North Dakota Permanency Survey
Final Report

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Team Background:

The North Dakota (ND) Department of Human Services (DHS) has contracted with a private agency to administer the North Dakota Post Adopt Network since 2016. Catholic Charities North Dakota is the current contracted agency. In 2020, DHS began a partnership with the Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG), a Children's Bureau grant administered by Spaulding for Children. A team was created through this partnership that included the DHS Adoption Services Administrator, Catholic Charities North Dakota program leadership and a consultant from the QIC-AG. This team, referred to as the ND QIC-AG Team, coordinated a series of projects to further develop the services and supports offered by the North Dakota Post Adopt Network. The ND QIC-AG Team was expanded through a collaboration with University of North Dakota (UND) to support the administration of the ND Permanency Survey. In addition to the Principal Investigator (PI) and Co-PI for the Survey Project, a faculty associate with clinical expertise in the field assisted with interpretation of survey responses.

Target Population:

All adoptive and guardianship families with children under the age of 21 in the state of North Dakota were eligible for the target population. Although the total number of all eligible families in the state was difficult to determine, the research team utilized multiple ways and various channels to reach out to target families in North Dakota. First, we invited families (approximate N=1,000) via a mailing list from the North Dakota Department of Human Services that contains the adoption subsidy and/or guardianship assistance check and/or remittance to over 1,600 children. Second, we distributed introductory and invitation emails via the North Dakota Post Adopt Network to members of their email distribution list (approximate N=500). Most of these families also received the postal mailing from the North Dakota Department of Human Services described above (may have overlapped). Third, we also posted the introduction and invitation information on the North Dakota Post Adopt Network website, social media, and/or in North Dakota Post Adopt Network Newsletters to advertise the survey opportunity. Lastly, families who adopted a child through a private agency, either domestically or intercountry, were also invited if contact information was previously obtained.

Primary Research Objectives:

This is the North Dakota Permanency Survey project at baseline. Adoptive parents and guardians were asked to answer questions about one adoptive child in their home, referred to as the "identified child." They were also provided with opportunity to answer survey questions on additional adoptive children in the home. The link to an online survey was sent to adoptive and guardianship families who assumed guardianship or adopted from North Dakota and had adopted children under the age of 21 in order to:

1. Develop a profile of characteristics for adoptive children and caregivers in North Dakota who responded to the survey.
2. Examine caregiver and child wellbeing and identify the strengths of the child and caregivers.
3. Identify child's challenging issues and risks/stress that impact family and child well-being.
4. Identify characteristics of families who may be at risk of post permanency discontinuity and explore the reasons behind it.
5. Explore caregivers' experiences and communications around adoption and guardianship in the past six months.
6. Explore the activities and attitudes toward connecting with the child's birth family, the perceived impacts, and the supports they have to navigate the contact.
7. Examine the role of kinship adoption on caregiver's strains and family and child wellbeing.
8. Explore the experiences of transracial adoption.
9. Identify the most needed services and the biggest barriers experienced by adoptive and guardianship families in accessing services.

North Dakota Permanency Survey:

The North Dakota Permanency Survey project took place between July 1st, 2020 to May 15th, 2021. The survey data was collected in August through early November, 2020. The questions in the ND Permanency Survey were adapted from the Vermont Permanency Survey (2017, 2019) that sought to identify the strengths, risks, and needs of families post permanency (Marra et al., 2019; National Quality Improvement Center for Adoption and Guardianship Support and Preservation, n.d.). The survey focused on the following areas of inquiry: family wellbeing, child wellbeing, caregiver wellbeing, adoption and guardianship experiences, community services, and demographics. The process of developing the ND Permanency Survey was as follows:

Determine area of inquiry: Except two new questions related to birth family contacts, most of the survey questions were adapted from the Vermont Permanency Survey to focus on assessing the following areas: basic information (e.g. family, relationship to child), child wellbeing (e.g. educational wellbeing, social and emotional wellbeing, strengths), challenging behavior, out of home care, overall impact of adoption or guardianship of the child and family, caregiver experiences over the past 6 months, adoption and guardianship experiences, contact with birth mother, birth father, and birth siblings, commitments, community services, transracial adoption experiences, and demographic questions. To keep the survey a manageable length, we removed

other questions from the original Vermont Permanency Survey. Assessing for strengths of child, caregiver and family wellbeing allows child welfare and partner agencies to identify and understand factors that may impact the family's permanency and stability. Identifying the most important services, the most needed services and the barriers that interfere with service provision inform the current strengths and areas for growth within the system of care in North Dakota.

Format survey administration: The survey was formatted to be administrated electronically using Qualtrics. A paper format was also available upon request.

Pilot test and finalize survey: The survey was piloted with some adoptive families to test the length, clarity, and relevance of the survey. Lastly, the ND QIC-AG & UND Team ran a stress test on the electronic version of the survey to ensure skip patterns and questions were displayed as intended. The online survey was implemented in 2020 (starting in late August and ending in early November).

Assertive outreach: In order to increase survey response rates and engage families with post permanency services, the ND QIC-AG Team used outreach strategies to reach families. A meta-analysis (Fan & Yan, 2010) identified factors that influence response rates in online surveys. They revealed that response rates are impacted by survey delivery factors such as sampling methods, contact delivery modes, invitation designs, informed consent methods, pre-notification letters, reminders, and incentives. They also revealed that survey completion and response rates are impacted by factors such as an individual's level of computer knowledge or web-use and whether an alternative method to take the survey is available. Based on these suggestions, the ND QIC-AG Team included an introductory letter/email, launch letter/email, reminder letter/email, and had multiple contact attempts and reminders in the assertive outreach method. The introductory letter clearly stated the purpose of the survey, asked participants for their help, provided organizational logos and letterhead to establish trust, and provided gift-card incentives. The team also prepared a paper format as an alternative method to take the survey.

Procedures:

The ND QIC-AG & UND Team first adapted the Vermont Permanency Survey, then developed communication letters and emails (e.g. introduction, launch information, and reminder) about the ND Permanency Survey, and updated and verified contact information in North Dakota Post Adopt Network Database. Second, the team determined a sample for the survey, reviewed and refined draft of the survey, and submitted the survey project for Institutional Review Board (IRB) review and obtained approval. Third, the team finalized communication tools (letters/emails), printed and inserted the introductory letter with the subsidy remittance, sent introductory emails to the distribution list of the North Dakota Post Adopt Network and promoted the survey at related activities and newsletters/websites. Fourth, the PI and Co-PI pilot tested the survey questions and displays with a small sample via survey (7 adoptive caregivers) and Zoom interviews (4 adoptive caregivers). Fifth, the team made adjustments to the survey based on the results from the pilot test. Sixth, the online survey was launched using Qualtrics in late August 2020, reminders were sent in September and October, and the survey was closed in early November 2020. All families who participated and completed the survey received a $10 gift card.

Measures:

Caregiver Strain Questionnaire:

We adapted the Caregiver Strain Questionnaire-Adoption /Guardianship Form (CGSQ-FC/AG22) (Mara et al., 2019), which is an adapted version of the Caregiver Strain Questionnaire (Brannan et al., 1997). The measure assesses the extent to which caregivers experience additional demands, responsibilities, and difficulties as a result of caring for a child who is in foster care, who is in a legal guardianship, or who was adopted (Mara et al., 2019). The measure examines three forms of caregiver strain which correspond to its three subscales namely – the objective strain, the subjective internalized strain, and the subjective externalized strain. Participants responded on a 5-point rating scale (1= not at all to 5= a great deal). Higher scores on the measure (and the subscales) show the caregiver is experiencing higher levels of strain (Brannan et al., 2012; Brannan et al., 1997). The scale demonstrated strong internal consistency ($\alpha = .92$) in this study. Additional details about the adaptations are presented below.

The CGSQ measure used for the current study contains 22 items (question/statement) compared to the 21 items in Brannan et al.'s (1997) survey. It is important to also note that the items in the CGSQ-FC/AG22 (Mara et al., 2019) are modified versions of the items originally developed by Brannan et al. (1997) with one "new" item - item "J" – "Increase in your alcohol consumption or substance use?" In computing the CGSQ-FC/AG22 measure's global score for the current study, item "J" was not included. Therefore, the global scale comprised a total of 21 items.

Subscales. The objective strain subscale examines concrete or tangible negative incidents resulting from parenting of the adopted child. The incidents include financial strain, disrupted family relations, and difficulty with neighborhood/community relations. For the current study, this subscale comprises nine items compared to Brannan et al.'s (1997) 11 items.

The subjective internalized strain subscale examines negative emotive experiences resulting from parenting of the adopted child which are however internalized. The feelings include worry, guilt, and fatigue.

The subjective externalized strain subscale examines negative emotive experiences resulting from parenting of the adopted child. In this case though, the emotive experiences which include anger and resentment are expressed outwardly (Brannan et al., 2012; Brannan et al., 1997).

For the current study, the objective strain subscale comprised nine items compared to Brannan et al.'s (1997) 11 items, the subjective externalized and internalized strain subscales also comprised three and seven items respectively compared to four and six items in Brannan et al.'s (1997) version.

Child Social and Emotional Wellbeing:

We used 10 items from the Vermont Permanency Survey to assess children's socio-emotional wellbeing (see Table 5). Sample questions included: In general, how easy or hard is it for your child to make friends? How easy or hard for your child to stay calm when faced with challenge? How easy or hard is it for your child to bounce back quickly when things don't go his/her way? Participants responded in a 4-point rating scale (1=very easy, 2=somewhat easy, 3=somewhat

hard, 4= very hard). The scale includes two dimensions that measure relationship and resilience. After reverse coding[1], higher score indicates higher level of socio-emotional wellbeing.

Caregiver Commitment Items:

We adapted five items from the Vermont Permanency Survey to evaluate the parent's commitment to their child in order to understand how families formed through adoption or guardianship from foster care fared after legal permanence. These items were originally developed by the Illinois Post Permanency Surveys and collected/tested by the Children and Family Research Center (CFRC) at the University of Illinois at Urbana-Champaign (Rolock et al., 2019). Sample questions are: "If you knew then what you know now, do you think you still would have adopted or assumed guardianship of your child?" "How often do you think of ending this adoption or guardianship?" "What were reasons why you thought about ending this adoption or guardianship?"

Community Service Items:

Families were asked to identify the most important services or supports, the most needed but hard to get or not available service or support, and the biggest barriers.

Results and Findings:

1. Characteristics of Survey Participants:

In this study, 847 caregivers from 847 adoptive families completed the North Dakota Permanency Survey online via Qualtrics. Among these families, 40 caregivers answered for the second adoptive child, and only 9 answered for the third child, 3 for the fourth child, 2 for the fifth child, and 1 answered for the sixth adoptive child.

A. Characteristics of Survey Participants:

Most households (92%) had two adult caregivers living at home (married or living with a partner). The numbers of children under 21 who were currently living at home range from zero (meaning infants under 12 months old) to nine. The average age of participating caregivers was 39.97 years old.

B. Characteristics of Identified Child:

For families formed through adoption and guardianship with more than one child in their home, a specific child was randomly selected by caregivers and was referred to as the "*identified child*" for the purposes of the survey. Caregivers were asked to think about their "identified child" as they answered the survey. Caregivers were also provided with an opportunity to answer survey questions on additional adoptive children in their home if they chose.

Table 1 provides an overview of these children. Almost half of caregivers (46%) fostered their child prior to finalization, and 17% were related to their child. For caregivers who were related to their child, the majority were aunts/uncles (61%), followed by siblings (18%) and grandparents (13%). 44% of identified children were female, 56% were male. Most identified children were

[1] The ratings were recoded. As an example, "very easy" had a corresponding rating of 4 and "very hard" had a rating of 1.

White (45%), followed by American Indians/Alaska Native (22%) and Black (21%). The average age of the identified child was 11.66 years old. The average age at the time of finalization was 3.97 years old, and the mean number of years since finalization was 7.01 years. Moreover, *Table 2* provides an overview of the crosstabs between child's age and years since finalization of the adoption.

Table 1. Characteristics of Identified Child

Identified Child Characteristics				
			N	**%**
Caregiver Fostered Child Prior to Adoption or Guardianship			388	46%
Child Is Biologically Related To Caregiver			147	17%
Child Is Adopted (versus assumed guardianship)			558	66%
The Child is Female			376	44%
The Child's Race				
White			377	45%
Black			182	21%
American Indian or Alaska Native			190	22%
Other			98	12%
	Total N	**Min**	**Max**	**M (SD)**
Mean Age of the Child (Years)	846	0*	21	11.66 (4.6)
Mean Age of Child At Time of Finalization	750	0*	19	3.97 (3.91)
Mean Time Since Finalization (Years)	762	0*	20	7.01 (4.2)

Note. * 0 means infants under 12 months old.

Table 2. Child's Age and Time since Finalization

	Time Since Finalization of the Adoption (Years)				
Child's Age	**<2 Years**	**2-4 Years**	**5-9 Years**	**10+ Years**	**Total**
0-2 Years Old	12	N/A	N/A	N/A	12
3-5 Years Old	35	38	3	N/A	76
6-10 Year Old	40	60	127	5	232
11 and Older	28	38	157	218	441
Total	115	136	287	223	761*

Note. *86 caregivers did not provide information on the date of their adoption finalization or guardianship court hearing.

2. Caregiver Wellbeing & Strengths:

A. Caregiver's Strain:

We assessed a caregiver's level of strain, or the extent to which a caregiver experiences additional demands, responsibilities, and difficulties, as a result of parenting their child for whom they have legal guardianship or who was adopted. Scores can range from one to five, and higher scores indicate higher levels of strain. The means of overall strain, subjective strain, and

objective strain scores are reported in *Table 3.* The mean caregiver overall strain score was 2.35. The mean score of objective strain (2.26) was lower than the score of subjective externalized strain (2.41) and the score of subjective internalized strain (2.49) experienced by caregivers. In addition, Cronbach's alpha in Table 3 is an indicator of reliability of the measure. The higher the score, the more you can trust the measure. Ideally, on or above .70 is acceptable.

Table 3. Caregiver Strain Scores

Measure	Range	N	Min	Max	M	SD	Reliability (Cronbach's Alpha)
Caregiver Strain Questionnaire- Global Scores	1-5	847	1	4.27	2.36	0.69	0.92
Objective Strain Subscale	1-5	847	1	4.78	2.26	0.83	0.91
Subjective Externalized Strain Subscale	1-5	847	1	5	2.41	0.78	0.75
Subjective Internalized Strain Subscale	1-5	847	1	4.86	2.49	0.69	0.76

Note. *Min= Minimum, Max= Maximum, M= Mean, SD= Std. Deviation.

B. Strengths of the Caregivers:

The study explored various attributes and qualities as well as the resources of caregivers, recognizing that factors such as adaptability, resilience, and social and professional connections are important components in prevention interventions (Crumbley & Little, 1997). Respondents shared their greatest strengths as caregivers or guardians. The analysis of the responses revealed an intricate conceptualization or understanding of strengths. The results show that strength was viewed in a variety of ways including a person's values or standards for living (and relating to the child), the state of their home environment, their ability or capacity to meet a child's material and emotional needs, resourcefulness, being knowledgeable and being able to draw from one's professional or work experience. It is important to recognize that strength was also conceived as an integration of multiple factors, and the manner in which people responded to their current situation as an adoptive family to gain or ensure positive outcomes. Some of the specific responses given are reproduced below with supporting interpretations.

Using thematic analysis (Braun & Clarke 2006, 2013), we found several important competencies/strengths the caregivers believed they have, which are similar to the parental competencies suggested by Day et al. (2018):

(1) On the family environment, respondents stated that:

- "A healthy family can give children the love of their parents and grandparents"
- "Ability to adapt to the child and their needs"
- "Ability to provide a loving home"

The responses above suggest that an **adoptive family's ability to adapt** is a strength. There is also an indication that it is important that families recognize or accept that they are reconfiguring

their existing family structure with the adoption or guardianship. In that regard, they have a responsibility to establish an amiable and supportive environment.

(2) Caregivers' foreknowledge and understanding of challenges their adopted child may have, and their ability to provide the needed supports to the child, was also presented as a strength:

- "Awareness of trauma, community resources"
- "Accessing and getting the supports he needs sooner than later, to ensure he is successful in all aspects of his life"

These responses point **to proactive action on the part of caregivers in ensuring the well-being of their child**.

(3) In relation to the above, the responses below show caregivers' recognition of the challenges that are likely to emerge in their relationship with their adopted child. The respondents presented having the right disposition or temperament in engaging the child, and also having a positive outlook as strengths. See the following:

- "Compassionate communication-Not afraid to discuss (And listen to) tough issues and offer reassurance that we can get through things together."
- "Large heart for my child, loved her from the first time I held the child. Willingness to play and be silly, accept the child for where they are at and have strong faith and hope..."
- "Forgiveness - I think it helps to know that even if we get upset with each other or disagree I will ALWAYS love them and they will ALWAYS be my child and I will ALWAYS be happy to see them and each new day is a chance to start fresh."
- "Personally, I think my biggest advantage is my optimistic and outgoing personality, which can give children and families a good atmosphere"
- "Openness to talk about birth family and past."

(4) Professional and prior caregiving experience was also noted as a strength.

A. Adoptive parents get assessed and also receive training to boost their capacity for successful placement and post-adoption continuity. It is quite evident that through one's profession, a person could acquire knowledge and skills as well as develop social and professional capital that they can draw on in supporting their adopted child (Teska, 2018). Thus, adoptive parents or prospective parents who are already immersed in adoption process by virtue of their profession or even informal engagements may have an advantage relative to those who are new to adoption. The following responses were shared:

- "I am a social worker so I am more easily able to locate and access services for our children when needed than other parents might be able to."
- "Years of experience working with foster care agency."

B. Quite similar to point "A", a respondent shared how past caregiving experience, particularly with a child who was subsequently adopted, can be perceived as a strength. The respondent stated that, "I have been a caregiver for our child on occasion or as needed basis since he was three." Further, this suggests that having developed or already established a bond could be advantageous especially in terms building trust.

(5) A commitment to making changes and sacrifices as an adaptive response was also presented as a strength. Adoption often involves transitions across several domains

including the social and domestic as well as professional aspects of people's lives. These transitions can be stressful and disorienting. Therefore, the ability to adapt and respond optimally to the changes is critical (Foli et al., 2017). Some respondents shared the following:

- "I have moved, changed jobs and made tough decisions. I will stop at nothing for him."
- "Willingness to learn about child's needs as we go through life and change how we parent as his needs change."

3. Family Wellbeing:

In terms of family wellbeing, we focused on caregivers' overall adoption or guardianship experience and family functioning. 86.5% rated the overall impact of adoption on their family as positive. Specifically, 28.7% of all sample rated it as extremely positive.

Table 4 provides an overview on the impact of the child's adoption or guardianship on the family, the relationship with partner/spouse, and the other children. Scores can range from 1 to 7 (1=extremely positive, 4= neither positive nor negative, 7= extremely negative). We re-categorized the impacts from 7-point rating to 3-point rating-- positive, neutral, and negative.

Table 4. Impact of Child Adoption/Guardianship on Family Wellbeing

Item	N (%)	Scale Range	M	SD
Impact on your family	847	1-7*	2.30	1.30
Positive	733 (87%)			
Neutral	66 (8%)			
Negative	48 (6%)			
Impact on your relationship with your partner, spouse, or other adult caregiver	827	1-7	2.51	1.32
Positive	668 (81%)			
Neutral	99 (12%)			
Negative	60 (7%)			
Impact on your other children	812	1-7	2.58	1.42
Positive	639 (79%)			
Neutral	97 (12%)			
Negative	76 (9%)			

Note. *1=extremely positive, 4= neither positive nor negative, 7= extremely negative.

4. Child Wellbeing:

A. Social and Emotional Wellbeing (Child):

Child social and emotional well-being was assessed by 10 items. *Table 5* provides an overview on children's social and emotional wellbeing. Most caregivers rated that their children found it easy to make friends (73.4%), bounced back quickly (57.3%), found things they liked about themselves (65.6%), stayed calm when facing a challenge (53.7%), and asked for help when needed (63.2%). Moreover, we found that more than half of the respondents (54.2%) indicated

that their child was very optimistic or extremely optimistic about their future. In contrast, 12.4% of the respondents noted that their child was not all or a little optimistic about their future, while a little over a third (33.4%) indicated that they were moderately optimistic. Further, 45-48% respondents indicated their child is liked by other children and get along with other adults.

Giving and seeking help is a function of positive and supportive relational contexts. Children who are adopted or in foster care are typically known to have histories of disruptive and difficult social relationships which may lead to maladjustment and less than optimum social skills. Further, in response to difficult and aberrant social and environmental conditions, these children develop adaptive behaviors for self-preservation which may include an inhibitory schema towards help-seeking (Barcons et al., 2014; Simmel et al., 2007). It is worth noting that, 47-55% of respondents indicated that their child always/often offers to help others and show interest and curiosity in learning new things. In contrast, a quarter (24.9%) of the respondents noted that their child offered help to others "never, sometimes", and 36.8% of the respondents noted that their child found it "somewhat hard, very hard" to ask for help.

Table 5. Social and Emotional Wellbeing (Child)

Item	N	**Response %**		
How easy or hard is it for your child to…			**Somewhat hard, very hard**	**Somewhat easy, very easy**
1. Make friends?	840		26.6	73.4
2. Bounce back quickly when things don't go his or her way?	845		42.7	57.3
3. Find things he/she likes about himself/herself?	831		34.4	65.6
4. Stay calm when faced with a challenge?	844		46.3	53.7
5. Ask for help?	845		36.8	63.2
How much…		**Not at all, a little**	**Moderately**	**A lot, a great deal**
6. Is your child liked by other children?	846	10.3	41.5	48.2
7. Does your child get along with other adults?	844	9.7	45	45.3
How…		**Not at all, a little**	**Moderately**	**Very, extremely**
8. Optimistic is your child about his or her future?	830	12.4	33.4	54.2
How often does your child...		**Never, sometimes**	**About half of the time**	**Most of the time, Always**
9. Offer to help others?	841	24.9	52.6	47.4
10. Show interest and curiosity in learning new things?	847	21.1	24.1	54.8

The items were further broken into two subscales - the Relationship Subscale (4 items: measures relationships and connections to other people [adults as well as children]), and the Resilience and

Optimism Subscale (6 items: measures their disposition and response to challenges). *Table 6* shows the mean of overall child social and emotional wellbeing, and their social relationships, resilience, and optimism. The higher mean scores indicate better social and emotional well-being. The mean score of child social and emotional wellbeing was 30.4. Reliability analyses (Cronbach's Alpha) were conducted to examine the quality of the overall scale and the two subscales.

Table 6. Child Wellbeing Indicators

Measures	Scale Range	N	Min	Max	M	SD	Reliability (Cronbach's Alpha)
Child Social and Emotional Well-being	0-47	847	11	44	30.40	5.13	.83
Social Relationship Subscale	0-21	847	6	21	14.00	2.69	.70
Resilience and Optimism Subscale	0-26	847	6	26	17.45	3.30	.75

B. Strengths of the Child:

In no particular order, participants were requested to list the three greatest strengths their adopted child possessed. Based on the responses provided the following themes were identified:

1. **Personal Characteristics/Attributes.** Some respondents identified children's physical/physiological attributes as strengths. Specific references were made to children being good looking, and athletic. In close relation to this, references were also made to children's skills, talents and creative abilities. The responses are reflective of character and moral traits as well as concrete and expressive attributes of the children. References were made to children's intelligence, academic success and performance in school. Additionally, references were made to behavioral and character traits such as honesty, being well-behaved and having a good work ethic.
2. **Knowledge, Skills and Abilities.** Regarding the socio-emotional strengths, responses were provided reflecting the children's emotional dispositions, as well as their ability or aptitude for understanding and managing emotions. The responses also conveyed how the children related to others. Children were noted to be friendly and also demonstrate empathy towards others. Further, references were made to children's ability to deal with challenging and stressful situations.

It is important to recognize the subjectivity of the responses. What is perceived as a strength may vary from one adoptive-parent / guardian to another, and also may not always fit with general societal views. For example, some participants provided responses like "quirky" and "naïve" as strengths. The stated attributes may also reflect the values and expectations of the adopting parent or guardian.

C. Educational Wellbeing:

The assessment of educational well-being involved two questions exploring whether the child had a 504 plan or an Individualized Educational Plan (IEP). The findings of the current study indicate that 45.7% of the children had a 504 Plan and 47.7% had an IEP.[2] There is some duplication in the actual number of children these percentages represent. There were 279 children who had both a 504 plan and an IEP.[3]

Having either of these plans suggests the child has learning and/or behavioral issues. Zill and Wilcox (2018) examined indicators of school adjustment and educational progress from the US Department of Education and found that adopted children compared to their contemporaries from single or blended homes, and those living with married biological parents were more likely to have academic and behavioral problems, and also more likely to be repeated, suspended or expelled. Further, Zill and Wilcox (2018) reported that compared to other students, a higher percentage of adopted students had psychological and physical health challenges including learning and speech impairments, and developmental delays. In that vein, inadequate support from schools may complicate the educational (and general life) experience of adopted children and may contribute to the stressors adoptive families (Emerson & Lovitt, 2003).

IEPs and 504 plans are designed to protect children with special educational needs against discrimination, and also provide a buffer against barriers by granting them the needed accommodations. IEPs and 504 plans also enable these children access the general education curriculum. These findings therefore suggest that about 45.7% (504 plan) and 47.7% (IEP) of the children have accommodations and supports for their special educational needs. parents may have to interact with the education system in securing the needed accommodations and modifications for their children.

D. Challenging Issues that Impact the Child's Daily Functioning:

The evaluation assessed various factors and tendencies impacting the daily functioning of children. Approximately 14% of the respondents indicated that their child had a mental health issue and 8% have intellectual disability, 7% have physical health problems and 4% have physical disability, 4% have alcohol/substance use, 8% have food challenges, and 7% have sibling conflicts (See *Table 7*).

Research shows that 17.4% of American children aged 2-8 years have a mental health or behavioral disorder. Another study found that among American children 0-17 years, 16.5% had

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[2] On the question about the 504 plan, 843 participants responded. The number of children reported to have a 504 plan was 385. On the question about the IEP, 844 participants responded. The number of children reported to have an IEP was 403.

[3] This can also be expressed in a number of ways – 69.2% of the children with an IEP also had a 504 plan or 72.5% of the children with a 504 plan also had an IEP.

at least one mental health disorder. Examining the incidence of mental health disorder at the state-level, in North Dakota, the prevalence ranged from 15.3% - 17.7% (Whitney & Peterson, 2019). Adopted and fostered children are however known to be at higher risk for mental and behavioral health disorders (Brand & Brinich, 1999; Fisher, 2015).

Table 7. Challenging Issues of the Identified Child that Impact Daily Functioning

Challenging Issue	N	Response n (%)	
		Yes	No
Physical health	843	61 (7.2%)	782 (92.8%)
Physical disability	842	33 (3.9%)	809 (96.1%)
Mental health	842	116 (13.8%)	646 (86.2%)
Intellectual disability	842	70 (8.3%)	772 (91.7%)
Alcohol/Substance use	845	31 (3.7%)	814 (96.3%)
Food Challenges	846	67 (7.9%)	779 (92.1%)
Sibling conflicts	844	62 (7.3%)	782 (92.7%)

Moreover, a child who has multiple disabilities and/or needs can be a risk factor that impact post adoption and guardianship stability (Reilly & Platz, 2004). The number of challenging issues was aggregated to assess the level of co-occurring issues among adopted/fostered children. Approximately 75% of the children had no challenging issue, 12.2% had only one issue, and 12.8% had two or more challenging issues (See *Table 8*).

Table 8. Numbers of Issues that Impact Daily Functioning

Number of Challenging Issues	Frequency (%)
None	639 (75.4)
One	103 (12.2)
Two	39 (4.6)
Three	23 (2.7)
Four	28 (3.3)
Five	13 (1.5)
Six	1 (0.1)
Seven	1 (0.1)

E. Caregivers' Descriptions of Challenging Issues:

More specifically, respondents described these challenging issues the child has.

(1) Physical Health and Physical Disability.

Thirty-three respondents (3.9%) indicated that their child had a physical disability issue. The disabilities reported included deafness or hearing loss and limb loss. Some of the responses provided indicated that some of the reported disabilities were congenital. Furthermore, some of

the responses point to seemingly complex conditions such as "…partial deletion of a chromosome", as well as multiple disabilities such as "He is Deaf. He is ID [intellectually disabled] and non-verbal." Some participants offered additional insight about the child's condition and experiences. A respondent shared that:

- "Sensory issues that make it hard to touch her and such. Incontinence is embarrassing and hard to deal with at school"

Another respondent who indicated that their child was deaf shared that:

- "Deaf, but has cochlear implants that enable her to hear during the day. She did not receive them until she was 8 so she continues to have some speech language delays which affect education and conversation. She has trouble hearing in noisy environments and certain sounds."

While the underlying reasons for the delay in getting the implants are not stated, it is suggested that the delay may have further hampered the child's language development. It is important to give attention to how these conditions can impact children's engagement in academic and social contexts.

(2) Mental Health and Intellectual Disability.

Seventy respondents (8.3%) indicated that their child had an intellectual disability. However, they did not elaborate or provide further details about the specific nature of their child's intellectual disability. Similarly, 116 respondents (13.8%) indicated that their child had a mental health issue. However, they did provide further information about the nature of the issue.

(3) Alcohol or Substance Use.

Thirty-one respondents (3.7%) shared that their child had an alcohol or substance use problem. In addition to alcohol, substances referenced included marijuana and vaping. Some of the responses suggest cases of polysubstance use. For example, "Trying to quit smoking. Has abused alcohol. Has done weed." There were responses suggesting substance use may have been a problem in the past but not at present: "has in the past". Some of the responses also suggest limited knowledge or uncertainty and assumptions being made by caregivers about their child's substance use status. For example:

- "He did use vaping not sure if he's still doing it or not"
- "We hope the problem has been solved"
- "He does use marijuana which we can tell because he will be very quite [quiet] and laid back"

The first two quotes reveal the caregivers' uncertainty while the last quote reveals an assumption about substance use and the related behavioral effects. Substance use, especially that which involves illicit substances, is often done furtively which may be a possible reason for the caregivers' uncertainty.

Substance use was also framed in the context of allergies. For example, regarding alcohol, a respondent shared that their child had "severe allergies to alcoholic beverages and foods, every time it takes a few days in the hospital to be cured".

Not all the responses provided for substance use pointed to problematic use. For example, a respondent indicated that their child "drinks a little wine occasionally."

(4) Food or Eating Issues.

Sixty-seven respondents (7.9%) indicated that their child had food or eating issues. Some of these respondents shared details about the nature of the issues revealing a varied and complex relationship with food and eating. The following themes – health conditions, food-related concerns possibly symptomatic of psychosocial problems, and food preferences– were identified. The health conditions included allergies and sensory disorders. For example:

- "Does not tolerate dairy. Functions well as long as she doesn't have dairy."
- "Can't eat seafood will be allergic!" (food allergy).
- "Sensory Processing Disorder."
- "Difficulty chewing and swallowing."
- "Previously g-tube dependent. Has ongoing difficulties with eating enough nutritious food."

The food-related concerns possibly symptomatic of psychosocial problems include:

- "Steals food and at times in excess."
- "Hoards food, will binge eat if she has the opportunity."
- "Possibly. Has a strong attachment to food and needs to eat and drink a lot, regularly. He gets very angry if he can't have something to eat/drink the moment he wants it."
- "He always FEELS hungry even after eating 2 full plates of food. Even though we have 3 scheduled meals and 3 scheduled snacks every day, he sneaks extra food often, which has impacted his weight."

The responses suggest that one could be parenting and living with a child with complex medical and behavioral health needs. In examining the responses about behaviors such as food hoarding, "anxiety with food running out", etc., it is probable that the children in question may have grown in a context where due to factors such as limited availability of food or concerns about health, weight gain, etc., caregivers overly controlled food access and intake. It is also plausible proper feeding habits may not have been modeled for these children in their earlier life (Eneli et al., 2008).

(5) Sibling Conflict.

Sixty-two respondents (7.3%) noted that their child had sibling conflicts that impacted their daily functioning. On the theme of conflict, the responses reveal different conflict types or situations as well as caregivers' perceptions and theorizing.

The conflict types or situations included:

- "Constant fights with bio brothers we also adopted"
- "He does not get along very well with his half-brother who also lives with us"
- "He and older brother frequently argue and get physical with each other"
- "Brothers feels tense around her"
- "Wants to be in control of everything the younger siblings do"

These responses reveal that the conflicts involved both male and female children. Further, some of the conflicts involved physical fights while others assumed the form of tense relations and

attempts to exert control over others. The responses also show that there may have been some age-based dynamics as there were conflicts involving older and younger siblings.

The perceived reasons for the conflicts could also be gained directly or through inferences from the responses. For example, a respondent shared that "they scrambled for toys and clothes". Another also shared that, "[with] Her biological sister…there appears to be some jealousy between the siblings as the biological sister has lots of friends and is very social and very smart". In the two cases these direct quotes represent, attributions to the children's level of development could be made. As children grow, the development of prosocial behaviors such as sharing and playing cooperatively usually forms part of their socialization. Exhibiting unpleasant or negative emotions like jealousy is not atypical. However, an inability to regulate the demonstration of negative emotions is considered problematic. There are multiple conditions that negatively affect the development of prosocial and inhibitory behaviors in children (Ferreira et al., 2016). However, adopted and fostered children appear to be disproportionately affected (Simmel et al., 2007; Smith et al., 2000). In addition to families adopting or assuming guardianship through the child welfare system, the survey included families who adopted privately and through inter-country adoption. A respondent shared that:

- "Children grow up in the orphanage without a care since they are young, feel insecure, and behave very strongly in front of their peers and are not welcomed by children"

Further, this direct quote infers that being in an orphanage is associated with inadequate care and attention, and an attendant effect is attachment disorders and poor social relations. Though what "behave very strongly" is not expounded upon it is apparent that it refers to an action or actions that do not elicit a positive response from other children. A respondent also observed that [in relation to their adopted child], "younger sister with RAD is difficult" while another [respondent] stated that their child, "has trouble communicating with them [siblings] at times and will lash out physically." Cases like this suggest that negative interactional or behavioral forms, though maladaptive, may be the way some children commonly engage with others.

In contrast to the views above, a respondent also shared that in their case the conflict was "nothing out of the ordinary. Fights with her brother." This view suggests such behaviors are commonplace. Nonetheless, while some of the conflicts may be normative, it is important to note that there may also be patterns or conduct that are concerning. For example:

- "LOVES riling up his siblings to get a reaction. Inappropriate with them. Takes advantages of their disability deficits."
- "She has no boundaries and will take things that don't belong to her that causes resentment. She also hates work so her brothers and sisters hate having to do her jobs when she refuses."

F. Challenging Issues that Impact Caregiver's Job/Employment:

While most caregivers (88.6%) indicated that the above issues did not impact their job, 11.4% reported having a job impact.

Some of the caregivers who reported a job impact further explained:

Respondents revealed how their job/employment opportunities had been impacted by the physical and mental health, behavioral issues, and child care needs of their child(ren). The job and employment-related impact were quite diverse. The responses revealed modifications to job roles and staying unemployed. It is also noteworthy, that there may have been respondents to whom this situation did not apply directly because of their status as a stay-home-parent.

(1) Job Modifications/Modifications to Job Roles/Accommodations. The responses provided showed general childcare responsibilities had impacted job opportunities or job roles for some respondents. Additionally, behavioral health issues were also tied to the impact on job roles and opportunities. Some examples include, "I need to do many things when my child is young. My current job is part-time" and "Opted out of a people lead position at work due to the hours of the job." Other ways in which participants shared the impact on their jobs had to do with taking time off, using their vacation, or seeking accommodations that allowed for flexibility. For example, "my boss allows me to leave when I have to for my daughter. Yes, it impacts my job greatly and my other kids".

(2) Not Working/Giving up a Job. Other respondents indicated they had to give up working or keeping a job was not feasible. For example, "I had to turn down a part time job", "YES! I cannot hold a job due to his behavioral issues".

(3) Stay-at-Home Parents. There were some respondents to whom this applied indirectly because they were already stay-at-home parents. Regardless, it appears considerations about employment or prospective employment decisions were impacted by childcare commitments. For example, a respondent noted, that "…I am a stay home mother but I do feel it would be detrimental to her mental health if I were to take a job. She had mental health and behavioral issues when she was placed with us four years ago and I think consistency of a reliable caregiver was a key factor in her improvement." For others stated it more clearly that they, "wouldn't have been able to keep a job so I stay at home."

5. Relationships between Caregiver Wellbeing and Permanency Commitment:

A. Caregiver Permanency Commitment:

Caregiver commitment is the extent to which adoptive or guardianship caregivers intend to maintain children in their homes and provide long-term care for them, no matter what challenges, stressors, or negative behaviors may occur (Liao & Testa, 2016; White, Rolock, Testa, Ringeisen, Childs, Johnson, & Diamant-Wilson, 2018). Among the respondents, 59.4% have never thought about ending their adoption or guardianship. 75.1% would definitely adopt or assume guardianship of their child again if they knew then what they know now. 86.5% rated the overall impact of adoption on their family as positive. Specifically, 28.7% of all sample rated it as extremely positive.

B. Caregiver Strains and Commitment Items:

We use correlation to examine the relationships between caregiver strains and three commitment items. The results indicated caregivers who perceived higher levels of strains were more likely to rate negative impacts of adoption on family (r = .32), would not have adopted the child if they

knew what they know now (r = -.50), and think about ending this adoption more often (r = .53). The levels of these correlations are moderate.

C. Caregiver Strains and Thoughts of Ending This Adoption or Guardianship:

In addition, *Table 9* provides an overview on how caregiver's strains were associated with their thoughts of ending this adoption or guardianship. The results showed that caregivers who usually or always thought of ending the adoption had statistically significant higher levels of caregiver strain (mean= 3.22) than those who sometimes (mean= 2.81) or rarely/never (mean= 2.18) thought of ending adoption. Similar results were in the measures of caregiver strain subscales.

Table 9. Caregiver Strain Scores and Thoughts of Ending This Adoption or Guardianship

Measure	**Ending Adoption/ Guardianship**	N	Range	Mean	SD	SS	df	MS	F	p
Caregiver Strain Questionnaire-Overall	Rarely to Never	639	1-5	2.18	0.62	91.68	2	45.84	123.72	0.000
	Sometimes	156		2.81	0.59					
	Usually to Always	52		3.22	0.31					
Objective Strain	Rarely to Never	639	1-5	2.05	0.76	129.31	2	64.66	117.04	0.000
	Sometimes	156		2.75	0.74					
	Usually to Always	52		3.36	0.43					
Subjective Internalized Strain	Rarely to Never	639	1-5	2.33	0.64	64.79	2	32.39	80.68	0.000
	Sometimes	156		2.88	0.64					
	Usually to Always	52		3.21	0.40					
Subjective Externalized Strain	Rarely to Never	639	1-5	2.05	0.71	109.17	2	54.59	115.47	0.000
	Sometimes	156		2.77	0.64					
	Usually to Always	52		3.14	0.48					

SD= Standard deviation.

D. Factors Contributed to Thoughts of Ending This Adoption or Guardianship:

Respondents shared reasons why they had considered ending their adoption or guardianship. The reasons given ranged from factors centered on the child(ren) and their behaviors to the adopting parents lack of resources both financial and social. Identified themes and supporting references are presented below.

(1) Challenges Related to Behaviors and Mental Health Issues.

The responses suggest some participants may have been wearied by the challenges of raising their adopted child. Further, it appears what may be considered normal challenges associated with raising children may have been exacerbated by the behavioral and mental health issues the adopted child(ren) had. Conceivably, children with serious emotional disturbances may exhibit problematic and challenging behaviors and dealing with those behaviors can be strenuous for caregivers (Sawyer et al., 2010). This appeared to be the case for some adoptive parents who shared that:

- "It has been a struggle with her having ADHD. She doesn't always want to take her medication and that puts stress on us and our other family members if we are all together."
- "It is extremely hard to parent typical children. When you add in a child who has other issues it adds significant stress on most areas of life"
- "Dealing with behaviors and mental health issues that have arisen this past year"

(2) Family Conditions

Respondents also noted that family conditions were not conducive for raising their adopted child(ren). In some cases, it appears there was an outright lack of support or understanding for having an adopted child. For example, "sometimes my family's lack of understanding and support makes me feel pressure" and "difficulty of doing this 'alone' even though her adoptive dad (biological uncle) lives in the same house."

In other cases, the consideration about ending adoption appeared to be informed by how the adopted child(ren) was affecting the family's existing dynamics including their sense of safety and well-being. It is also important to note that some adoptive parents may have had concerns about being held liable for anything that happened to the adopted child(ren). Some of the responses provided include:

- "For the sake of my marriage and sanity and physical wellbeing"
- "The impact of her behaviors on my other kids, my niece and nephews, my mom. She gets physical and then doesn't remember how bad it gets. I have to constantly be aware of her moods, her behaviors, where she is at, what happened to her at school to put her in a mood, etc. She can't be left alone. She doesn't make sound decisions for her safety. She is very naive."
- "Our child's behavior is violent and unsafe for the home. His behavior became worse after being adopted, which has led us to believe that moving to our home was not the best decision for him. Continued violent behavior in the home does not feel like an option, so we have pursued other supports in hopes of maintaining the adoption but also keeping everyone safe."
- "He is a danger to our other children. I feel he could be a danger to us, as he gets older."

(3) Erosion of Caregiver Capacity

Respondents offered diverse reasons for considering ending their adoption or guardianship. The responses revealed variations in the frequency as well as underlying reasons why participants thought of ending guardianship or adoption. For example, a respondent shared that their consideration to end adoption happened or happens "when you are in a bad mood." In the absence of additional details or a well-established context, it may appear as though there was a casual attitude about ending adoption or guardianship. However, other responses suggest considerations about ending adoption were borne out of the challenges of being an adoptive parent. The responses also revealed shifts over time. On their considerations about ending adoption, some other respondents shared:

- "not so much anymore have I 'thought' of ending this adoption, but it was really tough in the beginning. No support at all from the state (i.e.: emotional. respite to get a break) we all suffered because of it."
- "When he was in the sixth grade it was absolute hell. Every minute of every day. He called the sheriff on us because he didn't want to practice his drum lessons (that he begged for). We spent every week in therapy, countless hours and dollars and medications...none of it did any good. We asked social worker for supports (multiple times...thanks [to their county]) they threw back that "they gave us enough money, what more did we want?"

The quotes above, in addition to showing the change that had occurred over time, reveal the lack of support and services contributes to considerations about ending adoption. That notwithstanding, the decision not to end adoption or not considering ending adoption should not be equated to the absence of problems or challenges. The quote below suggests people persist in maintaining the adoption in the midst of challenges:

- "There are times when I really question if I did the right thing, but then I hear about how their birth mom is doing, and I'm very glad they are out of that situation."

Further, the quote above shows concerns about the adopted child's well-being may override the challenges of maintaining the adoption in some cases.

On the spectrum of termination, some participants also shared that they had "rarely considered terminating the adoption" or this was not applicable to them. Other respondents shared the following:

- "I would NEVER end an adoption, it would be devastating to the child who has already lost so much. It was just something that crossed my mind in such a stressful time when we had no sleep, assistance or emotional support."

It is evident that concerns about the child's well-being was a key consideration in the decision not to terminate the adoption.

(4) Difficulties with Relationship Development

Considerations about ending adoption also appeared to be linked to feelings of inadequacy on the part of the adoptive families. A respondent indicated that, "I always feel a little estranged" while another stated:

- "Grief over difficulty in attachment. Fear that I will never be trusted as her mom. Fear that my other relationships with my husband and other kids will be harmed in the process of loving her. Fear that there will be no peace in my life again."

It is also important to consider the role or views expressed by the adopted children too. A respondent shared the following, "child does not want to live with us and has asked to leave the family on multiple occasions. She does whatever she wants and does not respect us as parents or adults."

Adoptive families often face social stigma that implicitly and explicitly question the authenticity of their relationship (Miall, 1987; Rampage et al., 2012; Wegar, 2000). Related to this, there is often an expectation that adoptive parents and their adopted child(ren) establish a family bond without realistic considerations of the time required to develop such a bond. Such situations impose psychological burdens on adoptive families and hamper their transition into a single and cohesive family unit. The impact of the complex dynamic of adopted children having ties to multiple families should not be discounted. Further, there may be the entrenched notion that a child's biological family is the only context for optimum development. This notion, though erroneous, may often be legitimized when challenges in settling as a family post-adoption persist (Kernan & Lansford, 2004; Taussig et al., 2001). Notably, some participants stated the following:

- "Letting children return to their biological parents is the best way for children to grow up."
- "Children feel safe after following their biological parents."
- "Children are truly happy only when they grow up with their biological parents."

Adoption, guardianship, and foster care issues often represent intricate and delicate situations. In efforts to promote family reunification and kinship care, adoption can sometimes be downplayed and even faulted. There may be a tendency to scapegoat adoptive families when challenges emerge or persist over long periods of time (Wegar, 2000). Balance and astuteness are critical in messaging to help adoptive families appreciate the universal nature of challenges in raising children rather than making false attributions to their adoptive status. Failure to promote balanced messaging may contribute to discontinuity if adoptive parents are made to believe that their child or the family's challenges are primarily linked to the lack of a biological connection (Wegar, 2000). The view that children always do well when with their biological parents is inaccurate. Research shows reunifying children with their biological families can be detrimental (Taussig et al., 2001).

(5) Child Attaining Adulthood and Perceived Maturity

Another factor informing considerations about ending adoption was the perceived maturity and independence of the adopted child(ren). Some respondents shared the following:

- "Children have grown up and should be able to live independently" [The child being referenced was 17 years old]
- "The child has grown up and is capable of self-reliance." [The adoptee being referenced was 20 years old]
- "She can take care of herself" [The adoptee being referenced was 19 years old]

It must however be noted that in some instances where similar responses were provided, the children being referenced, though teenagers, were relatively younger with some of them being 13 and 14 years old. It is conceivable that beyond age, difficult relational dynamics were informing some of these considerations about ending adoption.

Recognition of the vulnerability of children especially as they transition developmentally as teenagers and youth is important. At this age, children become more expressive and desire

independence, which is typical at this stage in their life. This may appear to an adoptive family as problematic but should not necessarily be a cause for terminating adoption (Child Welfare Information Gateway, 2020; Steffe & Barry, 2012). Matter-of-factly, support for children in foster care and adoptive contexts is necessary and should ideally extend beyond the teenage years into early adulthood. Some studies show foster care is a protective factor against substance use and generally associated with better outcomes across several domains of well-being including employment (Rosenberg & Abbott, 2019; Steffe & Barry, 2012).

6. Experience of Adoption and Guardianship of Your Child:

Participants shared both negative and positive adoption and guardianship experiences. Some of the negative and positive experiences were tied to the adoption process while others were tied to the relationship with the child(ren). The negative and positive experiences were linked to incidents that occurred at various points in the process of adopting or raising the adopted child(ren).

(1) Negative Agency-Related Experiences

Reflective of their experiences with agencies, respondents shared the following:

- "I believe we got lost in the system - too many people along the way were retiring or quitting, the distance and hand off did not go smoothly. We went from a seasoned social worker to someone right out of college- without kids. We were adopting two feral children and needed help!"
- "We had very negative experiences with the county agency we worked with."
- "Social services is a nightmare! They do not care about the child's well-being or the foster parents. It's a dirty game that they play with children's lives!"
- "Kid part was easy the social service side not so much"

Taking all the quotes into account, the general narrative appears to be that agencies are not as supportive as they should be. The first quote offers additional insight on some of the underlying reasons for the negative experiences. It suggests that the adoption process did not progress in a supportive and desirable manner for the respondent. It also appears that this respondent was negatively impacted by transitions in the workforce or some procedural mishaps in channeling their case through the adoption system. Further examining this quote, the respondent's preference for a social worker with certain qualifications or relatable experiences is evident. This highlights challenges pertaining to workforce development and the capacity of agencies to offer prospective families a desired match with social workers or other professionals. Though more person-centered descriptors may be preferred to the use of the term "feral" in describing the children, the respondent may be indicating a perceived need for specialized assistance.

Additionally, beyond the initial process of adopting a child, it appeared there were expectations of continued support which for some people may not have been available. A respondent shared the following: "the process can be a bit frustrating. Our child does not receive particular services she deserves for having a disability." In what appears to be a summation of their experience,

another participant shared that, “This [adoption] is way harder than anyone really knows and there is a true lack of support and understanding from most people.”

The negative experiences, it appears, were not limited to just public agencies. A respondent shared that, “dealing with a private agency was worse than dealing with the bureaucracy of the foster care system.”

(2) Positive Agency-Related Experiences

The following responses reflect some of the positive agency-related experiences:

- “The whole process was easier than I ever would have expected. My social workers were wonderful.”
- “Having the option for me to adopt my grandchild is important and in my opinion is the best for him besides being with his mom. She has addiction issues. The whole process in North Dakota in [our] county was really helpful. All of the social workers, case workers and staff were very helpful and supportive. Adults Adopting Special Kids (AASK) was awesome assistance also!”
- “His caseworker was amazing!!”

The responses underscore the critical role agencies, and more specifically, the social workers or professionals who work directly with adoptive families, play in providing a supportive experience.

(3) Positive Child(ren) Experiences

Several respondents shared positive experiences or reactions to having their adopted child. Examples include:

- “It has truly been the most rewarding and love-filled experience for our family.”
- “After adopting her, I feel very happy and live a happier life”
- “After the child came, I worked harder and felt hopeful in life.”

A respondent intimated that while they had a positive experience per the relationship with the child, there were other factors that were less desirable. They shared, “yes, I feel he is very different from other children, he is very sensible, but his native family is not good, so I really want to give him more love.” This response also highlights other aspects of the adoption process and factors that shape people’s experience. Notably, while there is no complaint about the interactions with the agency or county, or even the child, this respondent only appears to have been dissatisfied with the child’s family of origin.

(4) Expectations

Besides respondents who overtly stated they had negative experiences, others seemed to point out that they did not get what they hoped they would receive while going through the adoption process. For example, a respondent shared that, “the training doesn’t do much to prepare you for the challenge.” Though not necessarily saying the experience was negative, there were some

indications that the training given for adoption was inadequate. The following responses were also shared:

- "I wish we would have had more contact before the final placement with the team working with our child. If we could have had more time with therapists to know what needs they had/have and to learn specific tools for those needs we could have prevented a lot of unnecessary trauma and drama."
- "We wish the counties would be more supportive and informative and let us know what options are available to help with the medical needs of a special needs child. We get no support or guidance from our county we seek help from [a] medical provider that we have research[ed] ourselves."

From all of the above, the point remains that the adoption process entails more than just having the child. The responses reveal the inadequacy of supports and the burden borne by families in navigating the terrain of caring for or raising a child after adoption. These responses also suggest that families that, for one reason or the other, lacked the means to take certain initiatives, their adoption experience could have been irascible and disorienting. Again, the eventual outcomes for the children involved could be suboptimal. The lack of adequate training and support could temper the enthusiasm and commitment in the long-term relationship with the child.

(5) Evolving Nature of the Experience

Adoption (particularly, life post-adoption) was also noted as an experience that evolves or could evolve. This is quite similar to some of the views expressed about ending adoption. A respondent shared that, "it's getting easier the longer we've been together, we have good and bad days like any family." Another respondent also shared that, "There are ups and downs but we are blessed by this human that has been added into our life. A beautiful angel and the downs are worth the ups."

Quite comprehensively, another respondent shared that:

- "It was hard to answer the questions on the child's influence on the family because it affected each member differently and definitely was a stressful transition for all. Most of the stress after the first year is due to the number of children (most of whom have special needs) combined with my husband's frequent work out of town more than the child herself. So...even though it may have had a somewhat negative impact on the family unit to add another child it has been steadily improving and she is so worth it! It is amazing and rewarding to watch her growth. The first year she had trouble sleeping, tantrums that lasted for hours, frequent lying and stealing, and her insecurity caused relationship difficulties. Although she still has a strong personality no extreme behaviors have occurred in the last couple of years and overall she is a well-adjusted, responsible young teenager!"

These quotes suggest there are difficult or challenging phases post-adoption as the adoptive family and the child settle down. The quotes also suggest that a successful resolution of the challenges is possible. Further on the experiences, the lack of support in some cases extended

beyond the agency. In situations involving multiple parties or systems, there may have been challenges in streamlining the process and ensuring access to all eligible supports and services. This also begs the question whether adoptive families were fully aware of channels for addressing concerns or advocating for available benefits. A respondent shared that, "[the] Tribe stated children were eligible for enrollment in writing prior to adoption but after finalization said they were not eligible for enrollment. That support was counted on in terms of college planning when adopting older children. Now do not have financial resources in place for this."

7. Communications around Adoption and Guardianship:

A. Levels of Comfort:

We asked caregivers, "How comfortable or uncomfortable are you answering your child's questions about his or her birth parents history?" and "In the past 6 months, how often did you bring up adoption or guardianship with your child?" Approximately 49% of the caregivers indicated they were very comfortable or somewhat comfortable answering questions about their child's birth family history, 40% felt somewhat uncomfortable, and 12% felt very uncomfortable. However, most caregivers (61%) talked about adoption or guardianship with their child on a daily basis to monthly basis, and only 20% never talked about it. *Table 10* shows caregiver's level of comfort and how often they actually brought up adoption or guardianship.

Respondents expressed their views about the importance of contact with the birth parents of their child(ren). While some of the responses underscored the reasons for lack of contact, they also shed further light on the dynamics of contact. Some respondents did not rule out contact but it appeared certain relatives may have been preferred other than the direct birth parents. A respondent for instance shared the following, "much more comfortable on the maternal side, where we have frequent contact with the grandmother."

Table 10. Caregiver's Level of Comfort and How Often They Brought up Adoption or Guardianship

Level of Comfort Talking About The Child's Birth Family				
Very Uncomfortable	Somewhat Uncomfortable	Somewhat Comfortable	Very Comfortable	
12%	40%	31%	18%	
% Parent Brought up Adoption or Guardianship with Child				
Never	< Monthly	Month	Weekly	Daily
20%	20%	27%	16%	18%

B. Initiation of the Conversation:

We also looked at the comparison between how often parents bring up adoption or guardianship and how often children initiate that conversation. The results indicated that the frequency parent bring up conversations about adoption or guardianship with child was similar to the frequency of children initiated conversations (see *Table 11*).

Table 11. Conversations about Adoption and Guardianship: Child-Initiated vs. Caregiver-Initiated

% Parent Brought up Adoption or Guardianship with Child				
Never	< Monthly	Month	Weekly	Daily
20%	20%	27%	16%	18%
% Child Brought Up Adoption or Guardianship in Conversation				
Never	< Monthly	Monthly	Weekly	Daily
19%	20%	26%	18%	18%

8. Contact with Birth Family:

This section focuses on the relationship between families formed through adoption and guardianship and birth families. The literature indicates many benefits that can come from continued connections with birth family (Grotevant et al., 2013).We wanted to understand whether or not children had contact with their birth family, the type of contact, and how important contact was to caregivers.

A. Contact with Birth Parents:

We found that 9% of caregivers indicated that contact was not possible between their child and their child's birth mother, while 12% indicated contact was not possible between their child and their child's birth father. We asked caregivers who felt contact was possible how important it is to them that their child has contact with his or her birth parents. Approximately 16% of caregivers reported that contact with their child's birth mother was not at all important, while 17% of caregivers indicated that contact with their child's birth father was not at all important. (See *Table 12*). In the past six months, 25% of children had no contact with their birth mother and 28% had no contact with their birth father (See *Table 13*). The most common form of contact for both birth parents was through visitation or phone/Skype/FaceTime.

Table 12. Birth Parents: Is Contact Important?

Service Sector	**Contact Not Possible**			**Contact Not At All Important**		
	N*	n1*	%	N	n2*	%
Birth Mother	847	78	9%	847	133	16%
Birth Father	847	105	12%	847	145	17%

Note. *N= total sample, n1= subset of the sample who reported the contact was not possible. n2= subset of the sample who rated the contact was not at all important.

Table 13. Birth Parents: Did the contact happen?

Service Sector	**No Contact in Past 6 Months**		
	N*	n3*	%
Birth Mother	769	194	25%
Birth Father	742	205	28%

Note. N= total sample, n3= subset of sample who reported no contact in past 6 months.

B. Why Contact with Birth Parents Was Not Possible:

From the responses given the following themes were identified as reasons why contact was not possible. It appears that a multiplicity of factors were at play in shaping decisions or views about contact with the birth parents. Examples include the following situations: "he is a drug addict abuser alcoholic and felon he will never be a part of our child's life" and "contact would depend on birthfathers mental health and substance abuse status as well as child's readiness for contact". The former situation appears to be a definitive statement that contact between the birth father and the child is not going to be possible considering the phrasing "he will never be a part of our child's life". However, there were other seemingly innocuous reasons such as a birth parent not being known. For example, "birth father was never identified."

(1) Deceased. In some cases, contact was not possible due to the death of the birth parent(s). A respondent shared that, "we had a set schedule with contact with birth mother but then she passed away unfortunately." Another noted that, the "biological mother, my sister passed away."

(2) Abusive Past Relationship/Experience (physical, sexual, etc.). Other respondents noted that there were issues of concern and it appears contact had been ruled out based on those issues. Examples of such reasons include: "her bio mom sexually abused her" and "son's stepfather sexually molested him, we were just recently made aware and have made necessary reports to hopefully pursue charges."

(3) Incarceration and Drugs/Substance use issues. The incarceration of birth parents was another reason why contact was described as not possible in some cases. In addition to incarceration, some birth parents were noted to have substance use/addiction challenges. Regarding contact with a child's birth father, the following was shared, "he is in and out of prison had not had contact in over 5 years". For another child, the following was shared about both the mother and the father, "her mother is still using and not safe for her to be around and her father is in and out if prison and still using."

(4) No Interest from Either Child, Bio or Adopted Parent. The lack of contact was also attributed to lack of interest on the part of one or more of the people concerned. Some of the responses provided seem to suggest the party declining or not expressing interest varied. The disinterested party was sometimes the child, the birth parent(s), and/or the adopting parents. In relation to this, the relinquishment or termination of rights was also mentioned. For example, "mother gave up her rights" and "both [i.e. parents] terminated their parental rights". For a child whose mother was deceased (referenced earlier under "#1"), it was also mentioned that, the father's "rights were terminated. His where-abouts are currently unknown."

The case of termination may warrant further exploration. It is important to note that, the involuntary termination of parental rights due to involvement with the child welfare system or voluntary relinquishing of parental rights should not be assumed to mean that the birth parent(s) also does not wish to have ongoing contact with their child (Haugaard & Avery, 2002).

For an example of the child disinterested in contact with their birth parent, a respondent said, "Child is not interested in contact at this time but if he was interested it would be very important to me." This response seems to imply that child's interest and even consent is essential in decisions about contact with birth parents. This further suggests that care needs to be taken so that contact with birth parents does not become an imposition on a child.

Other responses also suggested that continued contact with a birth parent was possible and not permanently truncated. In one instance, it appears the birth parent(s) were not taking the initiative. For example, "Mom is not able/willing to be in contact. It is her choice." Another respondent also shared that, "we are avoiding contact at the present time for his siblings' sake. (They lived with birth mom for a while and were neglected.) Someday, we hope to restore the relationship!"

C. Contact with Birth Siblings:

A total of 152 out of 200 caregivers (76%) indicated that their child had at least one birth sibling living outside of their home. Caregivers generally placed more importance on contact with birth siblings. Almost half (46%) indicated contact was either "very" or "extremely" important; however, 17% of caregivers still indicated birth sibling connections outside of the home were not at all important (See *Table 14*). Moreover, in the past six months, 45% of children had no form of contact with their birth siblings outside of their home (See *Table 15*). For those who did have contact birth siblings, the most common form of contact was through visitation or phone/Skype/FaceTime.

Table 14. Birth Siblings: Is Contact Important?

	Did Not Adopt Birth Siblings			**Contact Not At All Important**		
	N*	n1*	%	N	n2*	%
Birth Siblings	200	152	76%	121	20	17%

Note. *N= total sample, n1= subset of the sample who did not adopt birth siblings. n2= subset of the sample who rated the contact was not at all important.

Table 15. Birth Siblings: Did the Contact Happen?

	No Contact in Past 6 Months		
	N	n3*	%
Birth Siblings	121	54	45%

Note. N= total sample, n3= subset of sample who reported no contact in past 6 months.

9. Kinship Families:

Child and family well-being outcomes were assessed through the lens of biological (kinship) and non-biological (non-kinship) relations. There were 147 (17.4%) caregivers who indicated being biologically related to their child(ren). The nature or type of biological relations varied. The aunt/uncle type of kinship constituted the majority (61.2%) of the biological relationships.

A. Child Social & Emotional Wellbeing for Kinship vs. Non-Kinship Families:

Table 16 indicated that there were statistically significant differences between biologically related and non-biologically related children relative to social and emotional well-being. Children who were not biologically related to the adopting parent/family had significantly better social and emotional well-being overall (mean= 30.9) than those in kinship (biologically related) families (mean= 28.01). For the subscales, they also had better social relationships and better resilience than children who were biologically related.

Table 16. Child Social & Emotional Wellbeing for Kinship and Non-Kinship Families

Measures	**Kin or Non-Kin**	N	Range	Mean	SD	t	df	p
Child Social and Emotional Well-being	kinship	147	0-47	28.01	4.62	6.36	845	0.000*
	Non-kinship	700		30.90	5.10			
Relationship Subscale	kinship	147	0-21	11.80	2.36	6.61	845	0.000*
	Non-kinship	700		13.19	2.32			
Resilience and Optimism Subscale	kinship	147	0-26	16.21	2.82	5.68	241.25[a]	0.000*
	Non-kinship	700		17.71	3.35			

a – Equal variances not assumed. *Statistically significant at the .05 alpha level

Previous research suggest that kin-based placements may offer adopted children better stability and limit the likelihood of discontinuity, especially for those kin-based adoptions involving grandparents compared to other relatives (Faulkner et al., 2016; Ryan et al., 2010). However, our results reveal that children who were not biologically related to the adopting parent/family had significantly better social and emotional well-being overall than those in kinship families. Kin adopters may sometimes proceed with adoption out of a sense of obligation and may not actually be prepared or resourced adequately (Ryan et al., 2010; Spence, 2004). Of kin-based adoptions that are necessitated by parental neglect, abuse, etc., it is believed that, in some cases, the children will remain in settings where they may continue to encounter, even if indirectly, negative family dynamics or tensions. Further, there is some indication that some non-kin based adoptions may be characterized by greater consensus and commitment from the adopting parents than kin-based adoptions (Font 2015; Ryan et al., 2010). In kin-based adoptions, it is conceivable that the party biologically or directly related to the child may be more supportive of the adoption than their partner/spouse. The reverse is also possible in which case the partner/spouse who is not biologically or directly related to the child may express greater support or commitment towards adopting a child. This means the child could end up in a fractious environment which can be detrimental to their socio-emotional well-being. Situations like this may partly explain why non-kin placements are sometimes considered to be desirable.

Font (2015, p. 15) observes that:

> …at least some portion of the stability gap that is being considered a benefit of kinship care, and used to promote kinship preferences, may be better explained by the policy preferences themselves. That is, children in non-relative foster care are more likely to experience positive placement changes (i.e., moves to a more desirable placement, as defined through policy priorities), whereas placement changes in kinship care tend to be to less desirable placements…

Font (2015) also notes that the intensive involvement of caseworkers in non-kinship based placements may have the added benefit of more fitting placements for children. Font's conclusions challenge some of the commonly held notions about kin-based placements.

B. Caregiver Strain for Kinship vs. Non-Kinship Families:

Respondents with a biologically related child (kinship families) reported statistically significantly higher levels of caregiver strain (mean= 2.65) compared to those who were not biologically related to the adopted child (non-kinship families) (mean= 2.32) (See *Table 17*). Similar results for the subscales of caregiver strains.

Table 17. Caregiver Strain Scores for Kinship and Non-Kinship Families

Measure	Kin or Non-Kin	N	Range	Mean	SD	t	Df	p
Caregiver Strain Questionnaire Global Scores	Kinship	147	1-5	2.65	.56	6.12[a]	250.79	0.000*
	non-kinship	700		2.32	.70			
Objective Strain	Kinship	147	1-5	2.58	.67	6.16[a]	257.84	0.000*
	Non-kinship	700		2.19	.86			
Subjective Internalized Strain	Kinship	147	1-5	2.57	.80	4.92[a]	240.60	0.000*
	Non-kinship	700		2.14	.91			
Subjective Externalized Strain	Kinship	147	1-5	2.72	.59	5.81[a]	233.24	0.000*
	Non-kinship	700		2.44	.70			

a – Equal variances not assumed. *Statistically significant at the .05 alpha level

C. Commitments for Kinship vs. Non-Kinship Families:

Respondents with a biologically related child (kinship families) were more likely to report that they would not have adopted the child if they knew what they know now (M = 2.52) than those in non-kinship families (M = 1.9). Respondents in kinship families thought more often about ending this adoption (M = 2.26) than those in non-kinship families (M = 1.63) (See Table 18).

Table 18. Commitments for Kinship and Non-Kinship Families

Measure	Kin or Non-Kin	N	Range	Mean	SD	t	Df	p
Adopted if they knew what they know now	Kinship	147	1-5	2.52	1.06	6.47[a]	212.69	0.000*
	non-kinship	700		1.90	1.06			

Thoughts about ending this adoption	Kinship	147	1-5	2.26	.94	6.82[a]	845	0.000*
	Non-kinship	700		1.63	1.03			

a – Equal variances not assumed. *Statistically significant at the .05 alpha level

10. Experiences of Transracial Adoption:

In our sample, 42.2% (n=357) caregivers reported itself as being a transracial family. Close to half of these families talked about being a transracial family at home (46.5%), chosen childcare providers/teachers or other role models similar to the child's race/ethnicity (49.3%), and being involved in religious, social or recreational groups/activities that reflect the child's race/ethnicity (51.3%). Total 42% of caregivers reported the child had problems being in a transracial family, 45% indicated the child have problems with racial discrimination either presently or in the past, 49.6% said the child has resources of support in the transracial family, 50.7% felt they knew how to help the child when he/she is being teased or bullied or discriminated against because of race. Lastly, 42.9% reported the transracial adoption or guardianship had an impact of their wellbeing and 39% had an impact on their marriage or significant other relationship.

11. Community Services:

A. The Most Important Services and Supports for Families:

Regarding the most important services and supports for families, respondents mentioned family support, community support, financial support (sometimes noted as Government subsidy), and treatment supports (therapy/counseling), and agency trainings and support.

(1) Agency Trainings/Support. Respondents mentioned support from agencies such as "Adults Adopting Special Kids (AASK)" and "Path of North Dakota and Catholic family services." Respondents also expressed a desire or need for continued engagement and services with the relevant agencies. For example, a respondent presented the following, "People at PATH…still call when I have questions", pointing to their connection with PATH and utilizing the agency in having questions addressed.

(2) Family/Friends/Community Support: Respondents also expressed the need for various forms of support including "networking opportunities", "Facebook", and "church". Some respondents highlighted the importance of family support. For example, "great understanding and support from the family"

(3) Financial Support: Respondents frequently mentioned financial/monetary assistance. This was sometimes expressed as "subsidy support through the county" or "the government provides certain economic subsidies".

(4) Medical Care and Counseling/Therapy: Respondents also mentioned "medical and therapy" services. References were also made to specific types of therapy such as "trauma informed therapy."

(5) Legal services. Some respondents also mentioned the need for "free legal advice" and supports. In some instances, very specific services were desired. A participant

shared that, we hope that a lawyer can arrange to communicate with the biological parents of the child. In addition to normal visits, there is no need to intervene in the child's life too much."

(6) Respite. Responses were also given on respite such as "respite relief, either day time or overnights."

B. The Most Needed But Hard-To-Get Services:

Respondents highlighted the need for several supports and services. Some of the expressed needs were similar to the services and supports that had been noted as being important to families formed through adoption. Participants frequently mentioned financial support, support groups and connections to other adoptive families, counseling and therapy services, and respite. It is worth noting that the identified services and supports can be framed within a post-adoption context.

(1) Agency Trainings/Support. Respondents requested for post-adopt services. Respondents also requested the simplification of adoption processes/procedures.

(2) Support Groups and Family/Friends/Community Support. Respondents highlighted the need for peer supports through connections with other adoptive families.

(3) Financial Support. Respondents frequently mentioned financial support with some of them using the term "subsidies".
In February 2021 and pursuant to state legislation, foster care and adoption subsidy eligibility functions were moved from the Human Service Zones (formerly county social services) to a state unit. This new unit, the CFS Foster Care & Subsidized Adoption Unit is designed to provide a more efficient and consistent process for adoption subsidy negotiation. Adoption workers communicate directly with the Unit during the adoption service process and a sub adopt negotiator is assigned to meet with the family for negotiation purposes. The goal of the Unit is for adoption subsidies to be negotiated within 7 days of the referral to the Unit by the AASK adoption worker. Adoption Subsidy amounts are individually negotiated, but cannot exceed what the child has received in foster care maintenance support.

(4) Counseling/Therapy and Medical Care. Respondents also requested for mental health supports. Some of the respondents noted the need for specialized supports such as attachment therapy. There were moderate references to medical services. Minimal reference was made to dental services.

(5) Educational Services. Respondents stressed the need for educational resources and supports. Some of the responses suggested that getting into/staying in school was challenging as access may not have been equitable. A respondent noted that they "need fair treatment from the school".

(6) Respite and Accessibility in Rural Areas. Other responses reflected an expansive view of the need for supports and services covering respite and daycare. Extending beyond the adopted child(ren) and the adoptive family, some respondents highlighted the need for connections to their child's tribe, as well as care for or connections to biological families. Other responses brought into sharp focus possible differences and

opportunities for support based on where one lived, i.e. whether in a rural or urban setting. A respondent shared that, "no services available right in our rural community, but can be accessed by travelling out of town."

C. Top Barriers to Services and Support:

Regarding barriers, respondents mentioned the following:

(1) Bureaucracy (Red Tape). Respondents noted that there were procedures and requirements that impeded access to services and supports. These included the volume of paper work as well as length of time involved with process. Some respondents shared that:

- "The loads of paperwork needed, how difficult it is to understand, the money needed and how to access people to provide services"
- "Every time we need to queue, wait, a lot of tedious procedures to waste most of our time"

(2) Lack or Limited Availability of Services. Respondents referenced the inadequacy of services as well as workforce challenges. This appears to be a situation that lengthened the waiting time even if one qualified for services. Some respondents shared the following:

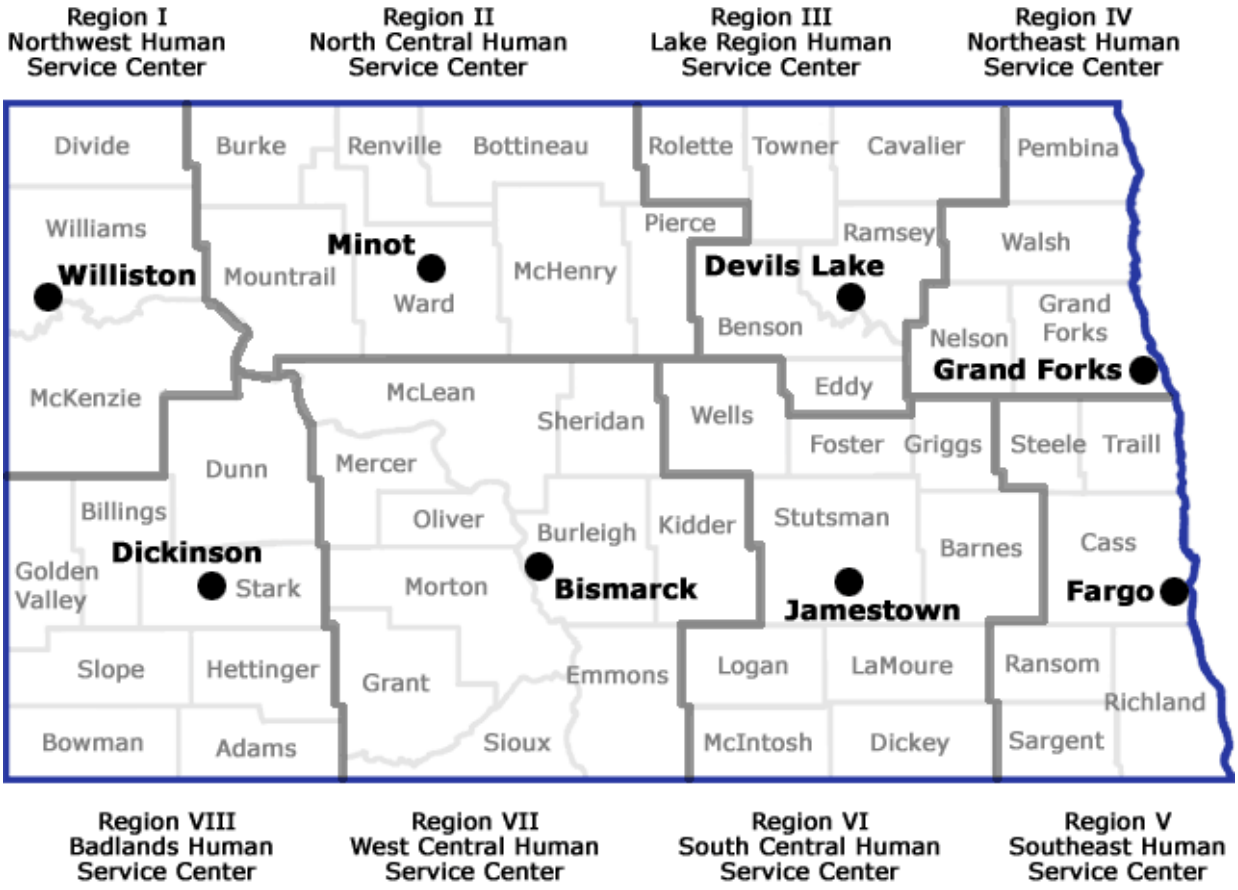
- "Some services have only a limited number of places and often do not get them"
- "High numbers of people needing mental health care combined with lower pay to attract professionals."
- "Specialists needed for behaviors-not available or months out to get an appointment"
- "Crisis Management—[some agencies] are only Crisis Pause or Crisis Delay. They do NOTHING to follow up or really set a good plan in place."

(3) Lack of Family support. Several respondents identified lack of family support or understanding as a barrier.

(4) Other Barriers. Barriers infrequently mentioned, included money and factors like the size of the community, rurality, and distance. A respondent shared "having to drive over an hour to get anything."

D. Regional Differences:

North Dakota Department of Human Services (2020) covers 68,976 square miles, with a 2019 estimated population of 762,062 people - 377,509 living in rural North Dakota. Bismarck, the capital, is located in the south-central region of the state. North Dakota has large areas with low population density, mixed with several densely populated larger cities. The state's largest cities are Fargo, Bismarck, Grand Forks, and Minot.



Among the eight North Dakota Human Service Centers, the following were identified regarding the most important and needed services as well as barriers (See *Table 19*).

According to the Department of Human Services in North Dakota, there are many services that can be accessed to support an adoption or guardianship. Services provided by staff or through contracted providers may include: assessment, care coordination, medication management, home and community-based services, residential services, crisis beds and inpatient hospitalization and emergency services.

Table 19. Community Services by Regions

Human Service Center	**Most Important Services**	**Services Needed but Hard to Get**	**Barriers**
Williston	Family Support, Economic Support	Medical, Education, Counseling	Complicated Adoption Process, Family Support
Minot	Economic Support, Family Support	Economic Support, Counseling,	Family Support, Adoption Procedures
Devils Lake	Economic Support, Family Support	Economic Support, Community Support	Family Support
Grand Forks	Family Support and Economic Support	Community Support, Counseling	Family Support

Fargo	Agency Support, Economic Support, Family Support	Support Groups	Family Support
Jamestown	Counseling, Family Support, Economic Support	Respite	Refer to General Discussion of Barriers Above (p. 32)
Bismarck	Economic Support, Agency Support, Medical Support	Support	Refer to General Discussion of Barriers Above (p. 32)
Dickinson	Family Support	Economic Support	Refer to General Discussion of Barriers Above (p. 32)
Outside ND	Agency Support, Medical/Health Support	Supports	Refer to General Discussion of Barriers Above (p. 32)

Most behavioral health professionals are found in urban areas, which include the eight largest cities in North Dakota. This includes psychiatrists, psychologists, counselors, licensed addiction counselors, and social workers. One of the most important services identified in the urban areas was agency support. Another discovery was the urban areas reported only one service that was difficult to get compared to rural areas, where many services were difficult to obtain. North Dakota's rural population consists of 39.4 percent and is defined as less than 50,000 people per area. This could be due to less resources however it also may be difficult for the respondents to access resources in rural areas, when travel and distance are continued factors.

Limitations:

There are several limitations to this study. First, we do not have demographic questions about the respondents (e.g. gender, education, income, and ethnicity) although we have demographic questions for the identified child. Second, although we asked respondents how many of their children are adopted from public child welfare agency or from intercountry and private domestic agency, we cannot be sure of the type of the adoption for the identified child in the survey they answered for (some respondents may have adopted more than one child from more than one agency type). Third, having the parent pick the adopted child to answer questions versus being prescriptive (such as having the parent answer for their oldest adopted child) can also skew the data. Fourth, in addition to the mailing list of adoption subsidy check/remittance from North Dakota Department of Human Services and the list of email distributions of the North Dakota Post Adopt Network memberships, we advertised the ND Permanency Survey on the website of the network and its social media (Facebook page) and newsletters to increase the response rate and being more inclusive. However, the downside is that we cannot effectively control and monitor if the respondents fit the criteria— One parent/caregiver per adoptive or guardianship family in North Dakota, especially when the survey is online and anonymous. Shortly after launching the survey, we soon found the loophole and stopped posting the advertisement on the post adoption network website and social media. Thus, we utilized several strategies to clean up the data. For example, we deleted subjects who completed the survey less than 10 minutes, used the same IP address repeatedly, had more than 50% survey incomplete, reported child's birth year that equal to age 21 and over (adult children are not eligible in the study), and those who

reported their own birth year equal to 18 and under (people under 18 cannot adopt a child). Moreover, we subtracted child's birth year from the finalized adoption year, and we deleted subjects who have negative values because the finalized adoption year cannot be earlier than the year child was born. After applying these strategies, we are more confident about the accuracy and representation of the reminding respondents (n= 847). Lastly, another limitation is that the nature of a survey cannot fully capture the underlying mechanism and complex circumstances and experiences these families had, but provide an overview and identify patterns or trends.

Discussion:

By surveying a high percentage of adoptive and guardianship families in North Dakota, we are able to have an overview on characteristics for adoptive children and caregivers and their wellbeing, and identify strengths, risks/stress, and needs of families post permanency in order to provide and advance relevant services and support. The North Dakota Permanency Survey was also able to understand caregivers' experiences and communications around adoption and transracial adoption, activities and attitudes toward contact with the child's birth family, and examined the role of kinship adoption on caregiver's strains and on family and child wellbeing. Moreover, the ND Permanency Survey was also able to identify the types of services and supports that are most important and most needed for families, identify the potential barriers to those services, and identify regional gaps in service.

Consistent with previous post adoption literature (Rolock, 2015; Rolock & White, 2016, 2017; White, 2016), the findings in this study indicate that most children and families in our sample adjust well after adoption was finalized, while a small proportion of families (about 6-11%) report negative impacts, unmet needs and some challenging issues. These families might benefit from additional outreach and relevant services. The ND Permanency Survey team reached out to statewide adoptive families and collected firsthand information about their experiences in adoption and guardianship to identify the needs to enrich and improve the services and support for families to thrive and improve their wellbeing.

The qualitative details presented are not based on in-depth interviews or focus group discussions. They are responses/comments provided to some of the survey questions that elicited additional comments. These responses/comments have been included to offer general insight into the experiences of adoptees children and adoptive families. We recommend full-scale qualitative studies to engender a comprehensive understanding of the experiences of adoptees and their adoptive families.

Challenging Issues. The findings also displayed several types of child's challenging issues, including mental health problems (14%), intellectual disability (8%), food challenges (8%), physical health problems (7%), sibling conflicts (7%), physical disability (4%), and alcohol/substance use (4%). Moreover, in caregivers' descriptions of these challenging issues, it appears that these challenging issues are common with children who have insecure attachment or trauma-related concerns. For example, hoarding or stealing food is one way that children with insecure attachment or a history of maltreatment gain control of their situation and utilize hoarding as a survival strategy. Children who have experienced trauma can demonstrate challenging behaviors that can stress families beyond their capacity to cope (Barth et al., 2005; Lloyd & Barth, 2011; Tan & Marn, 2013). Thus, it is important to practice trauma-informed care that allows caregivers to understand the child's behavior and figure out what might be causing

the behavior. Instead of asking "what's wrong with you", caregivers can address "what's happened to you." If a child is hoarding food and the family does not understand the implication of attachment/trauma around this behavior, they may choose a behavior strategy that will unintentionally cause behaviors to worsen. Knowledge around attachment and that it serves as a survival function and how this may go awry in children in foster/adopt situations will be vital in families accessing the appropriate service that their child may need. This will also increase the likelihood that families will be armed with the appropriate tools for managing challenging behaviors at home.

Moreover, formal and informal supports around preparing parents for the challenges that come with children who have experienced trauma will be an important piece of training. Parents will need access to tools and resources to face challenges and a holistic approach will be key. Trauma research reminds us that aggressive children are scared children and parenting practices must adjust to different ways to understand the child's behaviors and avoid re-traumatization. Lastly, helping parents build their capacity to endure challenges that may come in the months and years ahead. It is important to help parents have the mindset that developmental stages may bring new challenges and that it will be key to have supports in place to work through any concerns.

Impacts on Job/Employment. Respondents noted difficulties maintaining a job or going back to work post adoption. There are a variety of reasons why it may be difficult for caregivers to work including multiple mental health appointments, the child having difficulty at school, the need for constant supervision and the lack of informal support to help care for the child. This not only has an impact on the parent's emotional wellbeing but an economic impact. When parents are unable to work, this has economic impacts on the community therefore providing education and resources to business leaders in the community would be an important place to start. Resources including connection to quality childcare, tele-health services, flexibility with service providers including phone calls and virtual services and flexibility in their work schedule would allow parents to not have to choose between their job and their child. One thing to note is that parents who do not get a break from caregiving a child with high needs will resort to feeling burnout, leading to be less effective in their parenting practices.

Contact with Birth Family. The findings revealed a variety of reasons why a child may or may not have ongoing contact with birth parents. It appears more education for families around the benefits and concerns of contact would be important, as well as sharing best practices for ongoing contact. Previous research has shown that children that have contact with their birth families have a better understanding of their adoption story and more regulated in where they came from (Neil, 2019). Based on this, it will be helpful for each agency to assess the attitudes and beliefs around ongoing contact with birth parents and what type of education, training or support is needed. There may be many value systems regarding ongoing contact with birth parents within county workers and this may also differ based on each individual worker. Taking a Trauma-Informed approach would streamline these value systems, providing basic recommendations that would support the child and their family. Separation from their caregiver is already a significant trauma insult to the child and it will be vital that all parties work to avoid re-traumatization and improve the child's ability to understand their story. Finally, having clear

guidance on what role the child plays in determining if they should have contact with birth parents is important.

Kinship Adoption. In kinship adoptions, the relationships and dynamics between caregivers and their kin, the child's birth parents, are often complex and sometimes quite painful. The services and supports usually focus only on the child and the child's needs, but do not do well supporting kinship caregivers around their own struggle with their family members. For example, in kinship adoptions, there may be difficulties *setting boundaries* with birth parents. Grandparents that become kin parents often feel like they have to choose between their child and their grandchild. They may also get overwhelmed caring for small children again and want help from the birth parents. Because the boundaries are blurred, the child may be at risk of ongoing emotional or physical safety concerns. *Re-traumatization* is also a concern in kinship adoption, as the child may not have a clear then/now, which would make it more difficult to process the trauma and move forward. It is vital that kin parents have support from Trauma-Informed trained mental health clinicians in setting these boundaries and ensuring that the child is safe and able to move forward from the traumatic experiences. Moreover, respondents expressed concern over the lack of information and support. It will be important to review how training is rolled out and how often it is provided. There is an overwhelming amount of education families need during and after adoption and the frequency as well as timing will play a big role in how effective the education is.

Community Services by Regions. Similar to other research with families formed through adoption, families involved in this study reported that they need a variety of supports and services. However, these varied based on geographical location and more discussion is necessary to tailor services and supports based on what is identified. For example, families in Western North Dakota identified a need for more medical and counseling services, an area that we know is underserved. Interestingly, families in Fargo identified a need for support groups, although a wide variety of foster care and post adopt support groups exist. This may be an indication that services are available, however depending on the type of adoption or how connected a family is to formal services, may determine if the family seeks out this support. Assessing the attitudes around support groups may also be beneficial to determine why a family may or may not choose to attend. Future research might focus around different philosophies related to adoption-based services, based on geographical location or agency attitudes. Each region may have similar services, however may be underutilized or undervalued in some parts of the state. Likewise, each region may have services such as mental health providers, however vary in training and ability in working with foster care/post adopt. A focus around what works best for rural populations vs. urban populations would be important to improve service delivery.

One final concern noted around service delivery was the lack of a centralized component. Children that have a history of abuse/neglect often need a variety of intervention services to not only catch up in development but work through trauma and attachment concerns. These services are often weekly and in many different locations. This puts a significant strain on families, as noted earlier. Future discussions around a one-stop-shop or centralizing services for families as much as possible should be had, which will allow for better coordination between service providers and less barriers for families to access the services.

In sum, some suggestions moving forward:

- Maintain supports with families after adoption and guardianship. Connections to formal and informal supports, services and resources should begin prior to adoption or guardianship finalization and continued after.
- Offer nontraditional supports to rural parts of the state. Since Covid-19, tele-health services in the state of North Dakota has increased exponentially and should continue to meet the needs of families with less formal supports or access to services.
- Increase school based mental health services to reduce barriers of accessing services and to reach more children that may need mental health supports.
- Increase staff competency on services needed to increase the likelihood that families will access these supports.
- Provide outreach to post adopt families at risk periods or different developmental stages to avoid major concerns or stressors. This could be looked at similarly to a dental practice, where check-ups prevent long term negative outcomes.

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