually not to cure but to improve quality of life. This includes symptom reduction, preventing relapses, and improving social and occupational functioning. Treatments vary depending on the phase of the disorder. They include hospitalization, anti-psychotic medication, individual therapy, and support programs. With adequate treatment and support many people with Schizophrenia are independent and function well in various areas of their lives.

Although not fully understood, research indicates genetic factors play an important part in the predisposition to and development of schizophrenia. Environmental factors may play a role in whether the predisposed person develops Schizophrenia as well as its severity. Individuals with first-degree (e.g. parent, sibling) biological relatives have a risk of developing Schizophrenia that is 10 times greater than the general population. In contrast, the risk in the general population is about 1%.

SECTION L

Prenatal Alcohol and Drug Exposure

Effects of drugs and alcohol on infants vary greatly depending on the types and the amounts of drugs used, the stages of pregnancy in which drug or alcohol use occurred, the frequency of that use, the genetic make up of the mother, and how psycho-social and other elements such as diet, disease, poverty, housing, experience with violence, and prenatal care affected the mother. Because many infants have been exposed to a combination of various drugs including nicotine and alcohol, and the information regarding the quantity and timing of use is often unreliable, predicting a child's future needs is very difficult. All children are not affected in the same way, and predicting the future problems that children may experience is not possible.

These children benefit from early diagnosis and support, and continuing medical and developmental surveillance. As with all children, children exposed to alcohol and drugs progress better in stable, consistent and loving homes.

1. ALCOHOL EXPOSURE - LIMITED
2. ALCOHOL EXPOSURE - PROLONGED

   When a pregnant woman drinks alcohol, it is transported through the placenta to the unborn baby and all of its developing tissues and organs. Because the fetus cannot process alcohol as quickly as an adult, high concentrations of alcohol remain in the fetus for longer periods of time. An infant whose birth mother used an undetermined amount of alcohol during the pregnancy can appear healthy at birth, but remain at risk for developing symptoms later in life. It is not possible to predict future effects because of the many variables that influence the impact on the child. Some of these variables include how much alcohol was consumed per day, the stage of pregnancy during which it was consumed, the number of days in which alcohol was consumed during the pregnancy and when the alcohol consumption ended. Not all children are equally affected by exposure to small or large amounts of alcohol, and it is important to assess each child's experience and to plan individually for each child.

For the purpose of this questionnaire limited and prolonged alcohol use are defined as follows. Limited alcohol use refers to occasional use in limited amounts. This is generally not a pattern throughout the pregnancy. It is important to note that research indicates that even small amounts of alcohol consumed during pregnancy may cause damage to the unborn baby. Prolonged use refers to a pattern of continuous and/or heavy drinking throughout the pregnancy. Children whose mothers demonstrate this pattern of alcohol use are at higher risk for alcohol-related birth defects such as Fetal Alcohol Syndrome, Partial Fetal Alcohol Syndrome, Alcohol Related Neurodevelopmental Disorder and Neonatal Abstinence Syndrome (refer to section M). There is no information about the alcohol consumption of the mother or the symptoms of the child at birth that would indicate that a child might be mildly affected or not affected in later years.

3. DRUG EXPOSURE - LIMITED
4. DRUG EXPOSURE - PROLONGED

Children whose birth mothers used limited amounts of certain prescription and/or illegal drugs during the first three months of pregnancy, or small amounts on limited occasions during a later stage of pregnancy often appear healthy at birth. The long-term effects of this pattern of use are not clear. There are no known indicators that allow a physician to predict future effects.

For the purpose of this questionnaire, prolonged drug use is defined as a sustained pattern of drug use throughout the pregnancy. If the mother used drugs at the end of her pregnancy, her child is at risk for Neonatal Abstinence Syndrome (NAS). Some of the potential long-term effects for children who have been exposed to prolonged drug use prenatally are described in the discussion about NAS (refer to section M, #3). Children exposed to drugs prenatally require assessment and follow-up. Many do very well.

SECTION M

Drug and Alcohol Related Diagnoses

1. ALCOHOL-RELATED NEURODEVELOPMENTAL DISORDER (ARND)
   ARND is a disorder caused by maternal drinking during pregnancy. It is diagnosed when signs of central nervous system damage are present following fetal alcohol exposure and the other characteristic features (facial characteristics and delayed prenatal or postnatal growth) of Fetal Alcohol Syndrome (refer to section J, #2) are absent. Due to damage sustained by alcohol prenatally, children with ARND may have difficulties with learning, memory, attention, and judgement, poor impulse control, and poor social skills.

2. FETAL ALCOHOL SYNDROME (FAS)/PARTIAL FETAL ALCOHOL SYNDROME (PFAS) was formerly called FAE.
   FAS/PFAS are disorders occurring as a result of maternal alcohol consumption during pregnancy. Although diagnosis, treatment and support can improve outcomes for children with FAS/PFAS the effects of prenatal alcohol use are permanent. There is no conclusive information available to determine how much alcohol consumed at which stage of a pregnancy will predict a diagnosis of FAS/PFAS. Other factors thought to contribute to the effects of prenatal alcohol exposure include the mother's prenatal diet and health and her genetic make-up which determines how she metabolizes alcohol. There is no known safe amount of alcohol consumption during pregnancy.

   To be diagnosed with FAS, a child must be exposed before birth to alcohol and meet all of the following three criteria:

   a) Specific facial characteristics, such as short eye slits and a smooth elongated space between the nose and lip.
   b) Slow growth rates in utero and after birth.
   c) Evidence of central nervous system damage. Most children will exhibit mild to severe learning disabilities in addition to behavioural and emotional problems that may evolve and change with each developmental stage. They may have difficulty adapting to changes in conditions and circumstances. The impact of alcohol exposure on the I.Q. of children with FAS and PFAS can vary from mild to significant.

FAS without Confirmed Alcohol Exposure is the diagnosis given when a child has all of the characteristics of FAS but there is no way to verify the mother's alcohol use.

Partial Fetal Alcohol Syndrome (PFAS) is identified when it is known that a child has been exposed to alcohol before birth and has met any two of the three criteria for diagnosing Fetal Alcohol Syndrome (FAS). Although these children may have fewer physical effects, problems of the central nervous system (brain damage) may be just as severe as for the child with FAS.

Characteristics of Children with FAS and PFAS
The following are a few of many general indicators of patterns that are seen in some, but not every child, depending on many factors including the health and experiences of both the child and mother. Some effects become evident at an earlier age than others.

Infants with FAS and PFAS can be irritable and may have problems feeding and sleeping. They may also have some motor and speech delays.
Pre-school children may continue to have motor, speech and learning delays. They often have difficulty with transitions and can become easily frustrated. They may have little sense of danger and personal safety resulting in risk taking behaviour. They benefit from early diagnosis, supervision and consistent structure and routine.

Children ages six to twelve may need assistance with their social and learning needs that can include an inability to think abstractly and difficulty relating consequences to their behaviour. They can be disruptive and hyperactive, and may have difficulty focusing and paying attention.

Adolescents with FAS/PFAS may require support with their leaning needs and social relationships. Impulsivity and distractibility are common characteristics. They may have difficulty with critical thinking and abstract reasoning and may require personal attention at home and at school to structure learning and social environments that enhance their opportunities for success.

3. NEONATAL ABSTINENCE SYNDROME (NAS)

Neonatal Abstinence Syndrome (NAS) is the medical diagnosis given when a baby exhibits the medical and behavioural signs of withdrawal from substances such as opiates, cocaine, amphetamines, alcohol and other drugs. Most drugs pass from the mother's blood stream through the placenta to the unborn baby. Substances that cause addiction in the mother also cause addiction in the unborn baby. When the baby is born the dependence on the substance continues but since it is no longer available the baby goes through withdrawal. Although each baby may experience symptoms differently, some of the common symptoms include tremors, excessive and/or high-pitched crying, sleep problems, seizures, diarrhoea, vomiting, sweating, dehydration, poor feeding and tight muscle tone. NAS symptoms vary depending on the substance used, timing of last use, and whether the baby is premature. The specific symptoms associated with some of the different groups of drugs are described below.

Opiates

Opiates such as heroin and methadone can cause significant withdrawal symptoms, some that may last as long as 6 months. These signs usually occur between birth and 14 days of life. As infants, these children show signs of irritability and can be difficult to console. During the next six months of life they may be unable to regulate sleep and hunger patterns. There is no way to predict whether a child experiencing these problems will develop any difficulties as they mature, and there should be ongoing medical and developmental follow-up. It is known that many children respond very well to patience and consistency and may develop within a normal range.

Cocaine or Crack

Infants whose mothers used cocaine or crack are often born prematurely or with low birth weights, and are usually assessed for birth defects of the urinary tract, heart or brain. They have a higher risk of Sudden Infant Death Syndrome (SIDS) than non-exposed infants, may need medical attention for some acute or chronic conditions, and may be at risk for developmental delays and learning disabilities. Some studies indicate that with careful protection from over-stimulation, and provision of a nurturing and structured home, as well as a learning environment that provides stable and predictable routines, many cocaine-exposed children respond to their caregivers and develop within a normal range.

Each child must be assessed individually because drug exposure in itself is not a reliable predictor of future health or long term problems.

Other Prescription or Non Prescription Drugs
Depending on the amount used, children exposed to other drugs may require initial intervention for withdrawal when the symptoms appear, usually in the first two weeks of life. Medical professionals indicate that for the majority of children exposed to a number of drugs, discerning which drugs were used and the quantities of each is difficult. Studies of long term effects of other drugs are not conclusive and professionals are advising that each child should be assessed on an ongoing individual basis.

Characteristics of Children Affected by Prolonged Prenatal Drug Use
Symptoms of withdrawal from drugs may not be diagnosed at birth but some of these children may be at risk for effects later in life. Withdrawal symptoms can be, but may not necessarily be a predictor of later effects.

Effects may include sleep disturbances, a short attention span, delayed speech and language development, difficulties understanding and using information and poor impulse control. These children may find making and keeping friends a challenge. Some children may have weak muscle tone and problems with movement and co-ordination. They may not understand the relationship between their behaviour and consequences. Sudden changes or choices and making transitions from one activity to another may be difficult.

4. PARTIAL FETAL ALCOHOL SYDROME (refer to section M, #2).

SECTION N

Intellectual Disabilities

This section provides general information about children awaiting adoption whose overall functioning and development is affected by a mental disability or Down's syndrome. These children have many individual strengths and potentials. Many communities have supports

and services available for families and their children with mental disabilities. They include infant development programs, family support homemakers, daycare for children with special needs, specialized school programs and respite care.

1. DOWN'S SYNDROME
   Down's Syndrome is the term used to describe children born with an extra #21 chromosome, which causes mental disabilities and distinctive physical features. Only 4% of Down's Syndrome cases are hereditary. Down's Syndrome children are slow in their physical and behavioural development, and have unique facial and bodily features. No one child has all the possible features of Down's Syndrome. They can appear in a variety of combinations with no connection to the degree of mental disability. The level of mental functioning varies significantly. Extra stimulation and encouragement to learn during infancy and childhood help children with Down's Syndrome develop to their fullest potential. Many of these children can be educated in the regular school system, acquiring self-care skills that will contribute towards independence in adulthood. Medical concerns related to Down's Syndrome include congenital heart defects, gastrointestinal blockage, vision problems, hearing loss and susceptibility to respiratory infections. Despite some of the medical problems, it is important to emphasize that the majority of individuals with Down's Syndrome have long and fully functional lives.

2. MENTAL DISABILITY
   The term mental disability is used to describe significant deficits in an individual's intellectual functioning and social adaptive behaviour originating during the developmental period from birth to eighteen years. Levels of mental disability include mild, moderate and severe deficits based on I.Q. ranges. The vast majority of people with a mental disability are in the mild range (I.Q. 50-70). Causes may include prenatal infections, birth delivery complications, childhood illness, trauma from abuse and deprivation, accidents, toxins and genetic or chromosome disorders.

   Children who are mentally disabled are slow or delayed in all areas of development; i.e. thinking, speaking, motor skills, social-emotional growth and self-help. These children learn and progress more slowly than others and require assistance and repetition to

accomplish tasks. Pre-schoolers experience a lag in motor activities such as crawling, sitting, walking, eating and communication skills. School-age children have difficulties learning in school and utilizing intellectual skills.

SECTION O

Physical Disabilities

1. CEREBRAL PALSY (CP)
   Cerebral Palsy is the general term for a group of disorders caused by damage
   to the brain. Often the cause is not known for many cases of CP but the brain damage can occur during pregnancy, as a result of birth trauma, or as a result of complications in childhood meningitis, head trauma, or poisonings. It is a life-long condition that impacts the communication between the brain and the muscles. This irregular communication results in uncoordinated physical movement. Symptoms of CP include muscle weakness, inability to control muscle movement, muscle stiffness, spasticity (the inability of a muscle to relax) of the arms or legs and/or balance and coordination problems. Each individual with CP experiences symptoms differently and to varying degrees of severity. The muscle difficulty may compromise one limb or all four.

   Children with CP may have additional difficulties that may include seizures, vision, hearing or speech problems, learning disabilities, behaviour problems, mental disabilities, respiratory problems, bowel and bladder problems and bone abnormalities such as scoliosis. Infants with CP may be slower to reach developmental milestones such as rolling over, sitting, crawling or walking. Because CP is a life-long condition, the focus of support and treatment is on preventing or reducing physical deformities and providing opportunities to improve the child's functioning at home and in the community.

2. ORTHOPAEDIC IRREGULARITIES
   a) Club Foot-an irregularity of the foot and ankle. Most commonly, the foot is positioned downward and inward. Minor problems can be corrected through exercise. More complex problems could require a cast or surgery.

b) Polydactyl-a child born with extra fingers or toes. These are removed through minor surgery.
c) Syndactylia-a fusion of the skin or bones of two or more fingers or toes which can be corrected with minor surgery.
d) Absence of a limb.

3. SPINA BIFIDA
Spina Bifida is a condition where some of the vertebrae of the spinal cord are not completely formed and the spinal cord and its coverings usually protrude through the opening. Early surgical correction can help prevent infection, but cannot correct the condition. Spina Bifida is associated with a range of disabilities including physical abnormalities and learning difficulties. Sometimes a child with Spina Bifida will also have a condition called hydrocephalus (refer to section P, #14).

SECTION P

Medical Diagnoses (Physical/Mental/Behavioural)

1. AIDS – (Refer to section P, #14 HIV Positive)

2. ALLERGIES – Other

3. ALLERGIES - Pets

4. ALLERGIES - Smoking
An allergy is a condition in which a person has an unusual reaction to substances that are ordinarily harmless. These may be taken into the body by being inhaled, swallowed or through contact with the skin. The best treatment for allergies is the complete removal of the cause or causes of the allergy from the environment of the person involved. If this is not possible, medication can help alleviate symptoms. Many of the substances which cause allergies are found in food, so special diets are common.

5. ANXIETY DISORDER
Anxiety Disorders is the general term given to a number of disorders that are characterized by anxiety that is chronic and pervasive enough to impair an individuals daily functioning. Anxiety Disorders have both psychological and physiological components. There are a number of specific Anxiety Disorders

that include Panic Disorders, Agoraphobia, Specific Phobia, Social Phobia or Social Anxiety Disorder, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder, Acute Stress Disorder, Generalized Anxiety Disorder, and Separation Anxiety Disorder. Psychological symptoms include feelings of apprehension and worry that occur without a known reason or are out of proportion to the precipitating event or circumstance. Some of the physiological symptoms are jitters, twitches, tremors, sweating, racing heart, diarrhea, dizziness, and temperature fluctuations.

Although children and adolescents can develop any of the Anxiety Disorders, some are more common among these populations than others. Separation Anxiety and Specific Phobia are more common in younger children. Social Phobia or Social Anxiety Disorder and Generalized Anxiety Disorder are more frequently diagnosed in older children and adolescents. Depression often occurs concurrently with Anxiety Disorders, particularly in adolescents.

A child or adolescent with an Anxiety Disorder will usually experience both the psychological and physiological symptoms of anxiety. These symptoms vary with the specific disorder and often manifest differently in young people than in adults. Some of the following symptoms are specific to certain disorders but provide some examples of how children and youth may exhibit anxiety. These include trouble sleeping, nightmares, frequent stomach aches, fear of separation from parent, school refusal, fear of embarrassment or making mistakes, constant anxiety about school performance or friendships, seeking a lot of reassurance and excessive fear of something specific. The symptoms of clinical anxiety create difficulties for children and adolescents in their daily functioning. However, research indicates that Anxiety Disorders are highly treatable with therapy and/or medication.

The prevalence of each of the Anxiety Disorders varies but Anxiety Disorders, as a group, are the most common mental illness in America. Family members of individuals with an Anxiety Disorder generally have a greater risk of developing the disorder than the general population. There is some research that indicates that there may be a genetic component to some of the Anxiety Disorders including Panic Disorder and Generalized Anxiety Disorder.

6. ASPERGER'S DISORDER

Aspergers is part of a general category called Pervasive Developmental Disorders. It has some striking similarities to Autism (refer to section P, #9) although there are some distinctive differences. The essential features are **severe** and **sustained** impairment in social interaction and the development of restricted, repetitive patterns of behavior or interests. Unlike Autism, individuals with Aspergers do not usually have significant delays in language or cognitive development. Often Aspergers becomes more apparent over time because the impairment is in social functioning rather than cognitive and language delays.

There are a number of characteristics or behaviours that may be present. These include clumsiness, over-activity, and inattention. Many individuals with Aspergers have good verbal skills, however, communication and relationships are often hindered by the individuals inability to understand non-verbal cues, a lack of social or emotional reciprocity, and intense preoccupation with a particular topic often excluding other opportunities. Individuals with Aspergers have been described as "eccentric" and are often socially isolated.

Aspergers is 5 times more likely to occur in the male population. Although there is limited information regarding the familial pattern of Aspergers, there does appear to be a greater frequency of Aspergers among families of individuals with the disorder. Research indicates that many individuals with Aspergers are able to maintain employment and live independently.

7. ASTHMA

The word asthma is derived from the Greek word meaning "gasping". Asthma may be defined as an allergic disorder of the respiratory system in which the airway becomes temporarily constricted. An asthmatic attack is characterized by violent coughing, wheezing, shortness of breath, and general difficulty in breathing. There is no known cure for asthma. However, there are measures that can be taken to control the effects, allowing the person to carry on a reasonably normal life. Some children outgrow the problem without any particular treatment. Children showing symptoms of asthma should be treated medically at an early age to avoid permanent damage to the lungs and chest wall.

8. ATTENTION DEFICIT HYPERACTIVE DISORDER (ADHD)
   The crucial features of Attention-Deficit/Hyperactivity Disorder (ADHD) are inattention, hyperactivity and impulsivity. Many individuals exhibit both inattention and hyperactivity-impulsivity. However, there are some that exhibit a pattern of behavior that is predominantly characterized by one or the other. These patterns are differentiated through the three subtypes of ADHD. They are Combined Type, Predominantly Inattentive Type (previously known as ADD) and Predominantly Hyperactive-Impulsive Type. The pattern of behavior must be present in more than one environment and must persist for at least six months.

   Depending on the subtype, children with ADHD may have a hard time sitting still, focusing on a task, or thinking before they act. There are many associated features that may coincide with ADHD. Some of these are a low frustration tolerance, peer rejection, and low self-esteem. They can create significant barriers to school adjustment and constructive relationships. The inconsistency of a child's symptomatic behavior often causes others in the child's life to believe that the behaviour is intentional. As a result, it is not uncommon for the child's relationships with others to be characterized by conflict. This can result in emotional distress and frustration for all concerned.

   There are a number of associated disorders that are often present with ADHD. These include Oppositional Defiant Disorder or Conduct Disorder, Mood Disorders, Anxiety Disorders and Learning Disabilities. ADHD is diagnosed more frequently in males than females.

   Many individuals with ADHD have a family history of ADHD. There is some research that suggests there may be a genetic role in levels of hyperactivity, impulsivity and inattention. A child's environment and relationships can play a role in reducing the level of impairment to daily functioning. Treatment approaches for ADHD include provision of education about ADHD, creation of a team (e.g. parents, health care professionals, teachers, child or youth etc.) to devise and support management strategies that minimize challenges, therapy and medication. For most people, the symptoms of ADHD improve during later adolescence and into adulthood.

9. AUTISM

Autism or Autistic Disorder, along with Aspergers, is one of the disorders in the broader category called Pervasive Developmental Disorders. It is a complex developmental disability that becomes apparent in the first three years of life. The essential features of Autism are **significant** and **ongoing** impairment in social interaction and communication as well as a very restricted (through preoccupation or repetition) range of activities and interests. Many individuals with Autism exhibit a delay or complete lack of development in verbal language. In most cases there is also a mental disability that can range from mild to profound. The manifestations of these features vary and are dependent on the developmental level and chronological age of the individual.

There are a wide variety of behavioral symptoms that may be present. Some of these are hyperactivity, short attention span, impulsivity, aggressiveness, temper tantrums, and self-injurious behaviours. Some individuals with Autism may respond differently to sensory stimuli. There may be high tolerance for pain or sensitivity to sound and touch. It is important to remember that Autism is a spectrum disorder. Although Autism is defined by a certain set of characteristics, individuals with Autism can exhibit a wide array of combinations of characteristics ranging in degree from mild to severe.

Autism is 4-5 times more likely in males than females. However, females with Autism are more likely to exhibit a more severe mental disability. The cause of Autism has not been confirmed but many believe that it is caused by abnormalities in brain structure or function. Research continues to explore possible hereditary or genetic links in relation to Autism. It is known that 5% of siblings of individuals with Autism also have Autism. Follow-up studies indicate that only a small percentage of individuals are able to live and work independently as adults.

10. DIABETES

Diabetes is a condition that occurs when the body either does not make enough insulin or it does not use the insulin properly. Insulin's job is to ensure that the glucose (sugar) from the food you eat gets to your cells in order to fuel them to generate energy. When insulin doesn't do its job, the blood glucose levels get too high and cause diabetes.

The two types of diabetes that can occur in children and youth are Type 1 and Type 2 Diabetes.

Type 1 Diabetes: This was formerly called juvenile diabetes because it is usually diagnosed in children, youth and young adults. It occurs when the body does not make insulin like it should. Some of the treatments include insulin shots, controlled diet, regular exercise and controlling blood pressure and cholesterol.

Type 2 Diabetes: This was previously called adult-onset diabetes (although it can be diagnosed in childhood) and is the most common form. It occurs when the body does not use insulin properly. The treatments are similar to Type 1. Although Type 1 treatment always includes insulin treatment, Type 2 may not require it.

Diabetes is a serious chronic disease with no cure. However, with careful management some of the health complications such as heart and kidney disease can be delayed or avoided. Those living with Diabetes can live active and independent lives when there is a commitment to the management strategies required to maintain health.

11. EATING DISORDER

There are two general categories of eating disorders. The first is Feeding and Eating Disorders of Infancy or Early Childhood. These are characterized by an **ongoing** disturbance in feeding or eating. The specific disorders include Pica, Rumination Disorder and Feeding Disorder of Infancy or Early Childhood. Pica is related to eating non-food items such as plastic, paper, sand or pebbles for a sustained period of time. Rumination Disorder is repeated regurgitation and re-chewing of food after feeding after a period of normal functioning. The Feeding Disorder of Infancy or Early Childhood is characterized by failure to gain weight or significant weight loss related to inadequate caloric intake. For most children these disorders improve with time although in severe cases it can continue into adulthood.

The second category is Eating Disorders. The three disorders within this category are Anorexia Nervosa, Bulimia Nervosa and Eating Disorder Not Otherwise Specified. Anorexia Nervosa is

characterized by a refusal to maintain a “normal” body weight, a fear of becoming fat, and a distorted perception of the shape or size of ones body. There are two subtypes that describe the type of weight loss measures used by the individual.

Restricting Type: This means that weight loss occurs through dieting, fasting, or excessive exercise.

Binge-Eating/Purging Type: Individuals may regularly engage in binge-eating **and/or** purging.

For severe cases of Anorexia Nervosa hospitalization may be required in an attempt to restore weight to a normal level.

Bulimia Nervosa’s primary features are binge eating and the use of “inappropriate compensatory methods” to combat weight gain. As with Anorexia, there are two subtypes.

Purging Type: This specifies the presence of vomiting or use of laxatives or diuretics as a means to control weight.

Nonpurging Type: This indicates that other methods such as fasting or excessive exercise have been used.

Eating Disorder Not Otherwise Specified is a diagnosis used for disordered eating that does not meet all the criteria for other eating disorders.

Approximately 90% of those with Anorexia or Bulimia are female. The long-term outcomes for both of these disorders are highly variable and range from full recovery to a chronic and sometimes intermittent pattern of behaviour. Severe and persistent cases of Anorexia can result in death from starvation or electrolyte imbalance.

12. EPILEPSY/SEIZURES

Epilepsy is a disorder of the nervous system. The person with epilepsy has a tendency to have seizures, caused by erratic, uncontrolled electrical discharges in the brain. The three most common types of epilepsy are Grand Mal Seizures, Petit Mal Seizures, and Psychomotor Seizures. Anti-convulsive drugs can control most epileptic seizures. These drugs usually allow the person with epilepsy to lead a normal, productive life.

13. FAILURE TO THRIVE
    This term is used to describe infants and children who fail to gain weight or even lose weight without any apparent cause. "Failure to thrive" is considered to be a form of "infant depression" caused by emotional deprivation or environmental disruptions.

14. HIV POSITIVE/AIDS
    The Human Immunodeficiency Virus, or HIV, is the agent responsible for causing Acquired Immune Deficiency Syndrome (AIDS). As it progresses, HIV damages the white blood cells that protect us from disease. This weakens the immune system and leaves the individual vulnerable to "opportunistic infections" and other illnesses. AIDS is diagnosed when an individual is HIV positive and has experienced one or more "opportunistic infections" or illnesses and/or their immune cell count has fallen below a certain level.

    Infants born to HIV positive mothers will be HIV positive at birth. Because it takes babies 15-25 months to develop their own immune systems, these children should be tested every six months for the first two years of their lives. If, at the end of that time, they continue to test HIV positive, they have been infected and will likely develop symptoms of AIDS during their early years of life. If they test HIV negative, they have not been infected and have no further risk of becoming HIV positive from the pre-natal contact.

    Approximately 50 percent of infants who are HIV positive will experience some developmental delay, or loss of previous developmental achievements. These are expected to worsen as the disease progresses. They may also lose muscle tone and the ability to walk without support. Many children experience speech problems, such as poor pronunciation. Accompanying these problems will be other signs of symptomatic HIV infection, such as chronic fever, diarrhoea, poor growth, and various bacterial infections. The course of AIDS is different for each individual. Some individuals live only a short time after becoming infected and others live relatively normal lives for many years. The life expectancy for children born with HIV is increasing with the discovery of new treatments.

15. HEART DEFECT
    Some heart defects present at the time of the child's birth may be self-correcting, while others require surgery and annual monitoring. For the most part these children lead healthy, normal lives. In serious cases, a child's heart condition may require extensive medical intervention and daily monitoring by parents over a number of years.

16. HEPATITIS B
17. HEPATITIS C
    The Hepatitis B virus (HBV) causes the liver to become inflamed. Although many people fight off the infection, chronic infection occurs in 90% of infants infected at birth; 30% of children infected between the ages of 1 and 5; 6% of those who are infected after 5 years old. HBV can progress to chronic liver disease, cirrhosis and less frequently, liver cancer. Signs and symptoms of HBV include jaundice, fatigue, abdominal pain, loss of appetite, nausea, vomiting and joint pain. They are less common in children than adults. Individuals with chronic HBV are often treated with medication.

    HBV is more contagious than HIV and is transmitted when blood or body fluids from an infected person enter the body of a person who is not immune. The best protection against Hepatitis B is the vaccine.

    Like Hepatitis B, the Hepatitis C virus (HCV) also causes inflammation of the liver. Initial infection of HCV often goes undiagnosed and may not be discovered until years later. Although approximately 15% of those with acute HCV infection recover, an estimated 75-85% have chronic infection and at least 70% of chronically infected persons have chronic liver disease. Because HCV stays in the body for an extended period of time it can cause chronic liver disease. Chronic liver disease often develops over many years resulting in complications such as cirrhosis (severe scarring of the liver) and cancer of the liver. Chronic progressive liver damage caused by HCV can cause end-stage liver failure. This is the leading cause of referral for liver transplants.

    HCV is transmitted when blood or body fluids from an infected person enter the body of someone who is not infected.

Unfortunately there is no vaccination to prevent HCV. Chronic HCV presents in a variety of ways ranging from mild to severe. There are those who have no signs or symptoms of liver disease, who sustain only mild damage to the liver and have a good prognosis. Others experience the range of symptoms and eventually develop cirrhosis and end-stage liver disease. Many with HCV are somewhere in the middle of these extremes.

The signs and symptoms are similar to those of HBV. They include jaundice, fatigue, dark urine, abdominal pain, loss of appetite, nausea and joint pain. 80% of people with HCV have no signs or symptoms. Drug treatment can get rid of the virus in some individuals.

18. HYDROCEPHALUS
    This condition, usually diagnosed at birth or shortly thereafter, is characterized by the abnormal accumulation of spinal fluid within the brain. The accumulation of fluid leads to an increase in head size and causes pressure against the brain tissue. This pressure has the potential to cause permanent brain damage. Early treatment, which involves implanting a shunt to drain fluid from the brain, and good medical management, can reduce or eliminate the risk of brain damage.

19. MOOD DISORDER (Refer to section K, #6)

20. PERSONALITY DISORDER
    Personality can be thought of as a characteristic pattern of behaving, feeling, thinking, and perceiving. Personality traits are considered to be a Personality Disorder when they are inflexible and maladaptive to the extent that they cause significant impairment in an individuals social and occupational functioning. Often Personality Disorders are characterized by emotional distress either in the individual with the disorder or in those around him or her.

    There are 10 specific Personality Disorders. They are divided into three clusters. Those in the first cluster are characterized by odd and eccentric behaviour. Disorders in the second cluster are identified by dramatic and highly emotional behaviour while anxiety and fear distinguish those in the third cluster.

Generally the features of a Personality Disorder become apparent by adolescence or early adulthood. Children and adolescents can be diagnosed with a Personality Disorder but it is important to note that characteristics of a Personality Disorder that arise in childhood often do not continue into adulthood. The long-term course of Personality Disorder is dependent on the particular disorder. Some types tend to diminish with age while others do not. Although some of the Personality Disorders are more common among first-degree biological relatives than in the general population, the role of genetics is unclear.

21. REACTIVE ATTACHMENT DISORDER

The essential feature of Reactive Attachment Disorder (RAD) is a pattern of disturbed and developmentally inappropriate social interactions that is evident by the time a child is 5 years old. By definition, RAD is associated with persistent neglect of a child's emotional and/or physical needs as well as frequent changes in a child's primary caregiver. RAD can result when a child's bonding process with a primary caregiver is interrupted during the early stages of development. A child with RAD may respond to this interruption in several ways. RAD has two subtypes that describe these responses. Inhibited Type: These children do not initiate or respond to social interactions in a manner that is considered to be developmentally appropriate. They may be extremely watchful, inhibited or inconsistent in their responses to others.

Disinhibited Type: These children are socially uninhibited and may appear to be indiscriminate in their choice of attachment figures. They may be overly friendly or affectionate with strangers.

There are a number of emotional or behavioral characteristics that have been associated with RAD. Some of these characteristics are a lack of trust, inability to give and receive affection in a consistent and healthy way, and a need to control their circumstances.

It is important to note that abuse and neglect does not always result in the development of an attachment disorder. In fact, RAD appears to be quite uncommon. The severity of RAD throughout the lifespan varies. Some key factors are the severity and duration of the neglect and the type of intervention. Significant improvement can occur if an "appropriately supportive environment" is provided.

22. SCHIZOPHRENIA (Refer to section K, #7)

23. SHORT LIFE EXPECTANCY
    This applies to children whose diagnosed medical condition means that their life expectancy is short.

SECTION Q

Developmental Delay

1. MENTAL DEVELOPMENTAL DELAY
   Mental Developmental Delay is when a child is achieving the normal developmental milestones, but at a later age than is normally expected. The child may be delayed in the areas of speech and language, cognition and/or social-emotional growth. Though the child is late in achieving a developmental skill, it is accomplished in a normal manner. Mental Developmental Delays can be displayed by some premature infants up to a certain age, caused by brain or nerve damage and/or by abuse/neglect/ trauma.

2. PHYSICAL DEVELOPMENTAL DELAY
   A child is developmentally delayed when he/she is achieving the normal developmental milestones but at a later age than normally expected. The child may be delayed in the area of motor skills such as rolling, sitting, crawling and walking.

SECTION R

Other Special Needs

1. FACIAL IRREGULARITIES
   Cleft Lip and Palate-Cleft lip is a separation or slit in the upper lip. This condition ranges from a minor notching of the upper lip to a complete slit which extends from the edge of the lip to the nostril, and involves the bone that forms the framework for the upper gums and teeth. It may occur on one side or both. Cleft palate is a length-wise slit in the roof of the mouth, forming one cavity for the nose and mouth. It may be minor (affecting only the back part of the roof of the mouth) or complete. This abnormality can affect the development of teeth, and also affects speech and nutrition.

Birth Marks/Port Wine Stain-Strawberry marks due to an overgrowth of blood vessels in a confined area. They may be found on any part of the body, may be flat or raised, and may range in colour from light red to blue/black. Some are permanent while others gradually fade away. A skin specialist should be consulted.

2. FEEDING/SPECIAL DIET ADMINISTRATION
   Some children have medical conditions that require them to be tube-fed. These are not life threatening health concerns, but are time-consuming daily administrations for adoptive parents. Special diets, which can be costly, can require separate preparation from the family meal and constant monitoring.

3. USES WHEELCHAIR
   This category refers to children who use a wheelchair for mobility. These children will require a home that is wheelchair accessible.

4. WALKS WITH ASSISTANCE OR MOBILITY AID
   This category refers to children who do not use a wheelchair but need the assistance of another person or use a mobility aid such as a walker or crutches.

SECTION S

Sensory Loss

1. HEARING IMPAIRED
   This refers to the child who is deaf, or whose sense of hearing is non-functional. For these children primary communication occurs through signing.

2. VISION IMPAIRED
   This refers to the child who has a vision impairment severe enough to be considered legally blind.

SECTION T

Learning Disabilities

Learning Disabilities (LD) is the name given to a collection of learning problems that children may have, especially when mental disability

has been ruled out. LD children may be hyperactive, have perceptual-motor problems, attention problems, or disorders of memory and conceptual thinking. There is no agreement among the experts on the cause(s) of LD or its treatment.

1. ORAL LANGUAGE OR SPEECH IMPAIRMENT
   Speech impairment may include difficulty in producing speech sounds, maintaining speech rhythm, or controlling voice production. Problems in producing speech sounds are known as articulation disorders and may be characterized by omissions, substitutions, distortions or additions of speech sounds. Causes may be functional, such as having poor speech models, or organic, such as having a significant hearing loss. Problems in maintaining speech rhythm include stuttering and cluttering. There are many theories as to their causes. Voice disorders are characterized by a significant deviation in voice quality, pitch, intensity, or flexibility from the societal standard. All of these problems should be referred to a speech therapist for evaluation and correction.

2. READING/WRITING
   Reading disabilities are by far the most common form of learning disability. Since reading is the first skill in the development of the language arts, reading problems temporarily precede spelling and written expression problems. A child with language arts problems often has difficulties with handwriting and arithmetic as well.

SECTION U

Child has Experienced

The Ministry of Children and Family Development and the Regional Child and Family Development Authorities are involved in adoption planning for children who have experienced abuse (emotional, physical, sexual) and/or neglect (physical, emotional). Some of these children may have been separated from their birth families as well as from relatives and other significant people in their lives. Older children may experience a series of separations from different caregivers before they are placed with their adoptive family. The combination of traumatic experiences caused by abuse, and the loss of or separation from familiar and significant people contributes to a child's

vulnerability in adoption. Adoptive applicants who are planning to adopt a child from an abusive background need to have a realistic idea of what the child may have been through. The following broad discussions of the background factors that a child may have experienced are intended to give adoptive applicants some general information and exposure to the types of pre-placement histories of many of the children who are registered for adoption.

1. ABUSE - EMOTIONAL
   Emotional abuse is the chronically abusive behaviour by adults that injures the intellectual, psychological and emotional capacity of the child. This abuse can inhibit a child's ability to develop into an emotionally healthy adult.

2. ABUSE – PHYSICAL
   Physical abuse is the infliction of physical force that is non-accidental and beyond reasonable discipline upon a child. Physical injuries inflicted on children include: bruises, burns, broken bones and/or multiple injuries.

3. ABUSE - SEXUAL
   Sexual abuse is inappropriate sexual behaviour towards children. Sexual abuse of children most frequently involves adults, but can also involve older children or siblings, or youth. Mutual consensual sexual exploration between children or youth of similar ages is not considered sexual abuse.

   Sexual abuse includes sexual touching, sexual intercourse, sexual exploitation, sexual assault and incest. Children are dependent upon their family unit for emotional and physical security. The sexual abuse of children exploits children's needs for affection and approval, and their natural sexuality. The majority of children that are sexually abused are abused by someone they know. Children who have been sexually abused can be affected physically, developmentally and psychologically. They are at increased risk for sexual abuse by others because of their earlier experiences and emotional vulnerability. Therapy may be useful in helping children cope and manage the trauma associated with sexual abuse.

4. DETRIMENTAL PARENTING
   Parents of children in care may struggle with circumstances, disabilities or addictions that interfere with their parental

responsibility to meet the needs of their children and to provide a physically and emotionally stable and secure environment. These parents may be unaware, disinterested, or unable to deal with the effects of their circumstances on their children. Often children raised in these circumstances develop survival behaviours in order to cope with their stressful family environment. For example, the child may take on the parenting role for running the household and caring for younger siblings. The child's survival behaviours can create conflict for them and their adoptive parents as they adjust to traditional family roles and expectations.

5. MULTIPLE CAREGIVERS/ATTACHMENT ISSUES
   Attachment and separation are significant issues that affect the majority of children in the ministry's care who await adoption. For many of these children, the normal developmental attachment process has been disrupted by separation from parents and/or caregivers, often on more than one occasion.

   Separation from parents or caregivers to whom they are attached is traumatic for children. They may experience a range of intense feelings in relation to their individual circumstances. Many factors can influence a child's reaction to separation. These include the nature of the child's attachment to their caregivers, the circumstances of the separation, the environment they are leaving, and the child's perception of the reason for the separation. Abrupt separations for children create grief and loss issues that can, if unresolved, interfere with new attachments. Each new placement has an element of uncertainty for a child. Many children in foster care have lived in numerous placements. This contributes to the child's stress and anxiety, inhibits the development of trust in relationships and may impede the development of self-reliance. Some infants and children who have been severely neglected and abused have never formed primary attachments (refer to section P, #21). These children may have difficulty developing and maintaining relationships.

6. NEGLECT
   Child neglect is the gross lack of attention to the physical and/or emotional needs of a child by their birth parents or caregivers. Physical neglect is the failure to provide a child with the basic physical needs of food, clothing, shelter, safety, supervision,

education and medical attention. Abandonment of the child is also a form of neglect by an adult caregiver. Emotional neglect is the gross lack of attention to a child's emotional and social needs. Overall neglect can cause mental and physical developmental delays, failure to thrive, attachment issues, malnourishment, medical concerns and emotional/behavioural disturbances.

SECTION V

Child Exhibits

In this section, you are asked to consider some of the emotional and behavioural characteristics of children who have some of the special needs and experiences identified on the questionnaire. Children who experience trauma through abuse and separations react in different ways. These reactions may be displayed through behaviours such as anxiety, lying, stealing, temper tantrums, bed-wetting, soiling, nightmares, aggression, hyperactivity, destructiveness, withdrawal, profound dependency, inappropriate sexual behaviourand the use of drugs and or alcohol. For some of the children, the behaviours listed in Section V are transitory as they adjust to the changes in their new adoptive home. For other children, these behaviours are serious and chronic. Although there are many explanations for serious behaviour problems in children, we cannot predict or say with certainty that a specific trauma results in a specific behavioural response. It is important to recognize that these "acting out" behaviours are symptoms of abuse, not the actual problem. The abused child has learned not to trust feelings or communication. Many abused children believe they are responsible for their abuse because they assume they are bad. Their needs, values and interests have not been respected. Their behavioural reactions are often expressions of their underlying feelings of anxiety, rejection and shame. Past traumatic experiences can revisit and affect the child at different stages of development.

Some behaviours which become serious and chronic are extremely stressful for adoptive families. Parents and families all have different levels of acceptance and coping related to their expectations, lifestyles, resources and support systems. Openness to services provided by outside professional help can be both supportive and beneficial to the child and his or her adoptive family.

SECTION W

Knowledge and/or Experience with Special Needs

This section is to be completed by those adoptive applicants who are familiar with and/or have experience with specific special needs not mentioned on the questionnaire, and would consider parenting a child with these needs. Please provide a brief description of your knowledge or experience.

SECTION X

Acceptance of Openness

Section X addresses the concept of openness in adoption with birth family members, previous caregivers, and other significant individuals in the child's life. Adoptive applicants have the opportunity to indicate on their questionnaire the types of adoption openness they would consider in the initial adoption application process. When the adoptive applicants' homestudy is requested, their social worker will explore in depth the extent of adoption openness they wish to have.

Changing social attitudes and the complex and lifelong nature of adoption have led to the recognition that there is a desire and a need for more communication and participation in the adoption process by adoptive parents, birth family members and adoptees. Openness in adoption makes it possible for many forms of information sharing and contact to take place between adoptive parents and those who have important and significant relationships to the adoptee. The type of adoption arrangement is the choice and mutual decision of the adoptive parent(s) and the other party with whom the openness agreement is with. There is a range of options involving different levels of openness available. These take into account the unique circumstances of each adoption and include:

i. SEMI-OPEN ADOPTION
   A semi-open adoption is an adoption in which a variety of contacts can occur between the parties to the agreement for any length of time before and/or after the adoption order is granted, but does not involve an exchange of identifying information of either party. Examples of semi-open adoption include:

Prior to adoption placement:

- a meeting or phone contact between adoptive parents and birth parents or foster parents (without identification);
- visiting the infant in hospital.

Prior to an adoption order during the probation period:

- birth parents and/or foster parents can provide pictures and/or letters for the child;
- adoptive parents can provide progress letters about the child's development to the other party participating in the openness agreement;
- birth parents are advised of the first name given to the child by the adoptive parents;
- adoptive parents are advised of the first name given to the child at birth.

After the adoption order is granted:

- letters, gifts and photos can be exchanged through the Ministry of Children and Family Development Openness Exchange Registry.

ii. FULLY DISCLOSED ADOPTION

Fully disclosed adoption includes various contacts and information sharing between adoptive parents and the other party to the agreement before and/or after the adoption order. This involves the exchange of identifying information. Examples of fully disclosed adoption include all of the options described in semi-open adoption. There is also the possibility for ongoing contact throughout the child's growing years and the child may know the identity of the birth parent(s).

Openness in adoption is increasingly becoming a part of the adoption plan for children who are separated from their families and are continuing custody wards in foster care. For many of these children, significant relationships and family ties have developed that cannot be overlooked. Their background and experiences are an integral part of their identity and security. In some situations, social workers may recommend direct and/or indirect contact between the adopted child, the adoptive parents

and the birth parents or relatives, where it is appropriate. The degree of adoption openness would be mutually agreed upon by the adoption parties involved, and where it is desired by and in the best interests of the child.

Adoptive applicants may want to gather information about openness in adoption by talking to their adoption social worker, reading the available articles and literature on open adoption, contacting adoptive parents, adoptee and birth parent organizations, or attending workshops on open adoption.

SECTION Y

Access Orders
Acceptance of

1. Access Orders
   Some of the children who are in continuing care under the *Child, Family and Community Service Act* have an access order entitling significant individuals (usually birth parents or relatives) to specific contact with the child even though they are permanently in the care of a Director. Although access orders usually terminate when an adoption order is granted it is possible for an access order to continue following the adoption order if the court considers it is in the best interest of the child to do so. Access Orders are legally binding and any changes to vary the contact specified in the access order following the adoption order need to return to Supreme Court. This can be a time consuming and costly process.

2. Defacto Access
   Defacto access occurs when a person has had access to a child when there is no formal order for access through the court. Individuals with court ordered access and with defacto access are entitled to written notice when adoption is the plan for a child in continuing custody. Please check the types of access you are willing to consider.

SECTION Z

Birth Family Information

Often the full medical and social histories of the birth parents of children registered for adoption are not available or are incomplete. In many cases the medical and social history is available for one birth parent but not the other. When this information is missing it is not possible to be forewarned of potential genetic or health risks that may impact the child during his/her lifetime.

Each box you check identifies that you are willing to accept the unavailability of that information.