Transition-Age Youth in Out-of-Home Care: Predictors of Readiness Skills for Adulthood

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Abstract

Objectives: Youth who age out of the child welfare system are among the most vulnerable group of young people entering adulthood today. Unlike their generational peers, foster youth lack the familial supports necessary to postpone major life decisions and gradually enter adulthood. Although there are notable differences between Canadian and American child welfare contexts, young people exiting both systems experience a compressed transition and are tasked with quickly managing adult responsibilities. Few studies have examined pre-transition factors that correlate with adolescents' readiness skills prior to exiting out-of-home care. Methods: This dissertation presents two studies that examine factors associated with transition-age foster youths' readiness skills for adulthood. In the first study I used cross-sectional data (n = 278) from Illinois, United States to assess the impact of adverse childhood experiences (ACEs) on youths' independent living skills and life domain functioning. I hypothesized that exposure to ACEs would predict lower transition readiness, and that trauma-related stress symptoms and strengths would moderate this association. In the second study I used cross-sectional data (n = 1,026) from Ontario, Canada to identify youth-, placement-, and agency-level factors that predicted youths' self-care and financial literacy skills. I hypothesized that factors most proximal to individuals would impact readiness (e.g., academic performance, self-esteem). Results: Hierarchical regression analyses indicated that ACEs predicted lower transition readiness. Traumatic stress symptoms moderated these relations, and engagement in risky behaviours partially mediated these relations (study 1). Hierarchical linear modelling indicated that agency-level differences did not impact readiness. In contrast, general linear modelling indicated that a subset of individual- and placement-level factors did impact readiness. Specifically, higher academic performance, higher self-esteem, a greater number of developmental assets, older age,

an older age of entry into care, a greater number of placement transitions, and kinship care placement predicted higher transition readiness. A greater number of socioemotional difficulties, a greater number of long-term mental and/or physical health conditions, and a lower frequency of problematic parenting practices combined with a higher frequency of effective parenting practices predicted lower transition readiness (study 2). Conclusion: Findings illustrated that although ACEs exposure predicts lower adult readiness among transition-age youth, whether youth engage in risky behaviours and possess developmental strengths may be better predictors of their readiness to age out of care (study 1). Findings also illustrated that a subset of individual- and placement-level factors predict self-sufficiency skills among transition-age youth (study 2).

Keywords: Child welfare, transition readiness, risk and protective factors

Statement of Contributions and Co-Authorship

This dissertation was prepared in collaboration with Dr. John Hunsley, my thesis supervisor (2014-present), and with Dr. John S. Lyons, my thesis supervisor prior to his departure from the University of Ottawa (2009-2014). I am the primary author of the dissertation. As primary author, I was responsible for conceptualizing the research design and methods, conducting the literature reviews, managing the secondary datasets, conducting the data analyses, interpreting the results, and preparing the manuscript. Drs. Lyons and Hunsley contributed to the aforementioned activities as supportive supervisors. Dr. Lyons provided guidance and assistance in all aspects of the dissertation prior to 2014; Dr. Hunsley provided guidance and assistance in all aspects of the dissertation thereafter.

Dr. Lyons facilitated access to the secondary dataset used in the first study through his academic and professional affiliations with the Illinois Department of Children and Family Services (DCFS). Dr. Robert Flynn facilitated access to the secondary dataset used in the second study through his academic and professional affiliations with the Ontario Looking After Children (OnLAC) project and aided in the conceptualization of the second study. Dr. Dwayne Schindler provided guidance on the statistical analyses of both studies and Dr. Veronika Huta provided guidance on the statistical analyses of the second study.

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General Introduction

Every year in North America, thousands of young people transition from out-of-home care into independent living. The process of leaving the child welfare system by reaching the age of majority, rather than exiting via adoption or family reunification, is referred to as aging out, emancipating, or discharging from care (Bass, Shields, & Berhman, 2004; Courtney & Heuring, 2005; Stein, 2006; U.S. Department of Health and Human Services, 2015). These "care leavers," typically between the ages of 16 and 21 years, enter adulthood at an accelerated pace relative to their same-age peers (Dworsky & Havlicek, 2009; Stein, 2006). They find themselves responsible for their own welfare when the state ends its legal obligation to ensure their well-being and provide them with substitute guardianship (Courtney, 2009).

In practical terms, this means that these individuals are often abruptly tasked with finding their own shelter, financial resources, and daily living supports without a formalized source of assistance. Although some youth have the option and choose to return to their biological families, family reentry can be fraught with challenges given the period of separation that occurred and the reality that the factors within the home that resulted in removal may still exist (Jones, 2012). Longitudinal research tracking the outcomes of care leavers indicates that by 21 years of age, the majority are living on their own (Courtney et al, 2007).

The following review of the literature serves to emphasize the need for research examining predictors of transition-age foster adolescents' self-sufficiency skills. I first describe the typical journey into adulthood for contemporary youth, then contrast these circumstances with those of foster youth. Next, a rationale for care leavers' high risk for negative outcomes in adulthood is provided, as well as their need to demonstrate advanced self-sufficiency skills at a

younger age relative to their same-age peers. I then summarize conceptualizations of transition readiness. I describe how the care leaver literature has historically equated transition readiness with youth demonstrating the skills to succeed in adulthood without relying on government assistance.

Given the field's predominant focus on self-sufficiency skills as a proxy for transition readiness, as well as this dissertation's focus on these skills as an outcome of interest, the concept of self-sufficiency is next reviewed. I summarize studies demonstrating that, despite significant odds for negative outcomes, a sizable proportion of foster youth transition successfully into adulthood. I then review empirical research from American, Canadian, and international child welfare contexts supporting the common assertion that young people with higher self-sufficiency skills are more likely to succeed post-transition.

After summarizing the rationale for self-sufficiency skills indicating transition readiness, I discuss child welfare providers' efforts to equip young people with these skills. The rationale for independent living skills programming is provided, as well as evidence of these programs' modest rates of effectiveness. In light of these mixed findings, I propose that other, as-of-yet unidentified factors may be more influential than classroom instruction or tutorship in determining whether adolescents possess high or low levels of self-sufficiency skills prior to exiting care. I expand on this hypothesis by identifying individual and socio-environmental factors (e.g., maltreatment histories, ongoing traumatic stress symptomatology, engagement in risky behaviours, academic performance, supportive caregiver relationships) that may act as risk, promotive, or protective factors regarding care leavers' transition readiness skills. I emphasize the importance of exploring this question from both a trauma-informed risk and protective factors perspective and a multi-level ecological systems perspective.

Lastly, I describe the theory, conceptual models, objectives, and hypotheses of the two presented studies. I explain how the studies address existing gaps in the literature, given that only a minority of care leaver research is explicitly grounded in theory, oriented towards examining resilient functioning, focused on examining factors that promote or impede transition readiness, and quantitative rather than qualitative in analytic design. I conclude by discussing the significance of both studies and how results may inform future research, policy, and practice.

Conceptualizations of Adulthood

It is important to define what *adulthood* entails, given that this is the goal for emancipating foster youth. Two different conceptualizations of the period following adolescence exist, a traditional definition of adulthood and a more contemporary one. Both conceptualizations will be described here.

Traditional definition of adulthood. The traditional perspective, held for most of the twentieth century, conceived of adulthood as occurring immediately after adolescence (Furstenberg 2010; Hogan & Astone, 1986; Modell, Furstenberg, & Hershberg, 1976). This viewpoint reflected the typical journey into adulthood for young people prior to the 1960s. For these individuals, accomplishing major life milestones and adopting new social roles within a brief period was the generational norm (e.g., leaving home, marrying, becoming parents, entering the workforce).

The work of Erikson (1963) helped to inform this traditional conceptualization of adulthood. He conceived of human development as occurring via a series of transitions through chronological stages, each with its own psychosocial crisis to resolve. In adolescence (defined as ages 12 to 18 years), the conflict was identity formation versus role confusion, whereby youth needed to develop their self-image and life ambitions in order to successfully transition into

adulthood (Erikson, 1963). He theorized that individuals who were unsuccessful at these tasks would struggle to achieve adult independence (Kroger, 2002).

Sroufe and Rutter (1984) contributed to this life span theory of development by suggesting that unresolved issues from earlier life stages would complicate later stages. Also adding to this conceptualization of adulthood was the work of Furstenberg (Furstenberg, Rumbaut, & Settersten, 2005; Modell, Furstenberg, & Hershberg, 1976). Furstenberg examined economic and social trends to determine markers of adulthood. According to his research, traditional socioeconomic indicators of adulthood included living outside the familial home, marrying, bearing children, parenting, finishing schooling and vocational training, and starting one's career.

Contemporary definition of adulthood. Over the latter third of the past century, family institutions, labour markets, and social expectations in Western society began to change (Bynner, 2005; Côté & Bynner, 2008). In response to these shifting patterns, young people began delaying adult milestones, thus extending the maturation timeline (Furstenberg, 2010). Today, rather than quickly settling into traditional adult roles upon reaching the age of majority, many young people enter a prolonged period of experimentation (Arnett, 2007; Avery, 2010; Côté & Bynner, 2008; Furstenberg, Rumbaut, & Settersten, 2005; Settersten & Ray, 2010; Shanahan, 2000).

This protracted coming of age, extending into one's twenties and even thirties, has been designated a new developmental stage called "emerging adulthood" (Arnett, 2004). Characteristics of emerging adulthood include identity exploration, instability and uncertainty, an emerging self-focus, a felt range of possibilities, and a sense of being in-between adolescence and adulthood (Arnett, 2004). Achieving tangible markers of self-sufficiency is not a defining characteristic of this developmental stage (Osgood, Ruth, Eccles, Jacobs, & Barber, 2005).

Instead, young people spend this time refining their reasoning skills, negotiating relational interdependence, expanding their sense of social responsibility, and managing their behavioural desires (Arnett & Taber, 1994).

Emerging adulthood versus "aging out of care." There are perceived biopsychosocial advantages to emerging adulthood, whereby young people delay the onset of adulthood past the age of eighteen years. One biological advantage is that individuals may be more cognitively mature by the time they make meaningful, long-lasting life decisions. Age is a crude measure of maturity, and areas of the brain associated with impulse control, emotion regulation, long-term planning, and information processing continue developing into the third decade of life (Cohen, Kasen, Chen, Hartmark, & Gordon, 2003; Steinberg, 2005). One societal advantage is that young people may be better prepared to succeed in the current economy. It is now common for entry-level jobs to require postsecondary education; by delaying childbearing and entry into the workforce, emerging adults can acquire the training, education, and experiences necessary to increase their job marketability and compete for employment (Avery, 2010; Avery & Freundlich, 2009; Cohen, Kasen, Chen, Hartmark, & Gordon, 2003; Connell et al., 2006; Furstenberg et al., 2005; Furstenberg, 2010; Mouw, 2005).

Emerging adulthood is also costly. In order to experience this life stage, young people frequently rely on their immediate families to provide them with financial aid, shelter, and socioemotional support (Arnett, 2007; Clark & Davis, 2000; Fields, 2004; Furstenberg et al., 2005; Goldscheider & Goldscheider, 1998). Research indicates that all emerging adults tend to receive assistance from their families, regardless of socioeconomic background (Fingerman et al., 2012; Fingerman et al., 2009). Using American income and census data (n = 6,661 youth), Schoeni and Ross (2004) determined that, on average, parents were contributing $2,200 annually

in material support to their adult offspring (defined as ages 18 to 34 years; a total of roughly $38,000 per emerging adult). This value differed by parental socioeconomic status (a total sum of $25,000 for lower income families versus $70,696 for higher income families). Contributions of non-material support were also significant. Annually, parents were providing an average of 367 hours in ancillary help to their adult children (i.e., the equivalent of 9 weeks of full time, 40-hour-per-week assistance). Time expenditures were virtually identical for low and high income families (3,864 versus 3,869 total hours of help, respectively).

Although emerging adulthood is increasingly common within industrialized societies, this life stage is not experienced by all young people (Billari & Willson, 2001; Tanner, 2006). Particularly disadvantaged are adolescents who enter adulthood from out-of-home care (Collins, 2001). Increasingly, the demands placed upon the shoulders of these youth stand in stark contrast to the expectations placed upon their generational peers. Care leavers often find themselves navigating a sudden entry into adulthood with neither the support of their biological families (out-of-home placement and the reasons for out-of-home placement often weaken these connections) nor the support of the child welfare system from which they exited (Avery & Freundlich, 2009). This unusual life circumstance is referred to as a "dual transition" (Avery, 2010; Shook, Vaughn, Litschge, Kolivoski, & Schelbe, 2009). Not only must these youth transition from adolescence into adulthood, but they must also quickly assume the responsibilities of independent living after leaving care (Bussiere, Pokempner, & Troia, 2005; Courtney & Heuring, 2005). Both life adjustments tend to occur suddenly, simultaneously, and before many adolescents are ready for these tasks. These circumstances often result in young people scrambling to survive on their own in early adulthood (Collins, 2001).

Summary. It is important to define different conceptualizations of adulthood, given the significant differences in how care leavers and their same-age peers experience this life stage. Former foster youth are often abruptly tasked with managing adult responsibilities and ensuring their own well-being, whereas their peers are more likely to enter a developmental period called "emerging adulthood" after adolescence. There are perceived disadvantages to abruptly facing adult responsibilities, and perceived advantages to experiencing emerging adulthood.

Challenging Entries into Adulthood for Care Leavers

Given the unique expectations placed on youth who age out of care, namely that they shall succeed at independent living soon after entering adulthood, child welfare practitioners, policy makers, and researchers had long expressed a desire to know how these young people fare in adulthood (Collins, 2004; Courtney et al., 2001). Despite this, for many years the experiences of emancipated youth remained under-researched. This gap in the literature was likely partly due to competing system priorities (emancipation affects a relatively small proportion of young people in child welfare and many children in care have pressing needs) and partly due to how notoriously difficult it is to obtain follow-up data for this population.

Promisingly, in the past few decades a growing number of researchers have examined the welfare of these young people after exiting care (Avery, 2010; Courtney et al., 2001; Courtney et al., 2010; Courtney et al., 2011; Samuels & Pryce, 2008). Information is now available regarding their experiences in early adulthood, including their life trajectories, varying profiles, and challenges they face. The resulting research indicates that foster youth who do not achieve permanency (i.e., neither reunified with their families nor adopted) and instead emancipate from the child welfare system are vulnerable to experiencing many hardships (Collins, 2001).

Outcomes studies indicate that, compared to their same-age peers, youth who age out of care are more likely to experience arrest, homelessness, housing instability, unemployment, underemployment, poverty, a lack of access to health services, unplanned pregnancies, early parenting, social isolation, poor psychological adjustment, physical and mental illness, physical disabilities, and addictions problems in adulthood (Courtney et al., 2001; Courtney & Heuring, 2005; Havlicek, Garcia, & Smith, 2012; McMillen & Raghavan, 2009; Mendes & Moslehuddin, 2006). Many fall behind their contemporaries in terms of educational attainment and other developmental milestones (Courtney & Dworsky, 2006). Those who are employed often make too little to support themselves, may not finish high school, and may lack the financial means to pursue postsecondary education or career training (Courtney & Dworsky, 2006). Likely related to their maltreatment histories, in combination with hardships possibly experienced while in foster care (e.g., separation from family of origin, placement disruptions, failed adoptions), many foster adolescents enter adulthood while also managing physical, emotional, educational, vocational, relational, and/or behavioural difficulties (Buehler et al., 2000; Keller et al., 2007; Mendes & Moslehuddin, 2006).

Lacking transition readiness skills. These discouraging findings would seem to suggest that foster youth are often ill-prepared for independent living. The perspectives of recently emancipated youth, solicited by Loman and Siegel (2000) in their assessment of foster youths' independent living needs, support this estimation. These young adults reported that there were many adult tasks that they felt they had not been prepared for while in care. These included finding housing, budgeting, acquiring a job, accessing vocational training, planning a career, and raising a family. Child welfare providers were asked for their opinions on the subject and they agreed that many adolescents seemed ill-equipped for adult living tasks prior to exiting care.

They perceived transition-age youth as often lacking proficiency in decision-making and communication skills, job acquisition and money management skills, self-care skills, and tasks of daily living. They expressed their belief that many adolescents also lacked sufficiently healthy levels of self-esteem upon entering adulthood (Loman & Siegel, 2000). These findings are consistent with other studies examining what skills child welfare youth and staff perceive as being critical for adult functioning (e.g., English, Kouidou-Giles, & Plocke, 1994; Mares, 2010; McMillen & Tucker, 1999). One interpretation of these findings is that they underscore the need for child welfare providers to take advantage of the window of opportunity that exists to help youth acquire self-sufficiency skills while under government care.

Summary. Every year, thousands of young people age out of the American and Canadian child welfare systems when they are no longer within the age range to receive services. Although care leavers are often forced to become prematurely self-reliant and responsible for their own welfare, their peers tend to rely on their families for practical and socioemotional support while seeking out educational opportunities, gaining marketable skills, developing their identities, and cognitively maturing. This contrast in childhood circumstances and early adult opportunities relative to their same-age peers leaves care leavers at a societal disadvantage. They are among the most vulnerable young people entering adulthood today. They are at risk of experiencing physical, financial, psychological, and/or social difficulties in young adulthood, and often lack the skills necessary to transition successfully out of care.

Conceptualizations of Transition Readiness

Transition readiness is a key priority of agencies caring for older foster youth (note: the terms transition readiness and readiness for adulthood will be used interchangeably in this review). Within the child welfare literature, transition readiness has historically been defined as

synonymous with youth possessing self-sufficiency skills (note: self-sufficiency skills will also be referred to as transition readiness skills, adult readiness skills, and independent living skills in this review; Inglehart, 1994; Lindsey & Ahmed, 1999; Mallon, 1998; Propp, Ortega, & Newheart, 2003). This definition has originated from the common sense reasoning that for youth to become self-sufficient after care, they must possess independent living skills. Some researchers also use a more expansive definition of transition readiness that takes into consideration the intrinsic, interpersonal, and interdependent aspects of transitioning to adulthood, while still emphasizing the role of self-sufficiency skills in the process (Zeira & Benbenishty, 2011).

Conceptualizations of Self-Sufficiency

Although the term *self-sufficiency* was referenced in the previous section, the concept will be defined and expanded upon given its relevance to this dissertation. Self-sufficiency has been defined as the ability to provide for one's basic needs both financially and practically so as to be able to live independently and not depend on government assistance for survival (Bannink et al., 2015; Fassaert et al., 2014). Self-sufficiency is closely connected to notions of individuation, autonomy, psychological self-reliance, intrinsic motivation, competence, and personal and financial sustainability (Grolnick & Ryan, 1989; Hawkins, 2004). Self-sufficient individuals are able to carry out daily living tasks, be economically independent, and manage adult responsibilities.

As stated, despite the significant challenges facing foster youth upon leaving care, child welfare policies generally assume that they will be able to succeed independently (Avery, 2010; Samuels & Pryce, 2008). Researchers frequently cite evidence of vocational, educational, interpersonal, financial, health, safety, transportation, daily living, and self-care skills as

signifying adult readiness, and descriptions of successful aging out experiences are intertwined with depictions of self-sufficiency (e.g., Barth, 1990; Collins et al., 2008; Cook, 1994; Courtney et al., 2001; Nollan et al., 2000; Stein 2006; 2008). Researchers studying care leaver trajectories often define *stable* or *successful* transitions using self-reliance indicators. In contrast, *unstable* or *unsuccessful* transitions are typically defined by a dependency on the state and/or others for basic needs and survival, and are measured by indicators of self-survival difficulties (e.g., incidents of incarceration, homelessness, unemployment, and/or drug abuse; Hedenstrom, 2014).

Expectation of self-sufficiency. Whether self-sufficiency is a feasible and appropriate expectation for care leavers remains a contentious issue. On one hand, an abundance of research conducted over the past several decades indicates that young people are leaving the system ill-prepared for the challenges ahead and thus are at significant risk of experiencing negative outcomes (e.g., Barth, 1990; Cook, 1994; Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Goodkind, Schelbe, & Shook, 2011; Loman & Siegel, 2000). This would suggest that self-sufficiency is not an appropriate transition expectation.

On the other hand, studies have highlighted the heterogeneity that exists within this population and have called attention to the sizable proportion of former foster youth that appear to be adjusting well and handling adult responsibilities (Courtney et al., 2012; Daining & DePanfilis, 2007; Hass & Graydon, 2009; Hines, Merdinger, & Wyatt, 2005; Jones, 2012; Keller et al., 2007; Samuels & Pryce, 2008; Shpiegel & Ocasio, 2015; Yates & Grey, 2012). For example, one study identified distinct subgroups of former foster youth based on how they were faring in adulthood and found that the largest subgroup was succeeding in adulthood (approximately 36% of the study sample) and demonstrating advanced independent living skills (Courtney, Hook, & Lee, 2012). The authors stated, “the size of this group and its level of

success in negotiating the transition to adulthood should dispel any notion that former foster youth are doomed to fail as adults" (Courtney, Hook, & Lee, 2012, p. 7). These findings indicate that a proportion of care leavers possess the skills necessary to successfully age out of care.

Summary. Foster adolescents' readiness for the transition to adulthood has historically been defined by evidence of their self-reliance capabilities and independent living skills. Transition readiness within the care leaver literature has tended to be conceptualized via a common sense rationale that youth must become self-sufficient soon after leaving care; therefore, possessing independent living skills constitutes transition readiness. Self-sufficiency is a controversial transition expectation given care leavers' significant risk for negative outcomes in adulthood. Recent study findings indicate that a sizable proportion of care leavers are faring well in early adulthood, however. Although care leavers remain the most vulnerable group of young people entering adulthood, some appear to possess the skills necessary to succeed after exiting care.

Skills Required for Self-Sufficiency and Transition Readiness

The existing literature often identifies skills and resources young people can acquire or cultivate in order to facilitate transition readiness (e.g., Leathers & Testa, 2006; Scannapieco, Connell-Carrick, & Painter, 2007). *Tangible (hard) skills* are defined as concrete capabilities and behaviours necessary for independent living. These include self-care skills, home and money management skills, vocational skills, educational skills, health care capabilities, and transportation capabilities (English, Kouidou-Giles, & Plocke, 1994; Hahn, 1994; Inglehart, 1994; Nollan et al., 2000; Mech, 1994). *Intangible (soft) skills* are defined as those abilities necessary for fostering relationships and maintaining employability. These include interpersonal skills, problem-solving skills, emotion regulation skills, communication skills, organizational

skills, and resource knowledge skills (English et al., 1994; Hahn, 1994; Malucio, Krieger, & Pine, 1990; Nollan et al., 2000). Most literature examining the power of these skills for predicting resilient functioning has focused on foster youths' acquisition of tangible skills (Nollan et al., 2000).

Impact of self-sufficiency skills on adult outcomes. Empirical evidence across American, Canadian, and international contexts positively associates the acquisition of self-sufficiency skills with post-discharge adjustment. For example, Pecora and colleagues (2006) completed a nation-wide study assessing the functional outcomes of former foster youth (*n* = 1,609 across 13 American states, mean age = 30.5 years) and found that participants' retrospective ratings of their independent living skills upon exiting care were among a subset of key variables that predicted adult success. In this study, success in adulthood was defined by higher educational attainment, income, physical and mental health, and relationship satisfaction. Individuals in the top 20% of this "success index" were compared to individuals in the bottom 20%, and the most successful group (i.e., the top 20%) recalled possessing significantly more life skill proficiencies upon transitioning out of care (i.e., higher educational skills, vocational skills, legal skills, knowledge of community resources, money management, decision-making skills, transportation skills, safety skills, personal hygiene skills, housecleaning and maintenance, food purchasing and preparation skills, health knowledge, housing skills, and overall independent living preparedness). Given that this study used retrospective participant recall of earlier functioning, participants' current level of functioning may have affected their recall of functioning from years earlier.

Another American study with similar findings was conducted by Jones (2012), who interviewed former foster youth six months after emancipation (*n* = 97, mean age = 18.3 years).

In this study, independent living skills and resources were assessed using the *Ansell-Casey Life Skill Assessment – Short Version*, a standardized tool measuring young people's life skill proficiencies in the domains of daily living, self-care, relationships and communication, housing and money management, work and study, career and education planning, and future-oriented thinking (Nollan et al., 2002). Resilience was defined as being employed and/or in school, being prepared to live independently, having stable housing, avoiding substance abuse or incarcerations, and having an optimistic future outlook. Jones (2012) found that estimates of independent living competencies positively predicted resilient functioning.

An association between self-sufficiency skills and adult outcomes has also been identified in the Canadian context. For example, Flynn and Tessier (2011) assessed predictors of academic resilience among adolescents ages 18 to 20 years (n = 406, mean age = 18.8 years) who had signed extended care and maintenance (ECM) agreements with their respective child welfare agencies. ECMs are transitional living programs that allow youth to continue to receive government financial assistance while transitioning into young adulthood. Promising transitions were defined by successful educational outcomes, specifically high educational attainment, high educational aspirations, and participation in education, training, or employment opportunities. These researchers found that young people's self-care skills and resources positively predicted their higher educational attainment and educational aspirations. Self-care skills and resources were defined as proficiencies that would prepare youth for the transition to adulthood such as vocational, relational, money management, housing, and health care skills, as well as other knowledge competencies.

Similar findings have also been found internationally. In Israel, Sulimani-Aidan and colleagues (2013) examined predictors of care leavers' psychosocial adjustment one year after

exiting the Israeli child welfare system (n = 236). Positive adult functioning was defined by alumni's economic status, adjustment to military service, and living accommodation satisfaction and stability (note: military service is mandatory in Israel and positive adjustment is considered an indicator of normative functioning; Zeira & Benbenishty, 2011). Young people who endorsed higher readiness skills for independent living prior to exiting care demonstrated superior functioning one year later across all outcomes.

In England, Dixon and Stein (2005) examined adult outcomes among British care leavers and focused on factors that helped or hindered transitions (n = 106). Success in early adulthood (assessed at both 2-3 and 9-11 months post-discharge) was defined by ratings of care leavers' mental health, sense of well-being, and housing and employment progress. Former foster youth and their workers assessed care leavers' life skill proficiencies in the areas of healthy living, practical skills, financial competencies, and interpersonal skills. Life skills were positively associated with adult outcomes, and increased life skills at the 9-11 month follow-up were associated with improved adult functioning.

Summary. Skills and resources that contribute to successful adult functioning are often cited in the care leaver literature. Recently, several studies have supported the assertion that foster youth who possess adequately developed self-sufficiency skills around the time of exiting care are more likely to experience successful outcomes in adulthood.

Helping Foster Youth Develop Transition Readiness Skills

Given this population's elevated risk for negative outcomes upon transitioning to adulthood, the question becomes, what can child welfare agencies be doing to support youth and set them up for better adult trajectories? Specifically, what are the maximally impactful areas of intervention that agencies could be focusing on, and investing their limited energy and resources

in, to help young people thrive after exiting care? For many decades, child welfare stakeholders have been trying to answer this question.

Child welfare system initiatives to prepare care leavers for independent living. Over the past several decades, in response to the recognized need to prepare foster youth for the transition to adulthood, American and Canadian governments have provided funding for programs to teach adolescents self-sufficiency skills. Independent living programs (ILPs) are based on the theory that the more adult preparedness skills a minor possesses prior to exiting care, the more he or she will succeed when tasked with adult responsibilities. ILPs are designed to help transition-age youth develop the competencies they require to succeed at independent living (Donkoh et al., 2009). Life skills training, offered in either a classroom setting or via tutor-mentorship, is the backbone of many of these programs. These programs commonly target skills such as housing, transportation, health and self-care, daily chores, academic achievement, career planning, family planning, parenting, vocational abilities, and interpersonal relations (Cook, 1994; Courtney et al., 2001).

In the United States, this type of programming emerged from a series of legal reforms that prioritized caring for foster children's long-term well-being (Avery, 2010; Collins, 2004). Beginning in 1986 with the creation of the Title IV-E Independent Living Program, states were provided with federal funding to help foster youth ages 16 to 18 years develop the skills and resources to succeed in adulthood (Collins, 2001; Cook, 1994; Courtney et al., 2010; Geenen & Powers, 2007; Leathers & Testa, 2006). This statute was replaced in 1999 by the John Chafee Foster Care Independence Program (also known as the Chafee Act). The Chaffee Act allocated many more millions of federal dollars to states to assist foster youth up to age 21 with transition planning (Collins, 2004; Courtney, 2005). Most recently (2008), the Fostering Connections to

Success and Increasing Adoptions Act (also referred to as the Fostering Connections Act) was established. This Act allows states to extend living services until age 21 for a subset of youth who lack permanency and who meet strict eligibility criteria (i.e., enrolled in school, employed, or unable to work due to a medical condition). This Act was put into effect in 2011 (Courtney et al., 2010).

In contrast to the federal legislation in the United States, child protection legislation in Canada is a provincial and territorial responsibility. Services vary between jurisdictions; however, most child welfare services offer programs to help transition-age foster youth develop the skills required for independent living (Courtney, Flynn, & Beaupré, 2013). The need for agencies to better support these young people as they journey into adulthood has been noted in the news media in recent years, with child rights activists advocating for more resources to support care leavers and monitor their post-transition outcomes (Kovarikova, 2017). In 2017, the Ontario Ministry of Children and Youth Services announced several changes to its child protection legislation, including a decision to raise the age limit of protection from 16 years to 18 years. This follows the government's 2015 decision to offer voluntary extended foster care support to youth ages 18 to 21 years, so long as they are employed or in school.

Mixed findings regarding the effectiveness of life skills programs. Despite the high public cost associated with delivering life skills programs, in both Canada and the United States there has been a dearth of quality evaluations of their effectiveness. Common criticisms are that (a) the outcomes of too few ILPs have been evaluated, and (b) most evaluations have lacked the use of rigorous scientific methodologies (Courtney et al., 2011). As an example, a recent attempt at a systematic review of the literature on ILPs found no studies meeting the review's inclusion criteria (i.e., no randomized or quasi-randomized studies that compared ILPs to other

interventions, to care as usual, or to a wait-list control; Donkoh et al., 2009).

Despite criticisms of the existing literature, key findings will be briefly summarized. As to whether ILPs increase self-sufficiency skills and improve the odds for successful outcomes in adulthood, results vary (Donkoh et al., 2009; Mares, 2010; Montgomery et al., 2006; Naccarato & DeLorenzo, 2008). Some studies have found evidence of significant positive outcomes, while others have not. Naturally, these findings have led to different conclusions. Some stakeholders infer that current programming is likely ineffective at improving youths' self-sufficiency skills and requires revision, whereas others reason that ILPs likely enhance some skills but warrant more rigorous and nuanced study (e.g., Courtney & Zinn, 2009; Donkoh et al., 2009; Mares, 2010).

Summary. In order to thrive in early adulthood, care leavers require advanced self-sufficiency skills relative to their same-age peers. Research indicates that they often lack these skills and are at a high risk for negative adult outcomes. To better prepare youth for the transition to adulthood, child welfare systems have invested considerable resources into developing programs that teach independent living skills. Evidence of the effectiveness of these programs varies. These mixed findings have led to different opinions regarding whether direct instruction is the best way to ensure care leavers possess the skills they will need to succeed in adulthood.

Additional Factors that May Promote or Impede Transition Readiness

In this dissertation I present two studies that are designed to address the question, to what extent do risk, promotive, and protective factors present in the lives of transition-age youth predict their level of readiness skills for adulthood? Resilience theory will inform the design of both studies. To my knowledge, an investigation into pre-existing factors that may affect adolescents' possession of self-sufficiency skills prior to exiting care is missing from the

literature. Although recent research findings have stressed that adolescents who possess readiness skills are more likely to fare well after exiting care than those who lack these skills, factors that naturally predispose youth to having adequately developed self-sufficiency skills remain under-researched. Increased knowledge of individual and socio-environment factors that impede or promote the development of these skills could result in new strategies for increasing transition readiness.

Resilience theory. One way to describe care leavers who achieve markers of success in early adulthood is to classify them as resilient (Werner, 1994). Initially believed to be rare and extraordinary, after forty years of investigation, *resilience* is now understood to be a common phenomenon produced by normative processes and factors (Masten, 2001; Werner & Smith, 1992). Although resilience has been defined in different ways, generally the concept has been defined as the presence of average or above average functioning despite serious threats to one's development (Masten et al., 2006). The inverse of resilience is *vulnerability*, defined as an increased susceptibility to experiencing negative outcomes after coming into contact with serious developmental risk factors (Werner, 1994).

Although the Masten and colleagues' (2006) definition of resilience will be used for this review, it is important to note that the concept is often defined and measured in different ways. For example, some researchers define resilience as the absence of psychopathology following adverse life experiences, whereas others insist that an individual must present with above average functioning to merit being called resilient. As such, estimates of its occurrence in maltreated children and youth vary dramatically, with prevalence estimates ranging from 5% to 70% (Flynn, Ghazal, Legault, Vandermeulen, & Petrick, 2004; Kaufman, Cook, Arny, Jones, & Pittinsky, 1994). Because of discrepancies in conceptualization and measurement, many

researchers have moved away from diagnosing individuals as resilient or non-resilient based on functional cut-off scores. Instead they tend to look at resilience dimensionally (i.e., what factors predict positive outcomes in the face of adversity?) (Sapienza & Masten, 2011). Accordingly, in this dissertation I will adopt a dimensional approach to evaluate predictors of resilience.

Risk factors that may impede adult readiness skills. For resilience to occur individuals must (a) be exposed to significant adversity and (b) demonstrate positive adaptation despite that adversity (Masten & Powell, 2003). A term for circumstances that increase the odds of unfavourable outcomes occurring is *risk factors*. Risk factors experienced in childhood can negatively impact subsequent development (Pearlin et al., 1981). Pearlin and colleagues' (1981) stress process model describes the impact of risk factors on human development as follows: early adverse experiences (i.e., life stressors) can impact development via a chain reaction of heightening one's sensitivity to stress and increasing one's vulnerability to future stressors (Felitti et al., 1998). This results in higher odds for negative outcomes in adulthood. Adverse life experiences can have a unique, cumulative, or moderating effect on adult outcomes (Nurius, Green, Logan-Greene, & Borja, 2015). Repeated exposure to negative life events increases one's risk for experiencing impairments across multiple life domains (Dube, Williamson, Thompson, Felitti, & Anda, 2004; Shilling, Aseltine, & Gore, 2008).

Care leavers' histories of adverse childhood experiences are commonly cited by researchers as a primary risk factor likely hindering their odds for successful adaptation in adulthood (Buehler et al., 2000; Mendes & Moslehuddin, 2006; Tweddle, 2007). When making these claims, child welfare researchers frequently reference the groundbreaking Adverse Childhood Experiences studies (ACEs; n = 17,000) of the 1990s and 2000s that demonstrated the negative impact of early life adversities on human development (Min, Minnes, Kim, & Singer,

2013; Nurius, Green, Logan-Greene, & Borja, 2015; Taylor & Stanton, 2007). In 2012, the Royal Society of Canada, the Canadian Academy of Health Sciences, and an Expert Panel on Early Childhood Development produced a consensus report that concurred with the findings of the American ACEs studies, and concluded that chronic childhood adversity increases the risk of a range of difficulties later in life (Boivin et al., 2012). In addition to the risk factor of ACEs, other risk factors to adaption that have been identified in the child welfare literature include engagement in risky behaviours, leaving care at an earlier age, and experiencing placement disruptions (Courtney et al, 2005; Courtney et al., 2001; Courtney et al., 2007). Time spent in out-of-home care during childhood in and of itself has also been associated with increased odds of disadvantaged outcomes during midlife (i.e., ages 39 to 55; Brännström, Vinnerljung, Forsman, & Almquist, 2017).

The ACEs term is synonymous with experiencing potentially traumatic events in childhood (Anthony, Lonigan, & Hecht, 1999). *Traumatic events* are defined as experiences that are emotionally and/or physically threatening to an individual and that can have lasting adverse effects on functioning and well-being (Substance Abuse and Mental Health Services Administration, 2012). The ACEs studies demonstrated that by the time trauma survivors enter adulthood, they are at a higher risk for mental illness, behavioural disorders, substance abuse, poor daily functioning, work absences, intimate partner violence, risky sexual activity, unintended pregnancies, chronic illnesses, and premature death (Anda et al., 2006; Brown et al., 2009; Chapman et al., 2004; Dube et al., 2002; Dube et al., 2003; Felitti et al., 1998; Whitfield et al., 2003).

Promotive and protective factors that may predict adult readiness. As stated above, just as exposure to adversity is necessary for resilience to occur, factors that promote adaptability

are also required. Within the child welfare literature, fewer placement disruptions, higher educational achievement, positive peer relationships, positive parenting practices, and quality relationships with supportive adults have been identified as factors that promote positive adaptation (Bell, Romano, & Flynn, 2015; Legault et al., 2006; Osterling & Hines, 2006).

Child-, family-, and community-level characteristics that offer fulfillment and meaning in the lives of vulnerable children and youth are referred to as *strengths* or *developmental assets*, and are among the most commonly cited factors contributing to resilience (Masten, 2001; Masten & Powell, 2003; Rutter, 1999; Schofield, 2001). Strengths are necessary (but not always sufficient) precursors of resilience (Werner, 1994). Strengths act as *promotive factors* when they predict healthy development on their own, irrespective of whether an individual has experienced adversities. Strengths act as *protective factors* when they moderate the impact of risk exposure on individuals' potential to thrive (Luthar et al., 2000).

The term strengths refers to constructive characteristics, values, and supports that are available to a child and promote his or her healthy development. There is no fixed upper limit on the number of variables that can be conceptualized as strengths. Frequently cited strengths that promote adaptive outcomes include having high self-control, a warm relationship with a family member, secure attachment to a supportive adult, high intellectual functioning, talents, spiritual faith, academic achievement, positive school experiences, positive peer relations, a strong support network, participation in extracurricular/vocational activities, involvement in prosocial community organizations, and a caring mentor (Lyons et al. 2000; Lyons et al., 2009; Masten & Coatsworth, 1998; Sapienza & Masten, 2011).

Developmental assets is a term referring to a specific subset of strengths, investigated by the Search Institute, that have been found to minimize vulnerability, foster resilience, and

promote positive developmental outcomes (Masten & Reed, 2002; Scales, Benson, Leffert, & Blyth, 2000; Scales, Benson, Roehlkepartain, Sesma Jr, & Van Dulmen, 2006). Following their investigation of factors that promote healthy adolescent development, the Search Institute published a list of forty developmental assets itemized by domain (i.e., support, empowerment, boundaries and expectations, constructive use of time, commitment to learning, social competencies, and positive identity; Scales et al., 2006). The Search Institute categorizes these assets as either internal or external to an individual.

Conceptual models of resilience. Resilience theory and research has been guided by a few different conceptual models. Two of the most widely used models within the resilience literature will be reviewed here (Kaplan, 1999; Luthar, 2006; Luthar et al., 2000; Masten & Coatsworth, 1998). The first to be reviewed is a *protective model* (also known as an *interaction effects model*; Rutter, 1999). This model implies that the more risks individuals experience in their lives, the higher the likelihood they will experience maladaptive outcomes. It presumes that adaptive factors act in a protective capacity moderating the negative influence of risk factors (Begle, Dumans, & Hanson, 2010; Flouri & Kallis, 2007; Jaffee et al., 2007). The model weighs factors equally in terms of their potential to impact outcomes.

The second resilience framework to be reviewed is the *ecological systems model*. This model is based on the work of Bronfenbrenner (1979). It posits that human development occurs via a series of interactions between individuals and their environments (Bronfenbrenner, 1977; 1979). This model has been adopted by resilience researchers to describe how risk, promotive, and protective factors exist across multiple contexts that vary in proximity to an individual (Campbell, Dworkin, & Cabral, 2009; Garmezy, 1985; Masten & Coatsworth, 1998). Factors closest to the child are conceived as immediate influences (*microsystem*), whereas other

influences occur at the level of the broader community (*exosystem*; Lynch & Cicchetti, 1998; Luthar et al., 2000; Yates, Egeland, & Sroufe, 2003). Interactions can also occur across systems that a child is involved in (*mesosystem*). Unlike the interaction effects model which posits that all factors are equally influential, the ecological systems model proposes that factors closest in proximity to an individual are most influential to developmental outcomes. Studies using this model have found that the proximity effect is more impactful for risk factors than for protective or promotive factors (Luthar, 2006; Masten & Coatsworth, 1998).

Description of the Current Studies

There is a lack of knowledge regarding individual and socio-environmental factors that predict adolescents' transition readiness prior to exiting out-of-home care. In this dissertation I present two studies that examined factors associated with transition-age foster youths' readiness skills for adulthood. Transition readiness was defined in both studies using the historical definition within the child welfare literature, whereby readiness is synonymous with self-sufficiency indicators.

The first study employed an interaction effects model of resilience, where assets were hypothesized as protective factors reducing the negative impact of adversities on foster youths' transition readiness (Rutter, 1999). The second study examined resilience via an ecological systems model and investigated the relative contributions of individual-, placement-, and agency-level factors on adolescents' transition readiness (Bronfenbrenner, 1979; Masten & Coatsworth, 1998). These resilience models were chosen because they fit the respective research question and are widely used within the existing literature.

Given the focus of the dissertation, there are relatively few databases that would be both relevant and accessible. Therefore, datasets from two different jurisdictions were chosen for this

dissertation because they allowed for the questions in each respective study to be addressed. American data were used for the first study, and Canadian data were used for the second study.

Study #1: Do transition-age foster youth with histories of adverse childhood experiences possess lower transition readiness? If so, do certain factors moderate this relation? To my knowledge, despite researchers often referring to care leavers' histories of adverse childhood experiences to explain their risk for negative outcomes in adulthood, no study has examined whether ACEs exposure predicts lower self-sufficiency skill acquisition among foster youth approaching the exit from care. To address this gap, the first study investigated whether early life stressors (i.e., ACEs) negatively impacted transition-age adolescents' life functioning and development of self-sufficiency skills prior to exiting care. The study also explored whether strengths and traumatic stress symptomatology each moderated the impact of ACEs on transition readiness. This study was guided by an interaction effects model because it best fit the research question (i.e., what is the effect of ACEs exposure on transition readiness, and do strengths and trauma symptomatology moderate this relationship?).

I hypothesized that higher levels of ACEs would predict lower levels of transition readiness. Support for this hypothesis stemmed from the ACEs literature that has found that exposure to traumatic events predicts numerous negative developmental outcomes extending from childhood into adulthood (Felitti et al., 1998; Griffin et al., 2009; Hildyard & Wolfe, 2002). As for moderation effects, I hypothesized that strengths would act as a protective factor moderating the relation between ACEs and transition readiness. As the number of traumatic experiences increased, strengths were hypothesized to have a greater moderating effect on the relationship between ACEs and transition readiness. This hypothesis was based on research evidence that, compared to children with lower levels of strengths, children with higher levels of

strengths are often less impacted by adverse experiences and are more likely to experience positive developmental outcomes (Scales et al., 2006; Scales, Benson, & Roehlkepartain, 2011).

Findings from research on trauma experiences indicate that young people who have experienced the same number or type of past traumatic events often have different traumatic stress symptom reactions. As well, traumatic stress symptoms tend to greatly interfere with individuals' functioning abilities (Cook et al., 2005). It was therefore hypothesized that the presence of traumatic stress symptoms would moderate the relationship between foster youths' trauma experiences and their transition readiness. Across all levels of traumatic experiences, greater levels of trauma symptomatology would be associated with lower levels of transition readiness.

Study #2: Which youth-, placement-, and agency-level factors promote or impede foster adolescents' transition readiness? The second study used multilevel modelling to determine factors at the youth, placement, and agency level that are related to foster adolescents' acquisition of transition readiness skills. Study variables were selected in keeping with past research on factors that hinder or promote resilience, as well as research on factors that hinder or promote successful transitions to adulthood.

Individual-level variables of interest included adolescents' sex, ethnic minority status, age, age at first placement, number of placement changes, contact with biological parents, presence or absence of long-term physical and/or mental health conditions, reason for entry into care (i.e., maltreatment exposure, behavioural problems exceeding caregiver capacity), academic performance, self-esteem, daily living program enrollment, socioemotional problems, and developmental assets. Placement-level variables of interest included placement type, parenting practices (as rated by both the youth and caregiver), caregiver training, and size of the area in

which the placement was located (i.e., rural or urban environment). The agency-level variable of interest was CAS agency site. This level of analysis answered how much of the total explained variance among readiness skills was attributable to agency differences. Transition readiness outcome variables were youths' self-care skills and financial literacy skills.

In accordance with ecological systems theory and past research examining resilience factors at nested levels of influence, I hypothesized that individual-level variables would account for most of the variance in transition readiness, with this trend being more pronounced for risk factors than protective factors. Specifically, I hypothesized that female sex, a younger age at entry into care, contact with biological parents, higher academic performance, higher self-esteem, and a greater number of developmental assets would predict higher transition readiness, and that Black Canadian, First Nations, Métis, or Inuit ethnicity, placement transitions, maltreatment exposure, behavioural problems exceeding caregiver capacity, socioemotional problems, and long-term physical and/or mental health conditions would predict lower transition readiness. I made no hypotheses regarding whether daily living program enrollment and adolescents' current age would predict adult readiness, and retained these variables in the analysis for exploratory purposes.

At the placement-level, I hypothesized that parenting practices, caregiver training experiences, and kinship care placement rather than group care placement would predict higher transition readiness. I made no hypothesis regarding whether the size of the area in which the caregiver residence was situated would impact adult readiness. Similarly, at the agency-level, I made no hypothesis regarding whether CAS agency site would account for an amount of the total explained variance in transition readiness. These variables were included in the analysis for exploratory purposes. Support for these hypotheses stemmed from past resilience research

findings, whereby some of these variables have been found to frequently predict resilient outcomes, and others have been found to relate inconsistently to resilient outcomes.

Contribution of these studies to the literature. To my knowledge, the impact of individual and socio-environment factors on foster adolescents' development of transition readiness skills prior to exiting care is unclear in the empirical literature. The current studies therefore add to existing knowledge by identifying individual and environmental predictors of transition readiness skills among foster youth. Importantly, predictors of self-sufficiency skills were assessed in both studies while adolescents were in care. Most research on the well-being of care leavers investigates their outcomes in early adulthood and, in some instances, relies on retrospective assessment of self-sufficiency skills upon exiting care. Assessing these skills while youth remain in care ensures that retrospective biases do not affect the accuracy of the data and provides data that are directly relevant to efforts to develop interventions to promote greater transition readiness.

The results of these studies will increase our understanding of factors that hinder or enhance adolescents' readiness to transition to adulthood. Results will build upon prior research documenting the presence of resilient features in adolescents in care and may facilitate service providers' proactive identification of foster adolescents at high risk for negative outcomes during the transition to adulthood (Collin-Vézina et al., 2011). Overall, the results of these studies have the potential to enhance child welfare policies and practices aimed at preparing youth for adult transitions.

The Impact of Adverse Childhood Experiences on the Adult Readiness Skills of Transition-Age Foster Youth in Illinois

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Abstract

Objectives: To determine whether, for transition-age foster youth, exposure to potentially traumatic/adverse childhood experiences (ACEs) predicts fewer adult readiness skills, and whether adolescents' trauma-related stress symptoms and developmental strengths moderate this association. Design: Using cross-sectional secondary data obtained from the Illinois Department of Children and Family Services, data from adolescents (ages 17 and older) approaching discharge from foster care to independent living were selected for this study. The Child and Adolescent Needs and Strengths tool was used to measure adolescents' exposure to ACEs, traumatic stress symptoms, developmental strengths, and transition readiness (i.e., independent living skills and life functioning). Results: A series of hierarchical regression models tested the hypotheses that (a) ACEs exposure predicted lower levels of adult readiness skills and (b) these relations were moderated by traumatic stress symptoms and strengths. After accounting for variance attributable to engagement in risky behaviours, exposure to ACEs predicted lower adult readiness. Developmental strengths did not moderate this relation as a protective factor but did predict adult readiness independent from the variance attributable to ACEs. Traumatic stress symptoms moderated this relation. At low ACEs exposure, youth with more traumatic stress symptoms had fewer adult readiness skills than youth with fewer symptoms. At high ACEs exposure, transition readiness levels were similar for foster youth with high and low traumatic stress symptoms. A substantial proportion of the variance across all analyses was attributable to youths' engagement in risk behaviours, and engagement in risk behaviours partially mediated the relations between ACEs and adult readiness. Conclusion: Findings illustrate that although ACEs exposure predicts lower adult readiness among transition-age youth, whether youth engage in risky behaviours and possess developmental strengths may be better predictors of their readiness

to age out of care.

Keywords: Traumatic experiences, foster care, readiness for adulthood

The Impact of Adverse Childhood Experiences on the Adult Readiness Skills of Transition-Age Foster Youth in Illinois

Introduction

Every year in the United States, over 20,000 young people exit the child welfare system upon reaching the age of legal majority, a type of departure referred to as "aging out of care," "leaving care," "discharge to independent living," or "emancipation from care" (Courtney & Heuring, 2005; Stein, 2006; U.S. Department of Health and Human Services, 2015). Unlike other children who leave foster care via family reunification or adoption, youth who age out do so without the assurance of an enduring safety net. Child welfare policies generally assume that these adolescents will be able to succeed autonomously upon exiting the child welfare system; however, research indicates that many are unprepared for independent living (Avery, 2010; Samuels & Pryce, 2008).

Evidence that these adolescents often leave care ill-equipped for adulthood comes from outcomes research and qualitative interviews with care leavers. Compared to their generational peers, youth who age out of care are more likely to experience arrest, homelessness, inadequate housing, unemployment, poverty, a lack of access to health services, unplanned pregnancies, early parenting, social isolation, mental illness, physical disabilities, and problems with addiction in adulthood (Barth, 1990; Cook, 1994; Courtney et al., 2001; Courtney & Dworsky, 2006; Courtney & Heuring, 2005; Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Havlicek, Garcia, & Smith, 2013; McMillen & Raghavan, 2009; Mendes & Moslehuddin, 2006). Many fall behind their contemporaries in terms of educational attainment, developmental milestones, and general indicators of well-being (Berridge, 2012; Blome, 1997; Buehler, Orme, Post, & Paterson,

2000; Dregan, Brown, & Armstrong, 2011; Flynn & Tessier, 2011; Harris, Jackman, O'Brien, & Pecora, 2009; Scherr, 2007; Trout et al., 2008).

Qualitative research soliciting the perspectives of care leavers confirms that many of these young people exit the child welfare system professing to lack the self-sufficiency skills required for adulthood (Courtney, Dworsky, Lee, & Raap, 2009; Merdinger, Hines, Osterling, & Wyatt, 2005). During interviewing, foster youth have said they wished they (1) had received more support from social workers to help them acquire independent living skills, (2) had been instructed to begin preparing for the transition process at a younger age, and (3) had received more concrete financial literacy, housing, and employment assistance (Barth, 1990; Courtney et al., 2009; Geenen & Powers, 2007; Mallon, 1998).

Readiness for Adulthood

The question of how to define "readiness to age out of care" warrants consideration, as conceptualizations of pre-transition readiness can vary. A broad working definition of *transition readiness* is the capacity of an adolescent, with the support of his or her caregivers and service providers, to prepare for, begin, continue, and finish the process of moving from a child-oriented to adult-oriented system, with the goal of flourishing in the adult system (Schwartz et al., 2011). Within the care leaver literature, adolescents' life-domain functioning and acquisition of adult living skills are common ways that stakeholders assess transition readiness. For care leavers, transition readiness has historically been operationalized as foster youth possessing self-sufficiency skills (note: the terms adult readiness, transition readiness, and self-sufficiency skills will be used interchangeably in this review; Inglehart, 1994; Mallon, 1998; Propp, Ortega, & Newheart, 2003). *Self-sufficiency* has been defined as the ability to provide for one's basic needs both financially and practically so as to be able to live independently and not depend on

government assistance for survival (Fassart et al., 2014). The types of skills youth require to become self-sufficient in adulthood include educational, vocational, relational, budgeting, housing, and health care skills (Flynn, Ghazal, & Legault, 2004; Flynn & Tessier, 2011).

Policies and providers have long endorsed the idea that adolescents in care who function well and possess independent living skills will more successfully transition into adulthood than those who don't have these characteristics (Barth, 1990; Cook, 1994; Courtney et al., 2001). Nevertheless, self-sufficiency after exiting care remains a somewhat controversial transition expectation, given (1) evidence of care leavers' significant risk for negative outcomes in adulthood and (2) the gradual, rather than immediate, entry into adulthood expected of their peers (Avery, 2010; Avery & Freundlich, 2009). Research findings support the assertion, however, that foster youth who possess well-developed self-sufficiency skills are more likely to experience successful outcomes after care compared to those with less developed skills (Dixon & Stein, 2005; Pecora et al., 2006). As well, despite the plethora of research studies highlighting the risks these young people face, longitudinal research tracking cohorts of care leavers over time has found that a sizable proportion succeed in early adulthood and that a key commonality among successful care leavers is their advanced self-sufficiency skills (Courtney, Hook, & Lee, 2010).

Factors that Hinder or Promote Transition Readiness

Helping youth prepare for post-transition life is a key priority of child welfare agencies. Given the premise that the more adult preparedness skills a youth possesses prior to exiting care the more he or she will succeed when tasked with adult responsibilities, programming aimed at care leavers has tended to focus on the development of self-sufficiency skills. Findings are mixed, however, as to how successful these programs are at increasing transition readiness

(Geenen & Powers, 2007; McMillen, Rideout, Fisher, & Tucker, 1997). This uncertainty highlights a gap in the literature: namely, a lack of research examining factors that predict whether youth will possess high or low readiness skills prior to exiting care. Despite a heavy focus on direct instruction as the method for augmenting these skills, it is likely that other factors, such as the life circumstances and personal characteristics of care leavers, predispose them to being more or less equipped with the skills for transition.

Given this gap, my intention was to examine other plausible factors that may influence readiness skills. I examined readiness for adulthood via a trauma-informed lens and sought to answer the question, "what impact does a history of adverse childhood experiences (ACEs) have on foster youths' acquisition of self-sufficiency skills prior to exiting care?" (note: the terms potentially traumatic experiences and ACEs will be used interchangeably in this review). I sought to study the unique impact of ACEs exposure on transition readiness skills (distinguishing the influence of ACEs exposure from the influence of other sequelae of trauma) because I wanted to contribute to current empirical knowledge regarding the degree to which ACEs exposure in and of itself predicts care leaver readiness. There is a subtle but important distinction between attributing negative child welfare outcomes to ACEs exposure versus to the sequelae of ACEs exposure, and researchers do not always clarify this distinction (Griffin et al., 2009).

Although many variables could be examined for their relation to care leavers' transition readiness, the rationale for examining the impact of potentially traumatic experiences on transition readiness originates from the care leaver literature. Many researchers refer to (1) knowledge of the long-term risks associated with ACEs, combined with (2) knowledge of the prevalence of ACEs in the lives of foster youth, to infer that (3) care leavers' histories of potentially traumatic events likely increase their susceptibility to negative outcomes in adulthood

(Avery, 2010; Collins, 2004; Courtney & Heuring. 2005; Daining & DePanfilis, 2007). Although prior research has established a relation between ACEs and future difficulties, to my knowledge, no study has examined whether ACEs exposure predicts lower self-sufficiency skills among foster youth approaching the exit from care. I therefore sought to empirically examine this inferred relationship between ACEs exposure and care leavers' transition readiness skills.

Key Findings from the ACEs Literature

Although many facets of life may affect foster youths' acquisition of transition readiness skills to varying degrees, a history of potentially traumatic events is a probable risk factor given that it is one of the most widely implicated predictors of negative developmental outcomes. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), *trauma experiences* are defined as one or more events that are experienced as emotionally and/or physically threatening to an individual and have lasting adverse effects on functioning and well-being (SAMHSA, 2012). There is subjectivity in terms of whether an individual will experience an event as traumatic and, as a result, it is impossible to identify all types of possible traumas (Perry, 2009). Nevertheless, commonly cited potentially traumatic events include experiencing or witnessing: abuse (emotional, physical, sexual), violence (domestic-, community-, school-related), neglect, terrorism, disasters (natural, manmade), and grief-, medical-, crime-, refugee- or war-related traumatic stressors (Anthony, Lonigan, & Hecht, 1999; Kisiel et al., 2011). Of all adverse events that children may experience, maltreatment, a form of abuse in which significant omissions or commissions in parental/caregiver care result in harm or the threat of harm, may be most harmful to development (Boivin et al., 2012; Gilbert et al., 2009).

Societal understanding of the impact of trauma on human functioning has increased in the last three decades. In the 1990s and 2000s, the well-regarded Adverse Childhood Experiences

(ACEs; *n* = 17,000) studies established that exposure to potentially traumatic events in childhood raises the risk for multiple negative health and social consequences in later life (Edwards, Holden, Felitti, & Anda, 2003; Felitti et al., 1998). ACEs researchers discovered that, by the time they reached adulthood, individuals with higher ACE scores, compared to those with lower scores, were at higher risk for mental illnesses, alcohol and drug abuse, work absences, intimate partner violence, risky sexual activities, unintended pregnancies, chronic diseases, other physical illnesses, and premature death (Anda et al., 2006; Dietz et al., 1999; Dube et al., 2002; Dube et al., 2003; Felitti et al., 1998; Hills, Edwards, Holden, Anda, & Felitti, 2003; Whitfield, Anda, Dube, & Felitti, 2003). More recently (2012), the Royal Society of Canada, the Canadian Academy of Health Sciences, and a Canadian Expert Panel on Early Childhood Development produced a consensus report summarizing the impact of adversities on the development of children. This report concurred with the findings of the ACEs studies and concluded that chronic childhood adversity increases the risk of several subsequent difficulties (Boivin et al., 2012).

As stated previously, not all individuals who experience a potentially traumatic event react similarly. Some may experience few or no adverse reactions, whereas others may be profoundly negatively affected by their experience (Amaya-Jackson & DeRosa, 2007). *Traumatic stress symptoms* are defined as physiological responses an individual may have in response to a traumatic event. When people experience an event as traumatic, commonly experienced post-traumatic reactions include adjustment difficulties, grief, re-experiencing the trauma, hyperarousal, engagement in avoidance behaviours, emotional numbing, dissociation, and other adverse affective and/or physiological responses (Kisiel et al., 2011). Although some children and youth who have experienced an event as traumatic will express the same Post Traumatic Stress Disorder (PTSD) symptomatology as adults, others will present with

subclinical PTSD symptoms. There is evidence that subclinical symptoms can be as predictive of poor developmental outcomes as full presentations of PTSD (Amaya-Jackson & DeRosa, 2007; Anthony et al., 1999; Copeland, Keeler, Angold, & Costello, 2007; Feeny et al., 2004; Perry, 2009).

Relevance of ACEs Literature to Child Welfare

Knowledge of the impact of trauma on human development is relevant to the child welfare field, given that past experiences of neglect, abuse, and exposure to domestic and community violence are all-too-common in the lives of children in care. Additionally, the act of being removed from one's family of origin and placed in out-of-home care is a potentially traumatic event in and of itself (Guterman, Cameron, & Hahm, 2003). A study by Griffin and colleagues (2009) assessed children and adolescents as they entered the child welfare system and found that 97% of their sample (n = 8,000) was *suspected* of having experienced a potentially traumatic event prior to entering care. Using a stricter criterion of only *known* and *multiple* incidents of potentially traumatic events, 85% of the study sample qualified. The strictest rating captured only *repeated* and *severe* potentially trauma experiences known to have resulted in medical and physical consequences for a child: 37% of their sample met this criterion (Griffin et al., 2009). Similarly high prevalence estimates of ACEs exposure have been found when studying transition-age foster youth. For example, Salazar and colleagues (2013) interviewed youth transitioning from foster care to independent living (n = 723) and found that the majority (80%) endorsed at least one potentially traumatic experience, and many (61.7%) endorsed multiple potentially traumatic events.

When assessing lifetime prevalence rates of potential trauma exposure among youth transitioning from foster care, Salazar and colleagues (2013) did not distinguish between events

that occurred prior to care from those that occurred while in care. Although the function of the child welfare system is to protect young people from harm, on average approximately 2% of children and youth will experience a known and reported incident of abuse or neglect while living in out-of-home care, with foster parents and adult relatives of the child being the most common perpetrators of offences (Poertner, Bussey, & Fluke, 1999). When examined on an annual basis, this translates to approximately 1.6 to 4.4 per 100 children in out-of-home care experiencing abuse or neglect in a given year, with sexual abuse (followed by physical abuse and neglect) being among the most prevalent types of reported incidents (Garnier & Poertner, 2000; Tittle, Poertner, & Garnier, 2018).

As well, many children and adolescents in care exhibit trauma-related symptomatology. For example, the Illinois Department of Children and Family Services (DCFS) has identified adjustment to trauma as its most commonly endorsed clinical need amongst all of its children and youth in care (adjustment to trauma refers to "adjustment disorders, posttraumatic stress disorder and other diagnoses […] that the child may have as a result of their exposure to traumatic/adverse childhood experiences;" Griffin et al., 2011; NCSTN-CANS, 2011). During the timeframe that was investigated (2006-2011), the number of children who had clinically significant adjustment to trauma difficulties held constant at approximately 25% of the Illinois child welfare population (Griffin et al., 2011). High trauma-related symptomology has also been detected among transition-age foster youth specifically, with researchers concluding that many care leavers remain affected by ongoing trauma symptoms while exiting the child welfare system (Salazar, Keller, Gowen, & Courtney, 2013).

Resilience Theory: Risk, Promotive, and Protective Factors

Although a strong relation between ACEs and a higher risk for future negative outcomes has been established in the literature, not all children will experience negative outcomes after exposure to potentially traumatic events. In fact, over the past forty years researchers have demonstrated evidence of many children functioning well despite exposure to ACEs. This presence of average or above average functioning despite serious threats to one's development is referred to as *resilience* (Masten et al., 2006). Prevalence estimates of resilience among maltreated children vary given that operational definitions of the concept differ across studies. Nevertheless, resilience is understood to be a common phenomenon and is typically measured via evidence of individuals' (1) skill at developmental tasks and/or (2) absence of psychopathology (Masten & Powell, 2003). Within the care leaver literature specifically, resilience has been operationalized as evidence of care leavers' adaptive functioning in early adulthood and/or acquisition of transition readiness skills (Dixon & Stein, 2005; Jones, 2012).

Identifying factors that contribute to and enhance well-being after adversity is a key focus of resilience research. Positive qualities in an individual's life are known as *promotive factors*. When these factors moderate the impact of risk exposure on one's potential to thrive they are known as *protective factors* (Masten, 2001). Different conceptual models of resilience have been identified in the literature, with one of the most widely applied models being a *protective model* (also known as an *interaction effects model*; Rutter, 1999). This model posits that protective factors interact with risk factors and moderate the impact of risk exposure on a given outcome.

Research on protective factors is closely related to research on *strengths*, as strengths are among the most well-known protective factors (Luthar et al., 2000; Masten, 2001; Masten & Powell, 2003; Rutter, 1999; Schofield, 2001; Werner, 1994). Strengths are constructive

characteristics, skills, values, and supports at the level of a child, family, or community that promote healthy development (Lyons et al., 2000; Masten & Coatsworth, 1998). When a child uses these constructive resources to adapt to his or her environment under adverse conditions, strengths serve as protective factors fostering resilience (Werner, 1994). Many youth in care have been identified as possessing intrinsic and extrinsic strengths, and these strengths have been found to be associated with subsequent outcomes (Lyons, Uziel-Miller, Reyes, & Sokol, 2000). For example, a study by Griffin, Martinovich, Garson, and Lyons (2009) of children in care found that the presence of strengths moderated the predicted relation between children's past exposure to trauma and their engagement in risk behaviours. This finding was noteworthy given that an increased probability that young people will engage in high-risk risk behaviours is among the most well-known consequences of ACEs exposure (Dube et al., 2001; Griffin et al., 2009; Lyons et al., 2000). Although there is typically a positive linear relation between a history of trauma and engagement in risk behaviours, in this study, children possessing strengths were less likely to engage in risk behaviours (Griffin et al., 2009).

Focus of the Current Study

Do transition-age foster youth with histories of adverse childhood experiences possess fewer transition readiness skills than youth without such histories? Research that examines the relation between foster adolescents' ACEs exposure and their transition readiness skills prior to exiting care is lacking in the literature. I aimed to address this gap by evaluating the predictive power of ACEs on care leavers' readiness to transition from care. I sought to examine factors that impede or promote the development of transition readiness skills via an interaction effects model of resilience. Readiness was assessed by the degree to which care leavers were functioning well in life and exhibiting self-sufficiency skills. I hypothesized that

higher levels of ACEs would predict lower levels of self-sufficiency skills (Hypothesis 1). Given that ACEs exposure predicts negative developmental outcomes extending into adulthood, I predicted that a history of potentially traumatic experiences would negatively impact the life functioning and self-sufficiency skills of transition-age foster youth (Felitti et al., 1998; Griffin et al., 2009; Hildyard & Wolfe, 2002).

Do youth-, family-, and community-level strengths moderate this relation? I also examined whether care leavers' strengths acted as protective factors moderating the proposed relation between ACEs and transition readiness. I predicted that the more intrinsic and extrinsic strengths a youth possessed, the more ready he or she would be for the upcoming transition to adulthood. As the number of ACEs increased, strengths were hypothesized to have a greater moderating effect on the relation between ACEs and readiness (Hypothesis 2). This prediction stemmed from research showing that children with higher levels of strengths, compared to those with fewer strengths, are often less impacted by adverse experiences and more likely to experience positive developmental outcomes (Scales et al., 2006; Scales, Benson, & Roehlkepartain, 2011).

Do post-traumatic stress symptoms moderate this relation? I also examined whether youths' post-traumatic stress symptoms acted as a risk factor moderating the relation between ACEs and transition readiness. Across all levels of traumatic experiences, it was hypothesized that greater trauma symptomatology would be associated with less evidence of transition readiness (Hypothesis 3). ACEs research findings indicate that it is common for young people who have experienced the same number or type of potentially traumatic events to have very different post-traumatic reactions (Amaya-Jackson & DeRosa, 2007; Perry, 2009). Given that trauma symptomatology tends to greatly interfere with individuals' functioning abilities, it was

predicted that the more symptoms a care leaver exhibited, the more he or she would function poorly and possess fewer transition readiness skills (Cook et al., 2005).

Foster adolescents' sex, ethnicity, age, and placement type were examined as potential study covariates, given that sex can affect one's response to a potentially traumatic event, ACEs exposure can vary by ethnicity, older age predicts a higher acquisition of transition readiness skills, and estimates of youths' strengths can differ by placement type (Griffin et al., 2011; Kisiel et al., 2009; Kroner & Mares, 2009). Similarly, risk behaviours were also examined as a potential covariate, as there is a known to be a linear relation between foster adolescents' ACEs histories and their engagement in problematic externalizing behaviours, and the current study sought to distinguish between the effect of ACEs exposure on readiness from the effect of risk behaviours on readiness (Griffin et al., 2009). A model of how these variables were hypothesized to relate to one another is presented in Figure 1.

Methods

Participants

Cross-sectional, secondary administrative data from adolescents who were in court-ordered protective custody at the time of completing the Illinois child welfare system's Integrated Assessment (IA) program were selected for this study. The Illinois Department of Children and Family Services (DCFS) collected the original data between June 3, 2005 and May 28, 2010. For their data to be eligible for inclusion in the study, at the time of data collection youth had to be aged 17 years or older, have completed a Child and Adolescent Needs and Strengths (CANS) Integrated Assessment (IA), not have a serious developmental disability, and not be living with an adoptive family. The age of 17 was selected because research indicates that transition-age youth begin exiting care soon after this age, with most exits occurring between

ages 17 and 19 (Courtney & Barth, 1996; McCoy, McMillen, & Spitznagel, 2008). In the state of Illinois, foster youth are eligible to re-engage with the child welfare system until age 21, however, few do so (Havlicek & Peters, 2014).

Because of their relatively small numbers in the dataset relative to youth identifying as African American (54%) or non-Hispanic White ethnicity (41%), data from youth identifying as Hispanic ethnicity (5%) were not retained in the sample used for analyses in this study. After outliers and cases with data entry errors were removed (described below in the Results section), data from the CANS assessments of 278 transition-age foster adolescents were available for analysis. With a sample size of 278 and power set at 0.80, a power analysis indicated the sample size was more than sufficient to detect a small to moderate standardized effect size of $r = 0.1$ to 0.3 (G*Power 3.1.9.2; Faul, Erdfelder, Lang, & Buchner, 2007). Previous studies examining composite and individual CANS scores in comparably sized samples have been sufficiently powered to detect statistically significant effect sizes in this range (Lyons et al., 2009). Characteristics of the sample whose data were used in this study are presented in Table 1.

Data Collection Procedures

In 2005, in response to a federal review citing the need for more comprehensive child and family assessments in foster care, Illinois developed its Integrated Assessment (IA) program. The IA program is a multidimensional assessment intended to enhance service provision and to assist with foster care placement decisions. It evaluates children and their families' levels of functioning, needs, and strengths using the National Child Traumatic Stress Network version of the Child and Adolescent Needs and Strengths tool (CANS; Kisiel, Lyons, & Germain, 2011).

Within 45 days of a child's entry into care, the CANS is completed by an individual trained and certified for its use. Assessors must possess a minimum of a bachelor's degree, have

experience and training working in the child serving system, be certified to administer the CANS (a minimum reliability intraclass correlation [*ICC*] of 0.70 on case vignettes is required; the average reliability of those certified in Illinois is above an *ICC* of 0.80), and pass annual re-certification exams (ensuring assessors maintain their skills over time). Individuals with diverse professional backgrounds have been shown to be able to administer the CANS reliably (e.g., mental health providers, child welfare case workers, family advocates, and probation officers, among others; Praed Foundation, 1999). Because the DCFS is the guardian for children entering state custody by court order, separate parental consent is not required for completion of the IA program. The IA serves as the baseline for all subsequent assessments (follow-up assessments occur at 6 month intervals while a child remains in care). An intended function of the IA is to enhance communication of information between a child, his or her family, and the DCFS. Data collected from the IA program are routinely used to facilitate program evaluation and systems research.

The Illinois DCFS Institutional Review Board (IRB) and the University of Ottawa Research Ethics Board (REB) approved the use of these secondary data for this study. Eligible children (or their legal guardians) consented to their information being used for secondary analyses when their original consent was obtained. The DCFS does not compensate its clients for providing assessment information because the IA program is a component of ongoing service provision. Similarly, participants were not compensated for the aggregated use of their data in the present study. The data were anonymized prior to being released by the DCFS for this study.

Measure

The Child and Adolescent Needs and Strengths (CANS). The CANS is a clinician-rated functional behavioural health instrument that assesses the needs and strengths of children in

foster care (Kisiel et al. 2011). The CANS is used by the DCFS to collect information about the children and families they serve. Information from multiple informants and data sources can be incorporated using the CANS (e.g., child, caregiver, teacher, observation, case records). An information integration tool, the CANS is used prospectively by the DCFS for assessment and decision support, and retrospectively for program evaluation and research. The instrument measures multiple behavioural and functional domains, including a child's lifetime exposure to potentially traumatic experiences, their trauma-related stress symptoms, their intrinsic and extrinsic strengths, their engagement in high risk behaviours, their life-domain functioning, and, for transition-age youth in care, their readiness skills for adulthood (see Appendices A and B for a description of all items). The CANS can be scored at either the item-level or domain-level.

Reliability and validity. A body of research has demonstrated the reliability and validity of the CANS at the item-level and domain-level (e.g., Anderson et al., 2003; Lyons, 2009). Concurrent validity has been demonstrated when comparing the CANS to other established child and youth mental health assessment measures such as the Child and Adolescent Functional Assessment Survey (CAFAS) and the Child Behavior Checklist (CBCL; Anderson, Lyons, Giles, Price, & Estes, 2002; Lyons, 2004). Audit studies have found CANS item- and domain-level scores to be reliable and have high utility validity in training and field applications (Anderson et al., 2003; Rawal, Yeh, Leon, & Tracy, 2002). The average inter-rater reliability across studies that have used case records or current cases as the source of ratings is $ICC = 0.85$, and the average inter-rater reliability among clinicians who have used case vignettes as the source of ratings is $ICC = 0.78$ (note: clinical vignettes are understood to have lower reliability due to their brevity and potential vagueness; Anderson et al., 2003; J. S. Lyons, personal communication, March 16, 2017; Praed Foundation, 1999). Inter-rater reliability is assessed at the item level.

Trainee scores are compared to recommended scores in the case of clinical vignettes, and clinician scores are compared to case reviewer scores in the case of case reviews (J. S. Lyons, personal communication, March 16, 2017). A minimum reliability of at least *ICC* = 0.70 on test case vignettes is required for certification and annual re-certification in the use of the CANS. In 2016 alone, 65,000 trainees were certified on the CANS with an average reliability of *ICC* = 0.78; J. S. Lyons, personal communication, March 16, 2017).

Scoring. All CANS items have four possible scores that relate to different action levels. For items pertaining to children's exposure to potentially traumatic/adverse childhood experiences, as well as their clinical needs, ratings of 0 or 1 are "non-actionable" and do not warrant action in a treatment plan, whereas ratings of 2 or 3 are "actionable" and warrant inclusion in a treatment plan. For items pertaining to children's strengths, ratings of 0 or 1 are actionable because they can be included in a child's strengths-based treatment plan. Ratings of 2 or 3 indicate "buildable" strengths; that is, if developed, they may become useful in a treatment plan. For all domains except for the lifelong ACEs scale, scores reflect needs and functioning over the past 30 days.

The 4-level action responses for the exposure to potentially traumatic/adverse childhood experiences scale (ACEs) are: No evidence of any trauma of this type (a rating of 0), a single incident of trauma occurred *or* suspicion exists that this trauma occurred (a rating of 1), multiple incidents of this type of trauma or a moderate degree of trauma of this type (a rating of 2), and repeated, severe incidents of this trauma type with medical/physical consequences (a rating of 3). The 4-level action responses for all needs-related scales (i.e., the trauma stress symptoms, risk behaviours, life-domain functioning, and transition to adulthood scales) are: No evidence of a need and no need for action (a rating of 0), mild need warranting watchful waiting and/or

prevention (a rating of 1), moderate need where action is required (a rating of 2), and severe need where immediate and intensive action is required (a rating of 3). Lastly, the 4-level action responses for the child strengths scale are: Strengths exist that can be used as a centerpiece for a strengths-based plan (a rating of 0), strengths exist but require some building in order be useful for treatment (a rating of 1), strengths have been identified but they require significant building to be useful (a rating of 2), and either no strengths are identified or no information about this strength item is available (a rating of 3).

CANS Variables Used in the Study

Adverse childhood experiences. Foster youths' exposure to adverse childhood experiences was measured using the CANS Exposure to Potentially Traumatic/Adverse Childhood Experiences scale (ACEs). The ACEs scale assessed youths' exposure to sexual abuse, physical abuse, emotional abuse, neglect, medical trauma, community violence, school violence, natural or manmade disasters, war-related trauma, terrorism-related trauma, witness/victim to criminal activity trauma, parental criminal behaviour, and disruptions in caregiving/attachment losses. The ACEs score reliability for the sample was Cronbach's alpha = .55. Relatively low internal consistency is to be expected for scores on this scale, given that the scale measures a broad range of life events (cf. Streiner, 2003).

Traumatic stress symptoms. Foster youths' post-traumatic stress symptoms resulting from exposure to potentially traumatic/adverse childhood experiences were measured using the CANS Trauma-Related Stress Symptoms scale (hereafter referred to as stress symptoms). The stress symptoms scale measured youths' adjustment to trauma, traumatic grief, re-experiencing, hyper-arousal, avoidance, numbing, dissociation, and affect and/or physiological dysregulation. The stress symptoms score reliability for the sample was Cronbach's alpha = .73, indicating

adequate reliability.

Strengths. Foster youths' intrinsic and extrinsic assets were measured using the CANS Child Strengths scale (hereafter referred to as strengths). The strengths scale assessed the presence and treatment planning functionality of youths' family strengths, interpersonal strengths, educational setting strengths, vocational strengths, coping skills, optimism, talents/interests, spirituality/religiosity, community life, relationship permanence, and resilience. The strengths score reliability for the sample was Cronbach's alpha = .84, indicating good reliability.

Life domain functioning. Youths' current functioning was assessed using the CANS Life-Domain Functioning scale. The life functioning scale assessed how youth were doing in various life domains, including their family environment, living situation, social relationships, cognitive development, leisure activities, legal system involvement, physical health, medical ailments, sleep, sexual development, school behaviour, school achievement, and school attendance. The life domain functioning score reliability for the sample was Cronbach's alpha = .81, indicating good reliability.

Transition to adulthood. Adolescents' readiness skills for adulthood were measured using the CANS Transition to Adulthood scale. The transition to adulthood scale assessed youths' independent living needs, specifically their independent living skills, transportation, quality of parenting if a parent, quality of intimate relationships, medication compliance, educational attainment, risk of victimization, and job functioning. The transition readiness score reliability for the sample was Cronbach's alpha = .61. Relatively low reliability is to be expected for scores on this scale given the rather broad range of potentially unrelated items included in the scale.

Risk behaviours. Youths' engagement in behaviours that may harm themselves or others was measured using the CANS Risk Behaviours scale. The risk behaviours scale assessed youths' suicidality, non-suicidal self-injurious behaviour, danger to others, sexual aggression, risk of elopement, delinquency, judgment, fire setting, intentional misbehaviour, and sexually reactive behaviours. The risk behaviours score reliability for the sample was Cronbach's alpha = .82, indicating good reliability.

Demographic variables. Demographic variables that prior research studies have found to act as social determinants of foster youths' functioning were included in the analyses. These included age (a continuous variable measured from age 17 and older), sex (male or female), ethnicity (non-Hispanic White or African American), and living arrangement while in care (either in kinship care, regular foster care, treatment foster care, congregate care, or emergency care). Characteristics of foster adolescents across living arrangements are presented in Table 4. Descriptions of the different foster living arrangements are included in Appendix C.

Results

Initial Data Screening

The original dataset included all DCFS IA assessments collected between June 3, 2005 and May 28, 2010, and was comprised of 11,988 CANS assessments. When the dataset was limited to assessments from individuals ages 17 and older, 311 assessments (cases) were potentially available for analysis. When the dataset was limited to individuals without serious developmental disabilities, 308 cases remained for analysis. When impossible values and univariate outliers were removed from the dataset, this number was reduced to 301 cases (examples of impossible values included: a value of 3 on all CANS items, a non-IA CANS assessment mistakenly included in the dataset). Finally, when data from individuals living with

an adoptive family (5 cases) and data from a small number of Hispanic youth (16 cases) were identified and removed, 280 cases remained. Data from Hispanic youth were removed prior to analyses for statistical reasons; in the sample the prevalence of cases from Hispanic youth was notably discrepant (5%) relative to the prevalence of cases from African American (54%) and non-Hispanic White youth (41%). After two cases with multivariate outliers were identified using the Mahalanobis technique and removed, 278 CANS assessments remained for inclusion in the analysis (153 females, 125 males, M_{age} = 17.47 years, age range: 17.00-18.54 years, 158 African American youth, 120 non-Hispanic White youth). As described previously, this sample size exceeded the minimum of 103 study participants required for analyses to detect a small to moderate standardized effect size of r = 0.1 to 0.3, with a power of .80.

For the present study, scale scores were computed for all CANS variables of interest (i.e., ACEs, strengths, stress symptoms, risk behaviours, life functioning, and transition to adulthood). In order for participants' scale scores to be included in the analysis, 75% of the items on a scale had to have been completed (Bono et al., 2007; Downey & King, 1998; J. S. Lyons, correspondence, October 15, 2017). Scales with some missing data (i.e., 1% to 25% of the scale) were computed based on the weighted mean of the completed items (i.e., per participant, if 10 items were filled out on a 12 item scale, the mean of those 10 items was computed as that participant's scale score). For most scales, all items per case were completed (ACEs = 98.9%; stress symptoms = 100%; strengths = 88.3%; life functioning = 93.0%, risk behaviours = 99.3%). As well, the majority of scales also had few cases with 25% of scale items missing (ACEs = 0.4%; stress symptoms = 0.0%; strengths = 1.8%; life functioning = 3.3%; risk behaviours = 0.0%). The exception to this trend was the transition to adulthood scale, which had a lower total scale completion rate (54.4% of cases with all items completed) and a higher

proportion of cases with 25% of items missing (13.5%). The implications of the transition to adulthood scale having higher item per case missingness will be reviewed in the discussion.

The rationale for using this method of dealing with missing data is as follows. First, a missing value analysis on the data from the 278 cases used in the study determined that the data were not missing completely at random, meaning that an item's value predicted whether it was filled out or not. This precluded the appropriateness of using expectation maximization or multiple imputation to address missing data. In addition to this statistical determination of a meaningful pattern of missing data, there was also a theoretical explanation for why the pattern of missing data was meaningful. Although later versions of the CANS allow respondents to identify when items are non-applicable, the version used in this study did not provide respondents with that option. Therefore, a missing item could be due to respondent or data entry clerk error/oversight, or could reflect a non-applicable item that a respondent chose to skip over. Although a score of 0 on a CANS item means "no evidence of a need for action" or "a centerpiece strength," missing items were not filled with "0" scores because of the underlying uncertainty as to why an item was left unfilled (Praed Foundation, 1999). Respondents with missing data entries used the "0" rating for other items, thus implying that their reason for leaving items unfilled, rather than using a "0" score for those items, may be meaningful. So as to make use of the majority of existing data, as described above, a decision was made to only include scales with 3/4s of their items filled, and then to compute the mean scale score using only filled items.

Scale statistics are presented in Table 2, with intercorrelations among the composite scales presented in Table 3. Supplementary information about all scales used in the study is presented in Appendices A and B. Limitations to this method of computing item weighted mean

scale scores will be reviewed in the discussion.

No data were missing on the variables of ethnicity, age, or sex. Missing data were found on the variables of trauma stress symptoms (1.1% missing), strengths (1.4% missing), risk behaviours (1.1% missing), trauma experiences (<0.7% missing), life functioning (2.9% missing) and transition to adulthood (14.7% missing). Because of the level of missing data for transition to adulthood, complete versus incomplete cases were compared on demographic variables using Chi-square tests, and no significant differences were found with respect to ethnicity, age, or sex. Prior to conducting analyses to test study hypotheses, sex, ethnicity, age, ACEs, stress symptoms, strengths, risk behaviours, transition to adulthood, and life functioning variables were examined for accuracy of data entry, missing values, and fit between their distributions and assumptions of multivariate analysis. Discrete variables were dummy coded and continuous variables were centered. As described above, multivariate outliers were removed from the sample.

The bivariate correlation between the two CANS variables used to assess transition-age adolescents' transition readiness was large enough to suggest that they measured the same underlying construct. Give this finding, the CANS Transition to Adulthood and Life Domain Functioning scales were combined by summing all items to create a "Transition Readiness" scale. The transition readiness scale score reliability for the sample was Cronbach's alpha = .86, indicating good reliability. The results of the analyses conducted to test study hypotheses were comparable when the scales were kept separate and when combined. For clarity of presentation, results will therefore only be presented using the combined outcome variable (transition readiness).

To improve pairwise linearity and to reduce moderate positive skewness, a square root transformation was used on the risk behaviours scale and a logarithmic transformation was used on the ACEs scale. Although age was also moderately positively skewed ($z = 3.78$), square root, logarithmic, and inverse transformations did not improve its skewness and so age was not transformed. The results of the analyses conducted to test study hypotheses were comparable with and without the transformed risk behaviours and ACEs variables; therefore, for clarity of interpretation, only analyses using non-transformed variables will be presented. To avoid potentially high multicollinearity, all continuous variables were centered, and interaction terms between ACEs and strengths, and between ACEs and stress symptoms were created (Aitken & West, 1991).

Hierarchical Regression Analyses

Hierarchical regression analyses were conducted to test the first study hypothesis that exposure to ACEs predicts transition readiness. Following this analysis, two sets of hierarchical regression analyses were conducted to test the second and third hypotheses that strengths (i.e., intrinsic and extrinsic assets specific to a youth, his or her family, and/or community) and trauma stress symptoms moderated this relation (respectively).

Analyses were conducted with and without the inclusion of the demographic variables and the risk behaviour variable as control covariates in the model. The statistical significance of the analyses was comparable with and without the inclusion of these control covariates; however, there were substantial differences in the effect sizes of the results. Results indicated that the substantial differences in effect sizes were attributable to the inclusion of the risk behaviours variable in the first block of the model, and not attributable to the inclusion of the demographic variables.

This finding was further examined via two analyses whereby the demographic variables and the risk behaviours scale variable were separately included in the first block of the model. The statistical significance and effect sizes of the results were comparable with and without entering the demographic variables of age, sex, ethnicity, and living arrangement in foster care in the first block as control covariates. Therefore, for clarity of interpretation, analyses are presented without controlling for variance attributable to the demographic variables. The statistical significance of the results was comparable with and without entering risk behaviours in the first block of the model; however, there were substantial differences in the effect sizes of the results. Therefore, analyses with risk behaviours included as a control covariate are presented.

Testing the Main Effect of ACEs with Strengths as a Moderator

A hierarchical regression analysis was conducted to investigate the hypothesis that foster adolescents' transition readiness was predicted by their exposure to ACEs. After controlling for the effect of risk behaviours, the analysis indicated that ACEs significantly predicted transition readiness, $\triangle R^2 = .02$, $\triangle F(1, 228) = 9.16$, $p < .01$, $f^2 = .05$. The analysis also indicated that, independent of the variance attributable to ACEs, strengths significantly predicted transition readiness, $\triangle R^2 = .21$, $\triangle F(1, 227) = 145.16$, $p < .001$, $f^2 = .78$. A summary of these results is presented in Table 5.

Next, hierarchical regression analyses were conducted to examine the hypothesis that strengths moderated the relation between ACEs and transition readiness. Analyses indicated that the interaction term between strengths and ACEs did not explain a significant increase in variance in transition readiness. Therefore, there was no evidence that strengths moderated the effect of ACEs on transition readiness.

Testing the Main Effect of ACEs with Traumatic Stress Symptoms as a Moderator

A hierarchical regression analysis was conducted to investigate the hypothesis that foster adolescents' transition readiness was predicted by their exposure to ACEs. After controlling for the effect of risk behaviours, the analysis indicated that ACEs significantly predicted transition readiness, $\triangle R^2 = .02$, $\triangle F(1, 230) = 9.20$, $p < .01$, $f^2 = .05$. Independent of the variance attributable to ACEs, traumatic stress symptoms significantly predicted transition readiness, $\triangle R^2 = .03$, $\triangle F(1, 229) = 12.00$, $p = .001$, $f^2 = .06$. A summary of these results is presented in Table 5.

Next, hierarchical regression analyses were conducted to examine the hypothesis that traumatic stress symptoms moderated the relation between ACEs and transition readiness. Analyses indicated that the interaction term between traumatic stress symptoms and ACEs did account for a significant proportion of the variance in predicting transition readiness, $\triangle R^2 = .02$, $\triangle F(1, 228) = 9.42$, $p < .01$, $f^2 = .05$. Therefore, traumatic stress symptoms moderated the relation between ACEs and transition readiness. A summary of these results is presented in Table 5.

To better understand the nature of this moderation effect, the interaction was graphed using equations derived from unstandardized B values using centered variables (as recommended by Aitken & West, 1991). This effect is presented in Figure 2, in which higher transition readiness scores in the interaction plot indicate greater transition readiness concerns. The interaction plot demonstrated that, at high levels of exposure to ACEs, transition readiness levels were similar for foster youth with high and low traumatic stress symptoms. At low levels of exposure to ACEs, however, foster youth with high stress symptoms had fewer transition readiness skills than did youth with low stress symptoms.

Testing the Mediating Effect of Risk Behaviours

A final set of hierarchical regression analyses were conducted to investigate the post hoc hypothesis that risk behaviours mediated the relations between ACEs and transition readiness. These post hoc analyses were conducted because, across both hierarchical regression analyses, a substantial proportion of the variance in transition readiness was attributable to youths' engagement in risk behaviours. The mediation model for ACEs, transition readiness, and risk behaviours is presented in Figure 3.

A macro computational tool called PROCESS (Hayes, 2012) was used to test for mediation. PROCESS is a path analysis-based tool that can be used as an add-on within SPSS. It uses ordinary least squares or logistic regression-based path analytic frameworks for estimating effects in a variety of mediation and moderation models. PROCESS mediation analyses are based upon the Baron and Kenny (1986) model of mediation, with bootstrap confidence intervals implemented to test for indirect effects (Hayes, 2012; 2013).

Bootstrapping is a non-parametric test that is based on repeat sampling with replacement. It provides a confidence interval for the direct effect; if zero is not in the interval it indicates that (1) the indirect effect is significant, and (2) that a mediator variable accounts for all or some of the observed relation between the independent and dependent variable (Kenny, 2016; Preacher & Hayes 2004). Bootstrapping has more power than the Sobel test and is more definitive than the joint test of significance (Hayes & Scharkow, 2013). For these reasons, the use of bootstrapping to test for indirect effects is recommended over other plausible methods (e.g., the Sobel test and joint test of significance; Bollen & Stine, 1990; Hayes, 2013; Kenny, 2016; Shrout & Bolger, 2002).

In the first step of the mediation model for the prediction of transition readiness, the regression of transition readiness on ACEs was statistically significant, b = 1.07, SE = .18, t(236) = 6.07, p = <.001, *95% CI* =.72, .1.41. In the second step, the regression of the mediator risk behaviours on ACEs was also significant, b =.51, SE = .10, t(233) = 5.30, p <.001, *95% CI* = .32, .70. The third step of the analyses indicated that, after controlling for ACEs, risk behaviours significantly predicted transition readiness, b = 1.19, SE = .09, t(236) = 13.11, p < .001, *95% CI* = 1.01, 1.36. The fourth step revealed that, after controlling for the mediator (risk behaviours), ACEs remained a significant predictor of transition readiness, b = .46, SE = .15, t(236) = 3.13, p <.01, *95% CI* = .17, .75. The regression of transition readiness on ACEs when controlling for risk behaviours differed from zero. Results were therefore consistent with the hypothesis that risk behaviours partially mediated the relation between ACEs and transition readiness.

The indirect effect of ACEs on transition readiness was computed using a bootstrap estimation approach with 1,000 samples (Bollen & Stine, 1990; Shrout & Bolger, 2002). These results indicated there was a significant indirect effect of ACEs on transition readiness through risk behaviours, *ab* = .61, *BCa 95% CI* = .38, .83 (*ab* = indirect effect; *BCa* = bias-corrected and accelerated bootstrap interval). Given that the lower limit of the bootstrap confidence interval did not overlap with zero, a significant indirect effect was indicated. The mediator (risk behaviours) could account for more than half of the total effect, P_M = .57 (P_M = percent mediation; the percent of the total effect accounted for by the indirect effect). This partial mediation effect is presented in Figure 3, with the standardized regression coefficient between ACEs and transition readiness, controlling for risk behaviours, in parentheses.

Discussion

The current study used cross-sectional data to identify the impact that exposure to ACEs in childhood has on the transition readiness skills of youth in care. Overall, the findings indicated that exposure to potentially traumatic events predicted lower transition readiness characteristics among these adolescents, both directly (Hypothesis 1) and, as found in post hoc analyses, indirectly through their engagement in risk behaviours. The study findings are consistent with previous research findings that have established a relation between childhood exposure to potentially traumatic/adverse childhood experiences (ACEs) and an increased risk for negative life consequences (Edwards, Holden, Felitti, & Anda, 2003; Felitti et al., 1998). Many researchers examining the well-being of care leavers refer to the ACEs literature when accounting for these young people's increased risk for negative outcomes in adulthood (Avery, 2010; Collins, 2004; Daining & DePanfilis, 2007). The current study demonstrated supporting evidence of this recognized relation between ACEs and transition readiness among transition-age youth in care.

It is important to note, however, that the magnitude of this relation was small (ACEs accounted for only 5% of the variance in transition readiness). This appeared to be due to the fact that a substantial proportion of the variance in transition readiness was attributable in the regression analyses to youths' engagement in risk behaviours. This finding prompted the follow-up question: Does exposure to potentially traumatic events influence subsequent engagement in risky behaviours, which in turn influences how youth fare in life at age 17 and the degree to which they acquire transition readiness skills prior to exiting care? The cross-sectional nature of this study prevented the temporal assessment of these relations; however, post hoc mediation analyses revealed that in a statistical sense (but not necessarily a causal sense) engagement in

risk behaviours did partially mediate the relations between ACEs and transition readiness. Indeed, foster adolescents' engagement in risk behaviours accounted for more than half of the relations between ACEs and transition readiness (57%).

Moderation Effects

I also investigated whether the relation between ACEs and transition readiness was moderated by adolescents' strengths and post-traumatic stress symptomatology. The hypothesis that this relation would be weaker among transition-age youth with high levels of strengths was not supported (Hypothesis 2). In contrast, the hypothesis that traumatic stress symptoms would moderate the relationship between ACEs exposure and transition readiness was supported (Hypothesis 3).

The finding that strengths did not moderate the relationship between ACES and transition readiness was surprising, as research has found that strengths can act as a protective factor moderating the impact of ACEs on functional outcomes (e.g., Brown & Shillington, 2017; Sim, Li, & Chu, 2016). In prior studies, strengths have been found to moderate the relationship between children's exposure to potentially traumatic/adverse childhood experiences and their engagement in risk behaviours (Griffin et al., 2009). Given this knowledge, and given that strengths correlated with risk behaviours in the current study (the correlation between these variables was $r = .48$), it was important to consider whether strengths did not moderate the relation between ACEs and transition readiness because the variance attributable to a more modifiable variable, engagement in risk behaviours, was entered earlier in the analysis. In the current study, however, analyses were run with and without risk behaviours and other demographic variables as covariates in the model, and in all instances the regression analyses

yielded the same results (with strengths always exerting a main effect on transition readiness and never acting as a moderating variable).

Therefore, a plausible interpretation of this study's findings is that instead of acting as a protective factor minimizing the effect of ACEs exposure on adolescents' future functioning, strengths acted as a promotive factor by exerting a direct effect on transition readiness (Luthar et al., 2000). Acting separately and in opposition to the impact of ACEs, strengths independently and positively predicted transition readiness (r = .68). The more strengths care leavers possessed, the more likely they were to possess necessary skills for adulthood, irrespective of the impact of ACEs. This finding suggests that a different class of resilience model –a *compensatory model* – may better explain how strengths interact with ACEs to promote readiness (Fergus & Zimmerman, 2005). A compensatory model (also known as a *cumulative* or *main effect model*) describes promotive factors as directly impacting outcomes, independent from and opposite to the influence of risk factors (Luthar et al., 2000; Masten, 2001). This interpretation accords with past findings that (1) strengths and needs are not extremes on a continuum, (2) youth in care can present with both high needs and high strengths, (3) the number of strengths youth in care possess is positively associated with functioning, and (4) strengths and needs can independently predict outcomes (Griffin, Martinovich, Garson & Lyons, 2009; Lyons, Uziel-Miller, Reyes, & Sokol, 2000). Given that strengths impacted transition readiness, although not as a protective factor as hypothesized, the current findings were consistent with past research that has found that strengths correlate with more positive outcomes for youth (Griffin, Martinovich, Garson, & Lyons, 2009; Lyons, 2009; Lyons, Uziel-Miller, Reyes, & Sokol, 2000).

The current findings were also consistent with past research that has found trauma-related stress symptoms correlate with more negative outcomes (Amaya-Jackson & DeRosa, 2007;

Copeland, Keeler, Angold, & Costello, 2007; Feeny, Foa, Treadwell, & March, 2004; Luthar and Zigler, 1991). In this study, trauma-related stress symptoms exerted a small direct effect on transition readiness (accounting for 6% of the variance) as well as a small moderating effect (5% of the variance). The interaction effect was such that at high levels of ACEs exposure, transition readiness levels were similar for youth regardless of their traumatic stress symptoms. At low levels of ACEs exposure, however, youth exhibiting more trauma-related symptomatology possessed fewer transition readiness skills.

The research literature provides a host of possible explanations for why trauma-related stress symptoms negatively predicted transition readiness. For example, traumatic stress symptoms have been found to relate to numerous emotional and behavioural regulation difficulties that impact life functioning. Additionally, one of the reasons why child maltreatment can have such far-reaching effects is because ACEs can alter brain development (Anda et al., 2006; Cohen et al., 2002; De Bellis, 2001). It seems as though trauma alters the stress responses of some survivors by disrupting neurochemical systems that produce hormones and neurotransmitters such as cortisol, adrenaline, and serotonin (Alink, Cicchetti, Kim, & Rogosch, 2012; Cohen et al., 2002; De Bellis, Hooper, Woolley, & Shenk, 2010; Dozier, Peloso, Lewis, Laurenceau, & Levine, 2008). It is believed that trauma survivors' brains develop this way to enhance their odds for survival in a traumatic environment. Unfortunately, these alterations increase survivors' likelihood of experiencing subsequent adverse events as they tend to then have more difficulty functioning in non-traumatizing settings (Cohen, Perel, De Bellis, Friedman, & Putnam, 2002; Perry, 2009).

Study Limitations

There were several limitations to the current study. First, because the study was cross-sectional and included some variables that were assessed retrospectively, strong causal statements about the directionality of relations cannot be made. An important next step in this line of research will be to use longitudinal data to address the question of causality and to better capture the complex effects that are likely to exist among the variables included in this study. A longitudinal study with data collected after youth transition from care would help tease apart the degree to which adult adaptation is predicted by pre-transition readiness indicators. Secondly, although caseworkers who completed the CANS solicited input from other stakeholders in their assessments and completion of the CANS tool (e.g., youth, foster parents), differences of opinion were not recorded and it is possible that not all perspectives held by different stakeholders were adequately captured in the data. Thirdly, because the same case worker completes all sections of the CANS, the CANS rater is therefore not blind to knowing results of other scale scores. This increases the risk of rater bias occurring, whereby a case worker's knowledge of how a youth scores on one scale might influence their perceptions of a youth's rating on another scale. These limitations could affect the validity of the study results as foster youths' symptoms and life experiences may have been over or underreported by case workers. Fourthly, the transition to adulthood scale had higher per case item missingness (13.5% of cases had 25% of scale items missing) relative to the other scales. This was addressed by computing the weighted mean of observed items and imputing missing scores with the mean of the observed scores. Although the transition to adulthood met the threshold recommended by Graham (2009) regarding how many filled items are necessary to use proration, the use of this technique may have introduced unintended bias into the study design (Schafer & Graham, 2002).

Lastly, the internal consistency reliabilities for the transition to adulthood scale (Cronbach's alpha = .61) and the ACEs scale (Cronbach's alpha = .55) were relatively low. Low reliability on the transition to adulthood scale implies that items on this scale may not have been closely related to the same underlying construct. Analyses conducted with the transition to adulthood scale were comparable, however, to analyses conducted with the life functioning scale, and the bivariate correlation between these two outcome variables was large enough to suggest that they measured the same underlying construct. When combined, the new "transition readiness" outcome scale had good reliability (Cronbach's alpha = .86). A lack of clarity regarding the underlying construct being assessed by the transition to adulthood scale, however, and the degree to which it represents a unique construct similar to but distinct from life functioning remains a limitation of the current study warranting future investigation.

Regarding the ACEs scale, low reliability was expected given that it measures a broad range of life events; however, this low reliability may still have affected the interpretation of study findings given a potential lack of precision in how ACEs exposure was measured (cf. Streiner, 2003). Rather than using a single score to account for an individual's severity of ACEs exposure, for example, the study might have benefitted from a more multifaceted assessment of children's adverse experiences (e.g., taking into account the type, duration, and frequency of potentially traumatic incidents, the timing of ACEs exposures relative to children's ages and stages of development, as well as whether incidents were interpersonal caregiver-perpetrated traumas versus non-interpersonal traumas). Research indicates that these factors influence young people's experiences of and responses to potentially traumatic events and therefore the omission of this information is a study limitation (Salazar et al., 2013; Tittle, Poertner, & Garnier, 2018).

Implications and Future Directions

The current study adds to the growing body of research demonstrating the importance of examining young people's engagement in externalizing behaviours as both related to a history of potentially traumatic events and to negative outcomes (e.g., Griffin et al., 2009; Lee, Herrenkohl, Jung, Skinner, & Klika, 2015). The study highlights the independent contribution of strengths to increasing transition readiness among young people. This finding supports the development and implementation of intervention programs targeting the development of adolescents' strengths, regardless of their level of ACEs exposure. The study also highlights the adverse impact of ongoing trauma symptomatology on transition readiness. An implication of this finding is that youth who are exhibiting ongoing trauma symptomatology could be identified as potentially requiring more support to prepare for the transition to adulthood. Similarly, the study findings suggest that interventions to help youth struggling with significant externalizing symptomatology would also aid the child welfare systems' objective of readying youth for adulthood.

Future directions for this research include a closer examination of (1) the role of risk behaviours in predicting adolescents' transition readiness skills and (2) the longitudinal course of potentially trauma experiences, risk behaviours, and transition readiness factors in order to determine how these variables interact dynamically. Also, given that risk behaviours only partially mediated the relations between transition age foster adolescents' exposure to ACEs and their readiness skills, there may be additional mechanisms that explain why ACEs predicted lower transition readiness among foster youth. Future research can go beyond the scope of the current study and examine whether other sequelae of trauma (e.g., internalizing symptomatology, low academic achievement) mediate the relations between these variables (Gregorowski & Seedat, 2013; Romano, Babchishin, Marquis, and Fréchette, 2014).

Additionally, researchers may wish to consider using other life skills assessment questionnaires in conjunction with, or as an alternative to, the CANS Transition to Adulthood scale. The CANS Transition to Adulthood scale had low internal consistency, suggesting that the items in this scale may be overly broad. This CANS scale may be measuring more than one latent variable, as opposed to a single interrelated construct of "transition readiness." A possible alternative that researchers can use is the Ansell-Casey Life Skills Assessment (ACLSA) tool. The ACLSA has been found to have acceptable internal consistency values and has been used to assess the independent living skills of transition-age foster youth (Nollan et al., 2000).

Another direction for future research is to select specific ACEs, traumatic stress symptoms, strengths, and risk behaviours to study. Certain variables may be more important than others at influencing foster adolescents' functioning and their degree of transition readiness prior to exiting care. For example, it seems not all ACEs are equally impactful, with variability depending upon factors such as the type, duration, and severity of the adverse event (Elklit, 2002; Perry, 2009). Research indicates that foster youth with histories of interpersonal traumas, sexual traumas, and dissociation symptoms may be particularly at risk for poor socioemotional functioning and engagement in risk behaviours, and that youth with supportive mentoring relationships and educational success may be more protected from negative outcomes in adulthood (Cloitre et al., 2009; Forsman, Brännström, Vinnerljung, & Hjern, 2016; Griffin et al., 2009; Kisiel et al., 2009; Kisiel et al., 2014; Kisiel & Lyons, 2001; Lemon, Hines, & Merdinger, 2005; Lyons, McClelland, & Jordan, 2010; Munson & McMillen, 2009). Researchers should direct their attention to studying how these variables may impact foster youths' transition readiness skills.

Overall, the current study adds to the literature by demonstrating that the adverse childhood experiences of foster youth do predict an increased risk of poorer transition readiness at age 17. These results supported the hypotheses that young people exposed to ACEs would be more likely than other youth to experience functional difficulties and to be less prepared for adulthood prior to exiting care. Connections between foster adolescents' histories of potentially traumatic experiences and later difficulties in adulthood are often referenced in the literature on young people who age out of care, and the current study confirmed the existence of a relation between these variables. The strength of the relation was affected, however, by the amount of variance in transition readiness attributable to these adolescents' engagement in risky behaviours.

This finding accords with a growing body of literature suggesting that externalizing behaviours (of which risky behaviours are a subset) are sequelae of ACEs exposure that warrants targeted intervention (Anda et al., 2006; Becker, Jordan, & Larsen, 2006; Duke, Pettingell, McMorris, & Borowsky, 2010; Felitti et al., 1998; Grella, Stein, & Greenwell, 2005; Griffin et al., 2009; Margolin & Gordis, 2000). Longitudinal research investigating the impact of ACEs on externalizing behaviours, life functioning, and transition readiness skills would clarify the temporal order of these relationships. Such research could also explore whether, and how, youths' strengths and trauma-related stress symptoms interact with their ACEs histories, risk behaviours, and readiness to transition out of care.

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Table 1

Descriptive Statistics of the Study Sample (N = 278)

Variable	*n*	*(%)*	*M*	*SD*	*Range*
Age			17.47	.33	17.00-18.54
Sex					
Female	153	(55.0)			
Male	125	(45.0)			
Ethnicity					
Non-Hispanic White	120	(43.2)			
African American	158	(56.8)			
Living Arrangement					
Kinship care	117	(42.1)			
Regular foster care	57	(20.5)			
Treatment foster care	23	(8.3)			
Congregate care	42	(15.1)			
Emergency care	39	(14.0)			

Table 2

Descriptive Statistics and Cronbach Alpha Coefficients of the Major Study Variables

Variable	*n*	*M*	*SD*	*SE*	Range	Skew	*α*
CANS composite scales							
ACEs	276	-.01	.30	.02	1.33	.45	.55
Stress symptoms	275	-.01	.50	.03	2.29	.37	.73
Risk behaviours	275	-.005	.46	.03	2.09	.78	.82
Life functioning	270	.90	.49	.03	2.46	.10	.81
Transition to adulthood	237	.99	.48	.03	2.55	.09	.61
Strengths	274	-.01	.59	.04	2.70	-.22	.84

Note. N's range from 237 to 275 due to missing data.

Table 3

Summary of Intercorrelations for the Demographic and CANS Mean Centered Composite Variables

Variable	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*M*	*SD*
1. ACEs	-								-.01	.30
2. Stress symptoms	.47***	-							-.01	.50
3. Risk behaviours	.31***	.44***	-						-.01	.46
4. Ethnicity (non-Hispanic White = 0, African American = 1)	.00	-.05	-.20**	-					.57	.50
5. Sex (female = 0, male = 1)	-.04	.00	.17**	.07	-				.45	.50
6. Age	-.10	.00	-.08	.07	.04	-			-.01	.33
7. Life functioning	.32***	.44***	.74***	-.03	.18***	-.03	-		.90	.49
8. Transition to adulthood	.32***	.43***	.52***	-.08	.04	-.03	.72***	-	.99	.48
9. Strengths	.29***	.38***	.48***	-.02	.05	.04	.72***	.62***	-.01	.59

*Note. * $p < .05$. ** $p < .01$. *** $p < .001$.*

Table 4

Characteristics of Foster Adolescents by their Living Arrangement

Variable		Kinship Care 1		Regular Foster 2		Treatment Foster 3		Congregate Care 4		Emergency Care 5		ANOVA		Dunnett's C Post Hoc Test
		M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*p*	
CANS Scales														
	Life functioning	.77	.49	.85	.43	1.04	.42	1.04	.55	1.16	.44	6.39***	<.001	5>1, 5>2
	Transition to adulthood	.85	.48	1.05	.45	1.14	.33	1.01	.47	1.19	.54	4.32**	.002	5>1, 3>1
	Strengths	-.12	.59	.02	.57	.13	.58	.10	.61	.11	.53	2.14	.08	-
	ACEs	-.05	.29	-.04	.31	-.04	.23	.03	.32	.01	.29	1.25	.29	-
	Stress symptoms	-.10	.48	-.02	.06	.02	.49	.002	.55	.20	.47	2.75*	.03	5>1
	Risk behaviours	-.16	.42	-.04	.06	.08	.43	.20	.47	.27	.46	9.62***	<.001	5>1, 5>2, 4>1
Age		17.51	.35	17.40	.27	17.45	.36	17.50	.35	17.44	.30	1.24	.30	
		n	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	χ^2	*p*	
Sex[a]	Female	70	59.8	36	63.2	12	52.2	22	52.4	13	33.3			
	Male	47	40.2	21	36.8	11	47.8	20	47.6	26	66.7	10.22*	.04	
Ethnicity[a]	Non-Hispanic White	32	27.4	36	63.2	9	39.1	14	33.3	29	74.4			
	African American	85	72.6	21	36.8	14	60.9	28	66.7	10	25.6	38.49***	<.001	

[a] Pearson chi-square test.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 5

Hierarchical Regression Predicting Foster Youths' Transition Readiness from Demographic and CANS Variables (n =231; 233).

Predictor Variables	Step 1			Step 2			Step 3			Step 4		
	B	*SE B*	*β*	*B*	*SE B*	*β*	*B*	*SE B*	*β*	*B*	*SE B*	*β*
Risk behaviours (centred)	1.27***	.09	.67	1.18***	.10	.61	.70***	.09	.37	.71***	.09	.37
ACEs				.46**	.15	.16	.21	.12	.07	.23	.12	.08
Strengths							.82***	.07	.54	.80***	.07	.52
ACEs x Strengths										-.23	.19	-.05
R^2			.44***			.46***			.67***			.68***
$\triangle R^2$			-			.02**			.21***			<.01
F for change in R^2			181.94***			9.16**			145.16***			1.41
Risk behaviours (centred)	1.28***	.09	.67	1.19***	.10	.62	1.05***	.10	.55	1.05***	.10	.55
ACEs				.46**	.15	.15	.24	.16	.08	.26	.16	.09
Trauma stress symptoms							.38**	.11	.20	.38***	.11	.20
ACEs x trauma stress symptoms										-.87**	.28	-.14
R^2			.45***			.47***			.50***			.52***
$\triangle R^2$			-			.02**			.03**			.02**
F for change in R^2			189.15***			9.20**			12.00**			9.42**

** p < .05. ** p < .01. *** p < .001.*

Note. Higher transition readiness scores indicate higher transition readiness concerns. Higher strengths scores indicate higher strengths concerns.

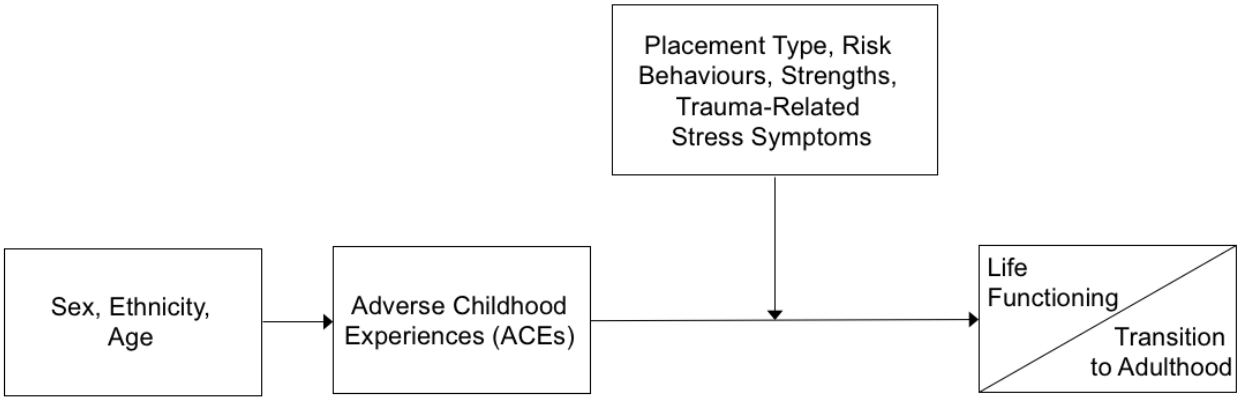

Figure 1. Conceptual model of the hypothesized relations between adverse childhood experiences, life functioning, transition to adulthood, strengths, and trauma-related stress symptoms, with foster adolescents' sex, ethnicity, age, placement type, and engagement in risk behaviours hypothesized as control covariates.

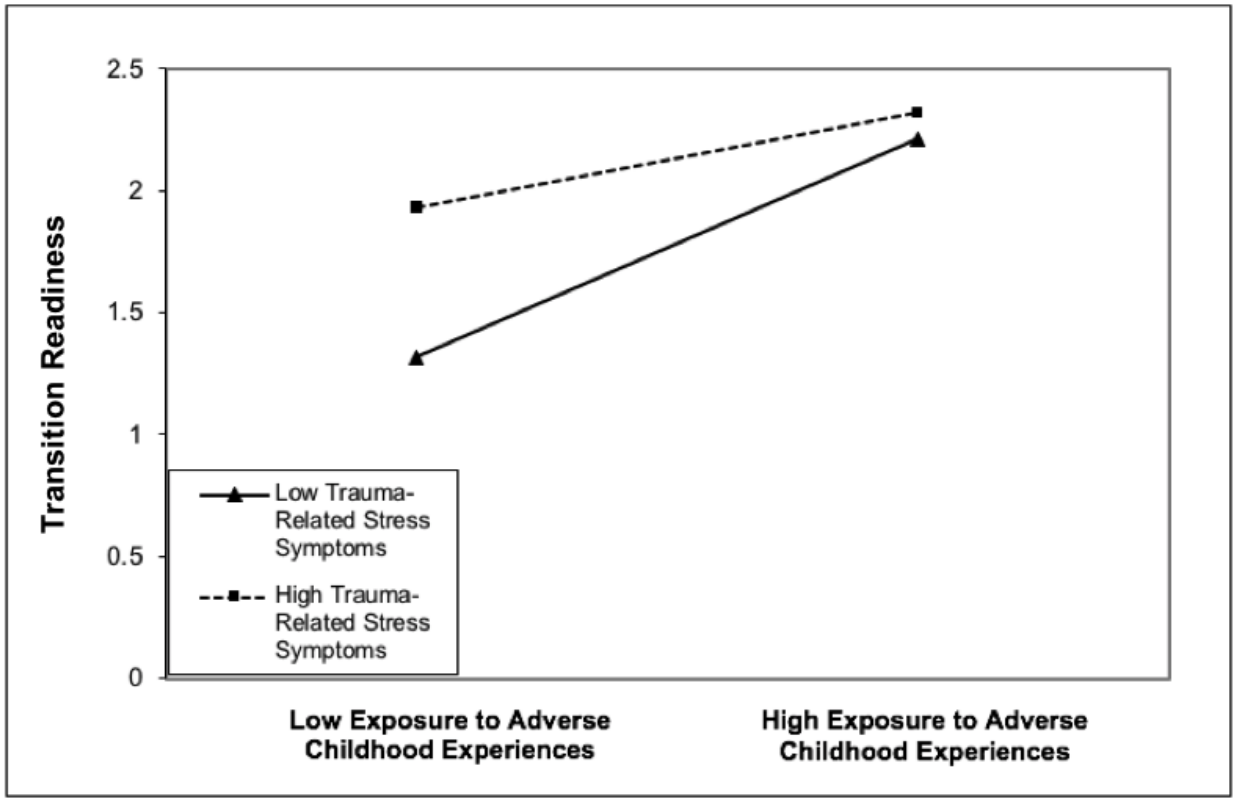

Figure 2. Simple slopes of adverse childhood experiences (ACEs) predicting transition readiness at high (+1 SD) and low (-1 SD) levels of trauma-related stress symptoms. Note: higher transition readiness scores (i.e., "adult readiness") indicate higher readiness concerns.

Figure 3. Standardized regression coefficients for the relationship between ACEs and transition readiness as mediated by risk behaviours. The standardized regression coefficient between ACEs and transition readiness, controlling for risk behaviours, is in parentheses in the path analysis. Note: higher transition readiness scores indicate higher readiness concerns.

Predictors of Self-Care and Financial Literacy Skills among Transition-Age Foster Youth in Ontario

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Abstract

Objectives: To determine individual, placement, and agency factors that correlate with foster adolescents' (ages 16-17) acquisition of self-care and financial literacy skills prior to entering adulthood. Design: Cross-sectional data during year 13 (2013-2014) of the Ontario Looking After Children (OnLAC) project were used for this study. In accordance with ecological theory and past research examining resilience factors at nested levels of influence, it was hypothesized that variables closest in proximity to these adolescents would account for most of the variance in outcomes. Results: Hierarchical linear modelling (HLM) analyses indicated that transition readiness did not significantly differ by CAS agency site. General linear modelling analyses indicated that a subset of individual- and placement-level factors did impact readiness. Specifically, higher academic performance, higher self-esteem, a greater number of developmental assets, older age, an older age of entry into care, a greater number of placement transitions, and kinship care placement predicted higher transition readiness. A greater number of socioemotional difficulties, a greater number of long-term mental and/or physical health conditions, and a lower frequency of problematic parenting practices combined with a higher frequency of effective parenting practices predicted lower transition readiness. Conclusion: Findings illustrate that a subset of individual- and placement-level factors predict transition readiness among transition-age youth.

Keywords: Child welfare, transition readiness, risk and promotive factors

Predictors of Self-Care and Financial Literacy Skills among Transition-Age Foster Youth in Ontario

Introduction

Every year in Canada, hundreds of adolescents enter into adulthood by exiting the child welfare system. These young people become legally responsible for their own welfare and autonomy, and are commonly tasked with managing this major life transition with minimal support. In Canada, there is no national record of how many adolescents leave care in this manner, but by applying a calculation method used by Flynn and Vincent (2008) to recent census data, it is estimated that 3,510 Canadian youth annually age out of care (8% of all foster children; Schibler & McEwan-Morris, 2006; Statistics Canada, 2016).

Child protection legislation is a provincial and territorial responsibility in Canada, and thus the age at which services are no longer accessible to these young people varies by jurisdiction (Courtney, Flynn, & Beaupré, 2013). Currently, the age limit for the purposes of protection varies between ages 16 years and 19 years nationally. Some provinces also offer extended services whereby specific supports and benefits (e.g., health, dental, counselling) may be accessible to a young person after they exit care, so long as they meet eligibility criteria (e.g., employed or in school) and are within a specified age range (e.g., typically under age 21 or age 25; OACAS, 2014).

Although there are many commonalities between American and Canadian child welfare systems, primarily their mandate to ensure children are safe and protected from harm, there are also key differences. Distinguishing features of the Canadian child welfare system include the overrepresentation of Aboriginal children in care relative to their representation in the Canadian population (in the United States there is a similar overrepresentation of African American

children in care) and the underutilization of outcomes evaluation research (Commission to Promote Sustainable Child Welfare, 2010; Courtney et al., 2013). Relative to the United States, there are far fewer studies specifically examining Canadian transition-age foster youth.

Ensuring care leavers are ready for life after care is a key priority of child welfare agencies (Courtney, 2013; Stein, 2006). Although many Canadian jurisdictions offer programs to help these youth develop the skills required for future independent living, knowledge of how they acquire self-sufficiency skills is limited. The need to track the well-being and functional outcomes of care leavers has been highlighted recently in Canadian news media (Kovarikova, 2017). Research opportunities for such tracking include examining care leavers' correlates of resilience, predictors of their transition readiness skills, and their well-being and functioning in early adulthood.

Predictors of Transition Readiness

With the current study, I aimed to contribute to the literature by examining factors that predicted higher or lower self-sufficiency skills among Ontarian transition-age youth (i.e., adolescents ages 16 years or 17 years who had been living in out-of-home care for one year or more and who were approaching the age at which they would no longer be eligible for these services). *Self-sufficiency skills* have been defined as abilities that allow individuals to provide for their needs both financially and practically such that they will be able to live independently and avoid relying on government assistance for survival (Fassart et al., 2014). Within the field of child welfare, acquisition of self-sufficiency skills is a common way that the concept of *transition readiness* has been defined (Inglehart, 1994; Mallon, 1998; Propp, Ortega, & Newheart, 2003). Accordingly in this manuscript the terms transition-readiness and self-sufficiency are used interchangeably.

There is considerable merit to tracking care leavers' acquisition of self-sufficiency skills and developing a greater understanding of transition readiness predictors at individual, familial, and community spheres of influence. Despite care leavers being a high risk group of young people entering adulthood, a substantial proportion do succeed in adulthood (Courtney et al., 2012; Keller, Cusick, & Courtney, 2007). A popular belief reflected in child welfare policies is that foster youth who possess self-sufficiency skills will fare better in early adulthood than those who lack these skills and many study findings have lent credence to this belief (Barth, 1990; Cook, 1994; Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Dixon & Stein, 2005).

There remains a lack of research examining the process by which foster youth develop these skills. Specifically, little is known regarding precursory factors that predict which care leavers will possess high or low adult readiness skills prior to exiting care. Given this gap in the literature, my intention was to explore predictors of self-sufficiency skills among a Canadian sample of transition-age youth living in out-of-home care. To my knowledge, based on my review of the literature, no study has examined predictors of self-sufficiency skill acquisition among Canadian foster youth approaching the age at which they will exit from care.

Resilience and Ecological Systems Theory

The selection of predictor variables for inclusion in the study was informed by both resilience research and the ecological systems framework. *Resilience* has been defined as an individual's adaptive response after being exposed to significant adversity (Masten & Powell, 2003). An individual needs to meet age-salient developmental expectations following exposure to adverse events in order to demonstrate resilient functioning. Above average or exceptional functioning is not the required threshold for resilience; rather, average or reasonably adequate functioning is sufficient (Jaffee & Gallop, 2007; Luthar, Cicchetti, & Becker, 2000; Masten,

2001; Masten & Powell, 2003). Given that operational definitions of resilience differ depending upon a study's outcome of interest, estimates of resilience vary within the literature (e.g., resilience as defined by average physical health outcomes versus average academic achievement).

Different resilience frameworks exist to explain how positive adaptation develops in the aftermath of significant adversity. One of the more impactful theoretical frameworks within the resilience literature is the *ecological systems model* developed by Bronfenbrenner (1979). This framework organizes factors impacting human development by their proximity to an individual (Kirby & Fraser, 1997; Schofield, 2001; Schofield & Beek, 2005). Factors nearest to an individual (e.g., intrinsic characteristics, interpersonal relationships) are located at the *microsystem* level of the ecological model. Interactions between aspects of an individual's microsystem are located at the *mesosystem* level of the model. Factors that indirectly impact an individual (e.g., school and organizational characteristics) are located at the *exosystem* level of the model (Anderson and Mohr, 2003; Bronfenbrenner 1977, 1979). According to this perspective, human development occurs via interactions between an individual and the layers of his or her environment, with factors more proximal to an individual believed to have more of an impact on functioning than distal factors (Campbell, Dworkin, & Cabral, 2009; Kirby & Fraser, 1997). Strong support for this proximity effect has been found with respect to risk factors, although the effect appears to be less pronounced for protective or promotive factors (Luthar, 2006; Masten & Coatsworth, 1998).

Many resilience researchers have adopted the ecological systems model to identify factors at the individual level that are nested within factors at the familial level and within factors at the extra-familial level (Kirby & Fraser, 1997; Luthar, 2006; Schofield, 2001; Schofield &

Beek, 2005). A stated advantage of this framework is its ability to take into account the situational context surrounding an individual when studying predictors of resilience (Schofield & Beek, 2005). Users of this framework commonly redefine the microsystem, mesosystem, and exosystem levels of Bronfenbrenner's model as occurring at the level of an individual, his/her family, and his/her community, respectively (Luthar et al., 2000; Luthar, 2006; Masten & Coatsworth, 1998; Werner & Smith, 1992). In recent years, this nested model of resilience has been used to investigate outcomes for children living in out-of-home care generally as well as outcomes for care leavers specifically (e.g., Bell, Romano, & Flynn, 2013).

Ecological Factors Associated with Resilient Outcomes

Within the resilience literature, many individual, familial, and community factors have been routinely found to either contribute to or decrease resilience (Masten & Reed, 2002). The following review highlights variables that have been identified in previous studies as capable of either promoting or impeding adaptive functioning. Particular attention will be paid to factors that may be relevant to predicting outcomes for youth aging out of care.

Individual-level factors. Individual differences related to young people's physical, emotional, cognitive, and social characteristics have been found to be capable of impeding or promoting resilience (Jones, 2012). Known protective factors for a variety of positive outcomes include higher intelligence, a more positive outlook on life, and higher self-esteem. Known risk factors for a variety of negative outcomes include cognitive or learning impairments and emotional or behavioural dysregulation (Masten & Reed, 2002). There is evidence to suggest that several factors relating to care leavers' demographics, personal characteristics, and/or life experiences may predict resilience.

Demographics. Regarding outcomes for young people in out-of-home care specifically,

demographic variables that have been studied as predictors of resilience include age, sex, and ethnicity. Adolescents who exit the child welfare system at an older age appear more resilient than those who exit at a younger age (Courtney et al., 2009; Courtney et al., 2012; Courtney & Dworsky, 2006). Being female has been identified as a protective factor for a variety of resilient outcomes (e.g., placement stability, behavioural regulation, academic achievement; Daining & Depanfilis, 2007; Keller et al., 2007; Masten, Best, & Garmezy, 1990; O'Higgins, Sebba & Gardner, 2017; Tessier, O'Higgins, & Flynn, 2018). Unlike the consistent research findings regarding age and sex, results related to ethnicity are variable. For example, when the outcome of interest is educational attainment, compared to foster children of White ethnicity, foster children of Aboriginal descent (in Canada) and African American descent (in the United States) have been found to be at risk for lower academic achievement, children of Asian heritage (in the United States) have been found to be more likely to experience higher academic achievement, and results for children of Hispanic ethnicity (in the United States) have been mixed (Burley & Halpern, 2001; Hegar & Rosenthal 2009; Mitic & Rimer, 2002; Turpel-Lafond, 2007).

One explanation for these mixed findings is that, rather than being a risk or protective factor in and of itself, being of minority ethnicity within certain communities may be a proxy for other factors such as poverty (O'Higgins, Sebba, & Gardner, 2017; Tessier, O'Higgins, & Flynn, 2018). In accordance with this reasoning, Tessier, O'Higgins, and Flynn (2018) emphasized the importance of identifying First Nations, Métis, & Inuit (FNMI) and Black Canadian ethnicities when studying minority ethnic status as a predictor of educational achievement among foster youth in Ontario. Their rationale was based, in part, on the rationale that these ethnic minority groups are the largest in Ontario and are disproportionately affected by poverty (Contenta, Monsebraaten, & Rankin, 2014; Fallon, Chabot, Fluke, Blackstock, MacLaurin, Tommyr, 2013).

Personal characteristics. Several characteristics of care leavers may also predict their resilient functioning. For example, several research studies have found that developmental assets and self-esteem are predictive of resilience (Legault, Anawati, & Flynn. 2006; Scales, Benson, Leffert, & Blyth, 2000). The term *developmental assets* refers to a large set of internal and external resources that have been found to promote resilience and minimize vulnerability in both out-of-home care and community samples of young people (Scales, Benson, Roehlkepartain, Sesma, & van Dulmen, 2006).

In contrast, academic difficulties, mental and physical health conditions, and socioemotional difficulties have been found to be predictive of adversity (Dumont & Provost, 1999; McDonagh & Kelly, 2003; Seiffge-Krenke, 2000). This is of concern given the high prevalence of academic, emotional, behavioural, and physical problems among foster children (Ahrens, Garrison, & Courtney, 2014; Berlin, Vinnerljung, & Hjern, 2011; Child Welfare League of America, 2006). Poor school performance in particular has been identified as a key risk factor for future adversity (Forsman, Brännström, Vinnerljung, & Hjern, 2016; Tessier & Flynn, 2011).

Life experiences. Several experiences relevant to living in out-of-home care have been found to promote resilience. For example, although contact with biological parents can be problematic given the initial reason for child welfare system involvement, research shows that care leavers who remain connected to their birth families fare better and feel more supported when transitioning to adulthood (Collins, Paris, & Ward, 2008; Courtney, Dworksy, Lee, & Raap, 2009, Courtney et al., 2001; Keller et al., 2007; McWey & Mullis, 2004). This is understandable given how critical parent contact is to development and how damaging child-parent attachment ruptures can be (Chamberlain et al., 2006; McWey & Mullis, 2004). Also,

independent living skills programs may positively impact transition readiness; however, evidence supporting this assertion is limited (Mares, 2010; Montgomery, Donkoh, & Underhill, 2006; Naccarato & DeLorenzo, 2008).

Life circumstances that have been found to act as risk factors for resilience include maltreatment exposure, placement instability, problematic behaviour as a reason for foster care, and an older age of care entry. Histories of maltreatment are common among foster children, and maltreatment is associated with a host of negative outcomes including mental and physical health problems, substance use, engagement in risk behaviours, criminal involvement, and lower economic attainment (Avery & Freundlich, 2009; Bolger & Patterson, 2003; MacMillan et al., 2001; Masten et al., 1990; Mersky & Topitzes, 2010; Simmel, 2012). The number of placement changes a young person experiences is also a risk factor for future adversity, in particular, increased engagement in externalizing behaviours (Leathers, 2002; Newton, Litrownik, & Landsverk, 2000).

The deleterious impact of risk behaviours on resilient functioning is well-documented, and may explain why an older entry into care and an entry due to problematic behaviour are associated with less resilient outcomes (Barber, Delfabbro, & Coooper, 2001; Courtney et al., 2001; Shpiegel & Ocasio, 2015). Individuals who enter care at an older age are more likely to enter for reasons related to delinquency and problem behaviour. These young people are at risk for lower educational outcomes and a more difficult time adjusting to out-of-home care (O'Higgins et al., 2017).

Familial-level factors. Among familial-level factors found to impede or promote resilience, perhaps the most well-researched factor is the quality of the child-caregiver relationship (Legault et al., 2006; Masten & Reed, 2002). Bowlby's attachment theory describes

how children develop internal working models of themselves, others, and the world through interactions with their primary caregiver, with these perceptions shaping their subsequent experiences and development (Ainsworth & Bowlby, 1991). Children placed in out-of-home care are vulnerable to experiencing significant attachment injuries. Despite this risk, quality connections with other caring adults may foster secure attachment (Dozier & Bick, 2007; Howe, 2006). Foster parent training programs may also improve child-caregiver interactions and result in fewer placement changes and attachment disruptions (Dozier, Peloso, Lewis, Laurenceau, & Levine, 2008).

Certain placement types are also associated with higher or lower odds for resilient outcomes. Traditional foster care refers to young people living in a family-type substitute care environment with trained or certified non-relative adults. Kinship care refers to young people living with extended family relatives. Group care refers to living with other young people in care under the supervision of trained staff (Winokur, Holtan, & Batchelder, 2018). In general, group care is associated with higher odds for negatives outcomes and kinship care is associated with higher odds for positive outcomes. The characteristics of young people selected for group or kinship care are believed to have some impact on these outcome trends, with young people with externalizing symptomatology being more likely to be placed in group care, and young people with more relative support being more likely to be placed in kinship care (Oswald, Cohen, Best, Jenson, & Lyons, 2001. Young people living in group care are then more likely to report placement dissatisfaction and engage in delinquent behaviours, for example, whereas young people living in kinship care are more likely to report closeness with their substitute caregivers and placement stability (Chamberlain et al., 2006; Leathers, 2002; Webster, Barth, & Needell, 2000). The positive findings associated with kinship care have been explained in part by virtue of

its family-like environment and the ability for youth to retain stable connections to pre-existing supports (Leathers, 2002).).

Community-level factors. Community factors found to promote resilient outcomes in young people include attending a higher quality school and residing within a safe and resource-rich community (Masten, 2001; Masten & Reed, 2002). For young people in out-of-home care, residing in a more urban or rural geographic location may also impact care experiences, with urban geography associated with a higher likelihood of being placed in intensive and restrictive placement settings (i.e., institutionalized care versus kinship care; Attar-Schwartz, 2008; Barth, Wildfire, & Green, 2006; Glisson, Bailey, & Post, 2000; Havlicek, 2010). Reasons for these observed relations may relate to differences in community resources and population characteristics (Havlicek, 2010). Young people's odds for resilient functioning may also be affected by child protection agency factors (e.g., funding and availability of resources), although evidence for this is limited (Attar-Schwartz, 2008; Bell et al., 2013).

Study Objectives

My goals in this study were to (a) determine the prevalence of transition readiness skills (i.e., self-care and financial literacy skills) among a sample of transition-age foster youth in Ontario, (b) identify the independent contributions of individual-, placement-, and agency-related factors on the frequency of these skills, and (c) identify the relative contributions of independent predictor variables within each level of analysis. Variables of interest were selected in keeping with past research on factors that hinder or promote resilience, as well as research on factors that hinder or promote successful adult outcomes for youth in care. Although there is a substantial body of research examining factors that promote resilience generally, there is limited research

examining factors that predict self-sufficiency skills in adolescents while in out-of-home care specifically, and limited research examining predictors within a Canadian sample.

Individual-level variables of interest included adolescents' sex, Black Canadian or FNMI ethnicity, age, placement type, age at first placement in out-of-home care, contact with biological parents, number of placement transitions, presence or absence of long-term physical and/or mental health conditions, reason for entry into care (i.e., maltreatment exposure, behavioural problems exceeding caregiver capacity), academic performance, daily living program enrollment, socioemotional problems, self-esteem, and intrinsic and extrinsic developmental assets. *Ethnic minority status* was defined as being of FNMI or Black Canadian ethnicity using the same reasoning as Tessier, O'Higgins and Flynn (2018) in their study of correlates of resilience among foster adolescents in Ontario. Placement-level variables of interest included placement type, parenting practices (as rated by both the caregiver and adolescent), caregivers' training experiences, and the size of the area in which the caregiver residence was situated (i.e., rural or urban environment; please note that this variable varied by placement rather than by children's aid agency and thus was retained at the placement level of analysis rather than at the agency/community level of analysis). The agency-level variable of interest was CAS agency site. Outcome variables of interest were adolescents' self-care skills and financial literacy skills; these were investigated at the individual level of analysis.

In accordance with both ecological systems theory and past research examining factors at nested levels of influence, I hypothesized that individual-level variables would account for most of the variance in adolescents' transition readiness skills (self-care and financial literacy skills), with this trend being more pronounced for risk factors than for promotive factors. At the individual-level, I hypothesized that female sex, non-Black Canadian or FNMI ethnicity, a

younger age at entry into care, contact with biological parents, fewer placement transitions, fewer long-term physical and/or mental health conditions, fewer maltreatment experiences, no history of behavioural problems exceeding caregiver capacity, higher academic performance, fewer socioemotional problems, higher self-esteem, and a greater number of developmental assets would predict transition readiness (i.e., a higher number of self-care and financial literacy skills). I hypothesized that a lower frequency of problematic parenting practices combined with a higher frequency of effective parenting practices (as rated by the caregiver and adolescent), a greater number of caregiver training experiences, and kinship care placement rather than group care placement would predict higher transition readiness at the placement-level of analysis. To my knowledge, based on a literature review, no prior studies have examined the impact of the size of the area in which the caregiver residence was situated (i.e., rural or urban environment) on transition readiness, although presiding in an urban environment is predictive of being placed in more restrictive placement setting (Havlicek, 2010). No hypothesis was therefore made regarding the impact of geography on transition readiness; instead, this variable was retained in the analysis for exploratory purposes. Similarly, based on mixed prior findings as to whether living skills programs impact transition readiness, and given the narrow age range of study participants (ages 16 and 17 years) such that age effects might be undetectable, no hypotheses were made regarding the role of daily living program enrollment and adolescents' current age in predicting transition readiness. At the agency-level of analysis, I made no hypothesis regarding whether CAS agency site would account for an amount of the total explained variance. Table 1 presents a summary of the study hypotheses.

Methods

Participants

The individuals from whom the data were initially collected are foster caregivers, child welfare workers, and youth living in out-of-home care in Ontario. Cross-sectional data regarding the welfare of adolescents (ages 16 and 17 years) who were in out-of-home care during Year 13 (June 2013 to May 2014) of the Ontario Looking After Children (OnLAC) project were selected for this study. The age range was restricted to 16 and 17-year-olds because transition-age youth were the focus of research interest, youth begin exiting care soon after this age, and participation in the OnLAC project is not mandatory for 18- to 21-year-olds as young people at this age are technically not "in care." For their data to be eligible for inclusion, the following sections of participants' Second Canadian Adaptation of the Assessment and Action Record (AAR-C2-2010; the instrument used to collect data for the OnLAC project) had to be completed: age, sex, placement type, agency ID, and self-care and financial literacy skill ratings. Participants had to identify on the AAR-C2-2010 as being in group care, foster care, or kinship care placement types to be eligible for inclusion in the study, as only individuals in those placement types had caregiver information included in the assessment. Participants who identified as being in the independent living placement type lacked caregiver-rated information on the AAR-C2-2010 and therefore had too much missing data across certain variables to be eligible for inclusion in the study.

From the initial cross-sectional sample of 1,583 young people in care, 557 were excluded from participation in the current study based on these selection criteria. A comparative analysis to assess for sample biases indicated that the proportion of young people included in the study (n = 1,026) did not significantly differ from the omitted sample (n = 557) based on sex, birth family

contact, entry age into care, and maltreatment exposure. Chi-square and *t*-test analyses revealed statistically significant differences on age, ethnicity, number of placement changes, and placement type. The sample of young people who were excluded from the study were more likely to be older (mean age = 16.98 years versus 16.86 years), less likely to be of Black Canadian or FNMI ethnicity (23% versus 30%), and more likely to have experienced many placement changes (mean placement changes = 7.35 versus 6.42) compared to the sample of young people who were included in the study. They were less likely to be living in foster care (63% versus 69%) or kinship care (6% versus 9%), and were more likely to be living in group care (31% versus 22% included in the sample).

Of the 557 young people in care who were excluded from participation in the current study based on the aforementioned selection criteria, 136 identified as living in independent living settings. A comparative analysis to assess for sample biases using Chi-square and *t*-test analyses indicated that individuals placed in independent living (n = 136) did not differ from the study sample (n = 1,026) based on sex, ethnicity, birth family contact, or maltreatment exposure. Analyses revealed statistically significant differences pertaining to age, entry age into care, and number of placement changes in care. Compared to the study sample (i.e., adolescents placed in foster, kinship, or group care), the sample of young people placed in independent living were more likely to be older (mean age = 17.27 years versus 16.86 years), more likely to have entered into care at an older age (mean entry age = 9.62 years versus 8.31 years), and more likely to have experienced a higher number of placement changes (mean placement changes = 8.98 versus 6.42).

The sample of young people placed in independent living were also compared to the study sample (i.e., those living in foster, kinship, or group care) on the outcome variables of self-

care and financial literacy skills, as well as on a combined "transition readiness" variable (note: the creation of this scale is discussed in the results section when data cleaning procedures are reviewed). The *t*-test analyses revealed statistically significant differences pertaining to all three outcome variables, with youth placed in independent living more likely to be rated as having more self-care skills (skills count = 18.50 versus 16.93), financial literacy skills (10.21 versus 8.37), and overall transition readiness skills (28.71 versus 25.30).

The characteristics of foster youth included in the current study were as follows: The mean age of eligible participants was 16.86 years (SD = .55) and the male-to-female sex distribution was relatively even (55.7% male, 44.3% female). Most adolescents were English speaking (94.5%, 4.1% French speaking, 1.4% other language speaking) and of European-Canadian descent (60.6%; 11.5% Black Canadian, 19.5% FNMI, 8.4% other). The majority (73.4%) had one or more long-term health conditions (34.9% attention deficit hyperactivity disorder, 33.2% learning disability, 25.4% emotional, psychological or nervous difficulties, 15.0% developmental disability, 6.7% fetal alcohol spectrum disorder, 6.7% other, 6.3% asthma, 2.6% respiratory allergies, 2.3% food or digestive allergies, 1.6% epilepsy, 0.7% heart condition, 0.7% cerebral palsy, 0.6% diabetes, 0.4% bronchitis, 0.3% kidney condition or disease, 0.3% blood disorder; note: percentages do not sum to 100% as multiple long-term conditions may apply). The majority were Crown wards (89.6%; 6.0% society wards, 4.4% other), meaning that the province was their legal guardian. At the time of data collection, the adolescents were living in foster homes (68.6%), group homes (22.3%), and kinship care (9.1%). Although the caregiving circumstances of these adolescents varied, all young people in the sample had an identified caregiver. Foster youth included in the sample were represented by 41 of the 53 agencies of the Children's Aid Societies in Ontario.

The prior life experiences of these adolescents were as follows: On average they entered into out-of-home care when they were 8.31 years old (SD = 4.62; ranging from entry at birth to entry at age 16.83 years) and had experienced 6.29 placement changes since their date of entry into care (SD = 3.80; ranging from 0 to 20). Participants had lived at their current placement for an average of 4.94 years (SD = 4.15, range = 0 to 17). As reported by child welfare workers based on their knowledge of adolescents' case history, the primary reason(s) these young people were admitted into care included a history of maltreatment (54.3% neglect, 35.2% emotional harm, 27.3% physical harm, 18.7% exposure to domestic violence, 9.0% sexual harm), caregiver abandonment or separation (22.8%), and/or problematic behaviour on behalf of the young person exceeding his or her caregivers' capacity to provide care (25.3%; note: percentages do not sum to 100% as several reasons for entry may apply). At the time of the AAR-C2-2010 assessment, 86.4% of youth were in contact with one or both of their biological parents.

Data Collection Procedures

The Ontario Looking After Children (OnLAC) project began in 2000 as a funded collaboration between Drs. Flynn, Angus, Aubry, and Drolet of the Centre for Research in Educational and Community Service (CRECS) at the University of Ottawa, in partnership with the Ontario Association of Children's Aid Societies (OACAS) and local Children Aid Societies in Ontario. Supplementary funding for the OnLAC project is provided by the Ontario Ministry of Community and Social Services (MCSS) and the Ontario Ministry of Children and Youth Services (MCYS). The mandate of the project is to improve the quality of substitute parenting provided to children in out-of-home care by child welfare organizations in Ontario, and to monitor annual quality improvement (Flynn, Ghazal, Legault, Vandermeulen, & Petrick, 2004). Since 2007, when use of the AAR-C2 was mandated by the Ontario Ministry of Children and

Youth Services, most (but not all) of the local Children's Aid Societies (CASs) in Ontario have used the AAR-C2 (thereby collecting and providing data for the OnLAC project). Of the 53 child welfare services in Ontario, there remain approximately five or six Indigenous CASs that do not use the AAR-C2, mainly for linguistic, cultural, or geographic reasons.

Measure

Second Canadian Adaptation of the Assessment and Action Record (AAR-C2). The instrument used to collect data for the OnLAC project is the Second Canadian Adaptation of the Assessment and Action Record (AAR-C2). The AAR-C2 is a structured needs assessment and outcome monitoring tool completed over a series of joint meetings by foster parents, child welfare workers, and foster children who are over 10 years of age (Legault et al., 2006). It is mandated for use across Ontario with children and youth who have been living in out-of-home care for one year or more. Items on the AAR-C2 are based on items from the original AAR developed in Britain. Measures from other sources such as the National Longitudinal Survey of Children and Youth (NLSCY) and the Youth in Transition Survey (YITS) are also included in the AAR-C2 (Statistics Canada & Human Resources Development Canada, 1999, 2002).

The AAR-C2 assesses the well-being of children in foster care across seven functional outcome domains: health, education, identity, family and social relationships, social presentation, emotional and behavioural development, and self-care skills (Flynn et al., 2004). Researchers at the University of Ottawa conduct needs assessments, outcomes monitoring, and quality improvement research with OnLAC data. These researchers use the OnLAC to annually monitor the progress of Ontario foster children (ages 0 to 21 years) in relation to five targeted outcomes: safety, permanency, greater educational achievement, higher degree of resilience, and smoother transitions to emerging adulthood.

There have been occasional revisions to the AAR-C2 (e.g., 2006, 2010, 2016). The current study used data collected from the 2010 version of the AAR-C2 (hereafter referred to as the AAR-C2-2010). Reasons for the 2010 update included eliminating the need to recode certain variables, the addition of an independent legal review to ensure that all questions being asked conformed to the guidelines of the Ontario Human Rights Code, and reordering sections in response to feedback from caregivers, caseworkers, and young people (thereby reducing the amount of time young people need to spend participating in the assessment interview). Different versions of the AAR-C2-2010 were developed that correspond with different age groups (i.e., 0-11 months, 1-2 years, 3-4 years, 5-9 years, 10-11 years, 12-15 years, 16-17 years, and 18-21 years).

The current study used data collected using the version of the AAR-C2-2010 that was adapted for youth who are 16-17 years of age. Psychometric and normative information for the multi-item AAR-C2-2010 scales was calculated using data from year 10 (2010-2011) of the OnLAC project. Internal consistency reliability norms as assessed using Cronbach's alpha and descriptive qualifiers as stated in the AAR-C2-2010 user manual (i.e., good, very good, excellent reliability) are provided when discussing the study scales (see below).

Variables Used in the Study

Dependent (criterion) variables. As part of the *self-care skills* developmental dimension of the AAR-C2-2010, adolescents rated themselves on two scales that assessed the degree to which they were learning to care for themselves in preparation for the transition to adulthood. The first outcome variable, Self-Care Skills and Resources, is a 23-item scale measuring young people's independent living skills (e.g., project management skills, job finding skills, post-secondary education/training application skills, and safety and personal hygiene skills) and

resources (e.g., possession of a valid driver's licence or health card). Responses are *yes*, *no*, or *not applicable*, with *yes* scores summed to create a scale ranging from 0 to 23. Higher scores indicate a greater number of self-care skills and resources. The second outcome variable, Financial Literacy, is a 14-item scale measuring young people's personal finance, money management, and career planning abilities (e.g., saving, spending, budgeting, and job search and interview skills). Responses are also *yes*, *no*, or *not applicable*, with *yes* scores summed to create a scale ranging from 0 to 14. Higher scores indicate a greater number of financial literacy skills.

Items for both scales were adopted from the National Longitudinal Survey of Children and Youth (NLSCY; Statistics Canada & Human Resources Development Canada, 1999) and the Youth in Transition Survey (YITS; Statistics Canada & Human Resources Development Canada, 2002). According to OnLAC norms (2010-2011), scores on the Self-Care Skills and Resources scale demonstrate very good internal consistency, Cronbach's $\alpha = .85$, and scores on the Financial Literacy scale demonstrate excellent internal consistency, Cronbach's $\alpha = .91$. For the current sample the Self-Care Skills and Resources scale scores demonstrated very good internal consistency, Cronbach's $\alpha = .83$, and, the Financial Literacy scale scores demonstrated excellent internal consistency, Cronbach's $\alpha = .90$.

Adolescent-related independent (predictor) variables. The following information was provided on the AAR-C2-2010 by the adolescent, the adolescents' welfare worker, and/or his or her foster caregiver(s), and investigated at the individual level of analysis: the adolescents' sex (dichotomous variable: *male*, *female*), current age (continuous variable), contact with biological parents (dichotomous variable: *yes*, *no*), Black Canadian, First Nations, Métis, or Inuit (FNMI) ethnicity (dichotomous variable: *yes*, *no*), age at first entry into out-of-home care (continuous variable), maltreatment exposure as the reason for entry into out-of-home care (continuous

variable from 0 to 5, with *physical harm*, *sexual harm*, *emotional harm*, *neglect*, and *exposure to domestic violence* being the 5 possible maltreatment exposure types), problematic behaviour exceeding caregiver capacity as the reason for entry into out-of-home care (dichotomous variable: *yes*, *no*), number of placement changes (continuous variable), presence of long-term physical and/or mental health conditions (continuous variable from 0 to 17, based on the presence or absence of 17 possible long-term health diagnoses as determined by a health professional), overall academic performance during the current school year (continuous variable; item responses were *very well or well*, *average*, and *poorly or very poorly*), and enrollment in a daily living program (*yes*, *no*). Adolescents, child welfare workers, and/or caregivers also provided item-level information that was then used to calculate composite scales assessing adolescents' total psychosocial difficulties, total developmental assets, and general self-esteem (composite scales described below).

The Total Difficulties scale is a 20-item subscale of the Strengths and Difficulties Scale (SDQ; Goodman, Ford, Simmons, Gatward, & Meltzer, 2000). It is part of the *emotional and behavioural development* developmental dimension of the AAR-C2-2010, and is comprised of the sum of four 5-item SDQ subscales that assess adolescents' psychosocial difficulties (i.e., emotional symptoms, conduct problems, hyperactivity and inattention problems, and peer problems). Each subscale score ranges from 0 to 10, and item responses are on a Likert-type scale of *true (2)*, *somewhat true (1)*, and *not true (0)*. Scale scores can be prorated if at least 3 out of 5 subscale items are completed. The Total Difficulties scale is a sum of the 20 items making up these four subscales (continuous variable with scores ranging from 0 to 40). Responses are provided by the young person's caregiver based on observations of the youth over the past six months. Higher total scores indicate a greater frequency of problem behaviours. The Total

Difficulties scale scores have very good internal consistency reliability using OnLAC norms (Cronbach's α = .87). The scale scores demonstrated very good internal consistency for the current sample, Cronbach's α = 87. Additional information regarding the SDQ's psychometric properties is provided on the SDQ website (www.sdqinfo.com) or in Achenbach and colleagues (2008).

The Total Developmental Assets profile is a 40-item scale that is completed by the child welfare worker on behalf of the young person. Scale items were developed based on the work of the Search Institute, which has identified forty internal (e.g., commitment to learning, positive values, social competencies, positive identity) and external (e.g., empowerment, support, boundaries and expectations, constructive use of time) developmental assets that are associated with positive outcomes and resilience in young people (e.g., Filbert & Flynn, 2010; Oman et al., 2004; Scales et al., 2000; Taylor et al., 2002). Response options are *yes/present (1), no/absent (0), or uncertain (0)*, with yes responses summed to create a total score ranging from 0 to 40. Higher scores indicate that the worker believes the young person possesses a higher number of developmental assets. The Total Developmental Assets profile scores have very good internal consistency reliability based on OnLAC norms, Cronbach's α= .80. The scale scores demonstrated excellent internal consistency for the current sample, Cronbach's α = 90. More information about these developmental assets is available in Scales (1999) and the Search Institute website (http://www.search-institute.org/assets).

The 6-item General Self-Esteem Scale for Young People Aged 10-17 is completed by the young person. It is part of the *identity* developmental dimension on the AAR-C2-2010. Scale items were adopted from the NLSCY (Statistics Canada & Human Resources Development Canada, 1999). Response options are *most of the time/always (2), sometimes (1), or rarely/never*

(0), with responses summed to create a total score ranging from 0 to 12. Higher scores indicate more positive general self-esteem. The General Self-Esteem Scale scores demonstrated very good internal consistency reliability based on OnLAC norms and in the current sample, Cronbach's α= .83 and .86, respectively.

Placement-related independent (predictor) variables. Due to a near 1:1 ratio of caregivers to adolescents in the study sample, it was not possible to investigate placement-related predictor variables at a separate placement/caregiver level of analysis. Therefore, they had to be investigated at the individual level of analysis. The following placement-related information was provided on the AAR-C2-2010 by the adolescent, the adolescent's welfare worker, and/or his or her foster caregiver(s): placement type (categorical variable: *foster care*, *kinship care*, *group care*), size of the area in which the caregiver residence is situated (continuous variable from 0 to 4, with a higher score indicating a less rural and more urban environment), and caregiver training experiences (a continuous variable ranging from 0 to 5, with *Looking After Children*, *Parenting Resources for Information, Development & Education [PRIDE]*, *agency-specific*, *foster parenting techniques*, and *other* being the 5 possible caregiver training program types). Adolescents and caregivers also provided item-level information that was used to calculate two composite scales assessing caregivers' parenting practices (composite scales described below).

The 9-item Parenting Practices scales are part of the *family and social relationships* developmental dimension on the AAR-C2-2010. Scale items were adopted from the short form of the Alabama Parenting Questionnaire (APQ; Elgar, Waschbusch, Dadds, & Sigvaldason, 2007). Across many studies, scores on the APQ have demonstrated adequate reliability and validity, as well as consistent associations with conduct problems and delinquency in young

people (e.g., Bladder, 2004; Chi & Hinshaw, 2002; Dadds, Maujean, & Fraser, 2003; Frick, Christian, & Wootton, 1999; Hinshaw, 2002; Shelton et al., 1996).

Separate but parallel Parenting Practices scales were rated by the young person and the caregiver, respectively, with each scale assessing respondents' perceptions of the caregiver's positive parenting practices (3 items; e.g., caregiver praises youth when he/she is behaving well), poor supervision practices (3 items; e.g., youth is out with friends the caregiver does not know), and inconsistent discipline practices (3 items; e.g., caregiver lets youth out of discipline consequences early). Item responses were based on a 5-item scale of *always (4)*, *often (3)*, *sometimes (2)*, *almost never (1)*, *and never (0)*, with the total Parenting Practices scale scores ranging from 0 to 36. The six problematic parenting practice items were reverse coded (i.e., poor supervision and inconsistent discipline items), such that a higher total Parenting Practices scale score indicated perceptions of a lower frequency of problematic parenting practices combined with a higher frequency of effective parenting practices. The youth-rated and caregiver-rated scale scores demonstrated adequate internal consistency reliability based on OnLAC norms, Cronbach's $\alpha = .74$ and .77, respectively. The youth-rated and caregiver-rated scale scores also demonstrated adequate internal consistency for the current sample, Cronbach's $\alpha = .75$ and .71, respectively.

Agency-related independent (predictor) variables. CAS agency site was included in the study as a specific agency-level variable. Of the 53 Children Aid Societies in Ontario, 41 were serving youth whose AAR-C2-2010 data were included in the current study.

Results

Initial Data Screening

Hierarchical linear modelling and univariate general linear modelling were conducted to examine the relationship between self-sufficiency skills and various potential predictors. IBM SPSS Statistics software (version 21.0) and Scientific Software International (SSI) HLM 7 student software were used to conduct analyses. Table 2 displays the descriptive statistics for all study variables. Intercorrelations among the study variables are presented in Table 3.

Data screening prior to hierarchical linear modelling. Given the near 1:1 ratio of caregivers to adolescents in the sample, the three-level hierarchical linear model was collapsed to a two-level model, with caregiver-related variables nested at the individual level of analysis. Data cleaning and screening requirements were therefore conducted for the data overall and for the data grouped by Children's Aid Society. To determine whether the Type I error risk was inflated, possible interdependence between groups situated at the upper hierarchical level was considered.

Prior to conducting analyses to test the study hypotheses, variables were examined for accuracy of data entry, missing values, and fit between their distributions and assumptions of multivariate analysis. Missing data at the individual level of analysis were retained for hierarchical linear modelling as the analysis accommodates missing data at this level of the model (Raudenbush & Bryk, 2002). No impossible values were found and univariate outliers were addressed by winsorizing outlying values (i.e., 1 value on the youth-rated parenting practices scale, 3 values on the caregiver-rated parenting practices scale, 2 values on the self-esteem scale, 8 values on the self-care scale, 6 values on the long-term conditions scale, and 11 values on the placement changes scale). Multivariate outliers were removed from the sample,

and the intercepts and slopes for each level 2 group were checked for outlying values (i.e., any level 2 intercept or slope greater than 3.29 *SD* from the mean of all the intercepts or slopes would have been removed from the sample; none were found). Discrete variables were dummy coded. Discrepant cell sizes across levels of discrete predictor variables were screened for and none were found (i.e., no cell sizes met or exceeded a 10:1 ratio). Given the large study sample size, a higher asymmetry in the variable distribution could be tolerated statistically, and so the eyeballing technique combined with assessing for absolute values of skew larger than 2 were methods used to determine substantial non-normality (Kim, 2013). Using these references the general self-esteem scale appeared moderately skewed. To improve pairwise linearity and to reduce moderate skewness, a square root transformation was used on the general self-esteem scale. The results of the analyses conducted to test study hypotheses were comparable using the original and the transformed self-esteem variable; therefore, for clarity of interpretation, only analyses using the non-transformed self-esteem variable will be presented.

Bivariate correlations among predictor variables indicated that the correlation between the Self-Care Skills and Resources and Financial Literacy scales was large enough to suggest that they measured the same underlying construct ($r = .73$). Given this finding, the scales were combined by summing all items to create a "transition readiness" scale. The transition readiness scale score reliability for the sample was Cronbach's $\alpha = .91$, indicating excellent reliability. Similarly, the bivariate correlation between the caregiver-rated and adolescent-rated parenting practices scales was large enough to suggest they measured the same underlying construct ($r = .62$). Given this finding, the scales were combined to create a single "parenting practices" scale. The parenting practices scale score reliability for the sample was Cronbach's $\alpha = .83$, indicating very good reliability. The results of the analyses conducted to test study hypotheses were

comparable when these scales were used separately and when combined. For clarity of presentation, results will therefore only be presented using the combined outcome variable (transition readiness, also synonymous with self-sufficiency skills in this manuscript) and combined predictor variable (parenting practices).

Tests for multicollinearity indicated that a very low level of multicollinearity was present across all variables (all *VIF* = less than 3). A principal components analysis using varimax rotation was conducted to assess whether it was most appropriate to treat the remaining predictor variables separate or to combine them in some manner. The scree plot of eigenvalues provided support for true distinctiveness between the constructs assessed by the predictor variables.

Given power restrictions, only a subset of the exploratory predictor variables could be included in the hierarchical linear model. Determining which variables to include in the analysis was decided pragmatically by examining the nature of the data. Predictor variables that were correlated with the criterion variables at a magnitude equal to or greater than a small effect size (i.e., $r \geq .1$) were selected for inclusion in the model. Of the exploratory variables, adolescents' entry age into care, academic performance, long-term health conditions, general self-esteem, socioemotional difficulties, developmental assets, and caregiver parenting practices (rated by the youth and caregiver) met this criterion for inclusion in the hierarchical linear model.

Data screening prior to univariate general linear modelling (GLM). Prior to running univariate GLM, a subset of participants who were missing all items on one or more composite scales were filtered from the dataset, as this missingness could not be accommodated for statistically using GLM as it had been able to be accommodated using HLM (n = 123). This filtering occurred after the previous analyses because HLM requires level-1 data missingness to be preserved in order to ensure the correct weighting of level-1 variables in analyses. A lower

completion rate of the parenting practices scale among participants was primarily responsible for this change in sample size. These filtered versus retained cases were compared on demographic variables using Chi-square tests, and no significant differences were found with respect to ethnicity, age, or sex. The Cronbach's alpha reliability value for the combined outcome variable ("transition readiness") remained highly comparable despite this change in sample size (Cronbach's $\alpha = .89$ for the $n = 903$ sample, versus Cronbach's $\alpha = .91$ for the $n = 1026$ sample).

For the remaining sample, a non-significant Little's MCAR test revealed that the data were missing completely at random (Little, 1998). With no variable exceeding 6% of its items missing and only 1.6% of items missing in total across the dataset, it was determined that it was appropriate to conduct a single imputation using the expectation maximization algorithm to improve statistical power and to reduce potential bias of the estimated parameters (Enders, 2001; Kang, 2013). Although power restrictions had resulted in only a subset of the predictor variables being included in the hierarchical linear model, there was sufficient power to include all predictor variables in the univariate GLM. Therefore, general linear modelling was completed twice, first only on the subset of variables selected for inclusion in the hierarchical linear model and secondly with all exploratory predictor variables.

Statistical Analyses

Hierarchical linear modelling and univariate general linear modelling were conducted to explore potential predictors of care leavers' self-sufficiency skills. Hierarchical linear modelling was used to statistically account for the nesting of adolescents within placements within agencies, and to model the relationship between individual-, caregiver-, and agency-related variables and outcomes (Raudenbush & Bryk, 2002). As previously stated, adolescents were not nested within the model by their respective caregiver given the near 1:1 ratio between youth and

caregivers in the study sample. Hierarchical linear modelling was conducted on a subset of the exploratory predictor variables given power restrictions for the analysis. Seven predictor variables (entry age into care, academic performance, long term health conditions, general self-esteem, socioemotional difficulties, developmental assets, and parenting practices) were selected for inclusion because of their association with the criterion variable ($r \geq .01$).

The multilevel base model of random effects variances partitioned variance in adolescents' transition readiness into agency and individual levels. The results indicated that the slopes between each predictor variable and the dependent variable did not vary significantly by agency. The intraclass correlation was .004 or .4% (.004 = .05/11.87), indicating that less than 1% of the variance in transition readiness scores was due to differences between agencies. This finding indicated that there was not enough variability in transition readiness scores across agencies to justify the use of hierarchical linear modelling, as most of the variability in transition readiness scores was not due to between group differences but due to differences within level 1 of the model. Given that the variance in adolescents' transition readiness scores partitioned by children's aid agencies was nonsignificant, it was appropriate to test the study hypotheses using univariate general linear modelling (GLM) instead of HLM. As stated previously, two sets of analyses were conducted. The first GLM included only the subset of variables chosen for inclusion in the hierarchical linear model (i.e., only a subset of the exploratory predictor variables were included in the HLM given power restrictions). The second GLM included all exploratory predictors of interest given adequate power to include all exploratory predictors using GLM rather than HLM (Munro, 2005).

The GLM with 7 predictors was significant and indicated that the combination of these predictors accounted for 24.4% of the variance in the sample, $F(7, 896) = 41.18$, $p < .001$, $\eta^2 =$

.24. As can be seen in Table 4, all 7 variables significantly predicted transition readiness scores. The individual predictors of academic performance, general self-esteem, age of entry into care, and total developmental assets were positively and significantly correlated with transition readiness, indicating that care leavers with higher scores on these variables tended to have higher transition readiness after controlling for other variables in the model. Conversely, the individual predictors of long term health conditions, socioemotional difficulties, and parenting practices were negatively and significantly correlated with transition readiness, indicating that care leavers with lower scores on these variables tended to have higher transition readiness after controlling for other variables in the model.

The GLM with 18 predictors was significant and indicated that the combination of these predictors accounted for 27.5% of the variance in the sample, $F(19, 884) = 17.61$, $p < .001$, $\eta^2 = .28$. As can be seen in Table 4, the inclusion of 11 additional predictors in the model neither impacted the direction nor significance of the relations between the aforementioned 7 variables and transition readiness. As in the prior GLM, academic performance, general self-esteem, age of entry into care, and total developmental assets remained positively and significantly correlated with transition readiness, and long-term health conditions, socioemotional difficulties, and parenting practices remained negatively and significantly correlated with transition readiness. Of the 11 additional predictor variables, 3 significantly predicted self-sufficiency, with the remaining 8 variables not contributing to the model. Care leavers' age and their number of placement changes were positively and significantly correlated with transition readiness, indicating that care leavers with higher scores on these variables tended to have higher self-sufficiency skills after controlling for other variables in the model. Pairwise comparisons between placement types indicated that after all other predictors were accounted for, youth living

in kinship care tended to have higher transition readiness than youth living in foster care. The difference in means between youth living in kinship care and youth living in foster care was 1.41, $SD = .65$, $p < .05$.

Discussion

Predictors of Self-Sufficiency Skills

This study used cross-sectional data to investigate the contributions of individual-, placement-, and agency-related factors on the transition readiness skills of foster youth in Ontario. Regarding findings at the most distal level of the ecological model (agency-level), hierarchical linear modelling (HLM) indicated that adolescents' degree of attained self-sufficiency skill (i.e., self-care and financial literacy skills and resources) did not differ by CAS agency site. The finding that CAS agency site did not account for a significant amount of the total explained variance was consistent with past research indicating that agency-level factors either have no significant impact on child outcomes or exert considerably less influence than family- and individual-level factors (Bell et al., 2013). This finding also accords with ecological systems theory, whereby distal factors are believed to exert less influence on child development than proximal factors (Bronfenbrenner, 1979).

Given the near 1:1 ratio of adolescents to caregivers in the secondary dataset, it was not possible to statistically account for the nesting of individuals within their respective placements using hierarchical linear modelling (Raudenbush & Bryk, 2002). Rather, the unique contributions of individual- and placement-related factors on transition readiness were assessed via general linear modelling (GLM). Two GLMs were conducted; the first GLM included only the subset of variables chosen for inclusion in the hierarchical linear model (seven predictors were included in the HLM due to power restrictions) and the second GLM included all 18 exploratory predictors.

The first GLM with seven predictors (i.e., entry age into care, academic performance, long term health conditions, general self-esteem, socioemotional difficulties, developmental assets, and caregiver parenting practices) explained 24.4% of the variance in outcomes in the sample. The second GLM with 18 predictors explained 27.5% of the variance in outcomes in the sample. The seven variables included in both models related to transition readiness/self-sufficiency skills similarly across analyses. Therefore, only the results of the second GLM will be discussed hereafter.

Ten of the 18 factors significantly predicted transition-age foster adolescents' self-sufficiency skills, with seven acting as promotive factors predicting higher self-sufficiency and three acting as risk factors predicting lower self-sufficiency. The study hypotheses were partially supported; of the 18 predictors, six predicted self-sufficiency skills in the same direction as was hypothesized, four predicted self-sufficiency skills in a direction that was not hypothesized, and eight did not predict self-sufficiency skills (with six of these eight factors having been hypothesized to be significantly predictive). Table 1 presents a summary of the study hypotheses. Table 5 presents a summary of the relations between the 18 factors and self-sufficiency skills. These hypotheses and results will now be discussed in further detail.

Regarding individual-level factors, higher academic performance, higher self-esteem, a greater number of developmental assets, an older current age, an older age of entry into care, and a greater number of placement changes predicted higher self-sufficiency skills after controlling for other variables in the model. In contrast, higher socioemotional difficulties and a greater number of long-term mental and/or physical health conditions predicted lower self-sufficiency skills after controlling for other variables in the model. Individual-level factors that had no significant impact on outcomes after controlling for other variables in the model included sex,

being of Black Canadian or FNMI ethnicity, birth family contact, daily living program enrollment, maltreatment exposure, and problematic behaviour as a reason for entry into care.

Regarding placement-level factors, kinship care placement positively predicted self-sufficiency, parenting practices negatively predicted self-sufficiency, and caregiver training experiences and size of the area of residence (i.e., urban, rural) had no significant impact on the outcome of interest after controlling for other variables in the model.

Findings that accorded with the study hypotheses included academic performance, self-esteem, developmental assets, and kinship care positively predicting self-sufficiency, and socioemotional difficulties and long-term health conditions negatively predicting self-sufficiency. The findings that academic success, self-esteem, and developmental assets related to higher self-sufficiency align with prior resilience research findings. These factors have routinely been found to predict positive outcomes in young people (Luthar, 2006; Masten & Coatsworth, 1998). Similarly, socioemotional difficulties and long-term health conditions have often been associated with future negative outcomes in young people (Dumont & Provost, 1999; McDonagh & Kelly, 2003; Seiffge-Krenke, 2000).

The finding that kinship care predicted higher self-sufficiency skill adds to a growing body of literature demonstrating that kinship care is associated with successful outcomes relative to group and/or traditional foster care. Kinship care is often selected as a "first resort" option so long as there are relatives willing, able, and approved to care for a youth, and the young person does not present with needs exceeding the caregiving capacity of relatives (OACAS, 2014). Given that kinship care placements are approved for children who do not require a higher level of oversight and structure, this type of placement may pre-select for individuals with higher self-sufficiency skills (Adam, 2004; Roy, Rutter, & Pickles, 2000). Youth placed in kinship care are

also statistically more likely to fare well academically, present with fewer behavioural issues, experience greater bonds with caregivers, and experience fewer placement disruptions, which are factors known to promote resilience (Leathers, 2002; Webster, Barth, & Needell, 2000).

Findings that positively predicted self-sufficiency but did not accord with study hypotheses included being of an older age at the time of the OnLAC assessment, having entered care at an older age, and having experienced a greater number of placement changes. Although a growing body of evidence relates leaving care at an older age (i.e., ages 19 or 21) with being better equipped for the transition to adulthood, no hypothesis was made regarding current age significantly predicting self-sufficiency given that the study sample range was limited to 16 and 17 year-olds (Dworsky & Courtney, 2010). The fact that age was a significant predictor of transition readiness despite the restricted age range suggests that relations between chronological age and the development of self-sufficiency skills warrant further study.

It was surprising that an older age of entry into care and a higher number of placement changes predicted higher self-sufficiency skills given that these factors are commonly associated with negative outcomes (Shpiegel & Ocasio, 2015). It is possible that youth may be demonstrating advanced self-sufficiency skills for maladaptive reasons related to having learned to depend on themselves for survival rather than rely on caregivers for safety or support, although a greater variety of outcomes measures would be required to explore this possibility. Some recent research supports the idea of care leavers being either adaptively or maladaptively self-sufficient. For example, Yates and Grey (2012) studied profiles of resilience among care leavers (n = 164, mean age = 19.7) and found that whereas the majority appeared generally resilient (47% of the sample), a minority (6.7%) appeared *only* external resilient (e.g., employed or in school) while exhibiting significant internal distress. Another possibility for understanding

this finding is that collinearity with other variables in the model may have adversely affected these results and thus the results are potentially due to statistical artifacts.

Similarly, the negative relation between quality parenting practices and self-sufficiency skill acquisition is noteworthy. This finding contradicted the study hypothesis and existing research literature, which tends to find a positive relationship between quality parenting practices and youth outcomes. Potential explanations for this finding include less transition-ready youth being matched to more skilled caregivers, and/or caregivers adjusting their parenting style to meet the needs of less self-sufficient youth. Measurement error is also a possibility, as Bell and colleagues (2013) used this parenting scale to predict emotional problems in foster children and also achieved a result that was contrary to their hypothesis and supporting literature (note: they also achieved other results with this instrument, however, that aligned with their hypotheses). Bell and colleagues (2013) noted that their contrary finding might be due the fact that the parenting practices measure rates the frequency of caregiver-child interactions rather than the quality of these interactions. The possibility that a social desirability bias may have resulted in inflated caregiver self-report responses was also suggested. To examine this possibility, Bell and colleagues (2013) recommended conducting a triangulation of more informant reports along with direct observation to better assess parenting practices.

Another possibility particularly relevant to the current study sample is the finding that the Alabama Parenting Questionnaire may be less valid when used with older adolescent populations (Zlomke, Bauman, & Lamport, 2015). The APQ has been used extensively for research studies with adolescent populations (e.g., Barry et al., 2007; Dandreaux & Frick, 2009; Eckshtain et al., 2010; Kung & Farrell, 2000; Mafestky & Farrell, 2005), and although generally considered to be a well-validated tool, the APQ was originally developed for school-age children (Zlomke et al.,

2015). Given the uncertainty as to how valid and applicable APQ findings are when used with adolescent populations, Zlomke and colleagues (2015) re-assessed the APQ factor structure for a sample of 11 to 18 year-olds. Although their results indicated that the measure was appropriate for use with 11 to 15 year-olds, they found a significant correlation between age and several of the APQ items which led them to conclude that APQ results are less valid when used with older adolescents (16 to 18 year-olds). It is important to note that Zlomke and colleagues (2015) assessed the factor structure of the 42-item long-form version of the APQ, not the short-form version on which the OnLAC parenting practices scale is based. Given that these researchers found many of the long-form APQ caregiver-child parenting practice items to be less applicable to older adolescent-caregiver relationships, the validity of the short-form APQ items for use with older adolescents is also called into question and warrants future investigation. In response to some of these APQ concerns, the OnLAC authors revised their method of assessing parenting practices in a recent OnLAC revision.

Lastly, a number of factors did not predict transition readiness for the current sample. Specifically, no relations were found regarding transition-age adolescents' self-sufficiency skill acquisition and their sex, ethnicity, or area of residence (i.e., urban, rural). Similarly, birth family contact, daily living program enrollment, maltreatment exposure, problematic behaviour as a reason for entry into care, and caregiver training experiences did not predict self-sufficiency skills when variance attributable to other factors was accounted for. Additional research is recommended to determine whether these null findings reflect true nonsignificant relations or are reflective of study design or measurement decisions.

For example, although female sex has been found to relate to a number of resilient outcomes among young people, this is not a universal finding across all outcomes of interest nor

all resilience studies. For example, Yates and Grey (2012) found no sex differences among their cluster analysis of resilient versus non-resilient youth. It therefore remains unclear whether sex differences do not exist with regards to transition readiness, or whether sex differences in self-sufficiency are merely not present at age 16 and 17 but become more apparent as youth age into adulthood. Research findings examining the impact of ethnicity, urbanicity of residence, and daily living programs on resilient functioning also vary, with null findings published in the literature (e.g., Yates & Grey, 2012). The current results therefore add to the mixed findings regarding whether these variables impact adolescent functioning (Donkoh et al., 2006; Keller et al., 2007; Yates & Grey, 2012).

As well, it is advised that the null findings related to maltreatment histories as problematic behaviour as a reason for entry into care be interpreted cautiously. Given the known relationship between externalizing behaviours and adverse childhood experiences, as well as the inclusion of other measures of problematic behaviour within the regression analyses, is it probable that the variance that may have been attributable to these two predictor variables was shared with the externalizing behaviour measures (i.e., socioemotional problems and long-term physical and/or mental health conditions). Indeed, items on the socioemotional problems questionnaires specifically assess for current conduct problems.

The maltreatment scale score was also a relatively crude and static indicator of adolescents' prior exposure to adverse childhood experiences, which may have affected the validity of this result. Although using scale indices to measure maltreatment exposure has been common practice within the ACEs literature, researchers have advocated for assessing exposure to adverse childhood experiences more dynamically. Although more dynamic assessment data were unavailable in the secondary administrative dataset used for this study, a more dynamic

measure of maltreatment capturing information regarding the type, frequency, timing, and severity of exposure (as well as other qualitative facets of maltreatment) would have been preferable to the current study's count method and may have yielded different results. Similar to the maltreatment variable, the caregiving training variable was also a relatively crude measure in that it only examined the number of training courses a caregiver attended.

Study Limitations

The current study's correlational design was a key limitation as it excluded statements about causality from being made. Also, although many exploratory variables were analyzed, some potential predictors were not included in the study as they were not assessed during the Year 13 OnLAC process (e.g., intellectual functioning, socioeconomic factors, prenatal factors, birth family characteristics; O'Higgins, Sebba & Gardner, 2017). Having caregivers, adolescents, and case workers complete the OnLAC interview together may have also introduced some bias in OnLAC responses. As well, despite this study capturing a broad section of the Ontario population of care leavers in its sample, assessment data on FNMI youth may have been underrepresented given that a handful of more remote CAS sites that service primarily FNMI youth do not participate in the OnLAC assessment process (Tessier, O'Higgins, & Flynn, 2018).

Measurement of some study variables could also be improved upon for future studies. For example, this research would benefit from the selection of a different measure assessing the quality of the child-caregiver relationship rather than assess parenting practices. Similarly, as stated in the preceding section, the current study crudely assessed maltreatment exposure and caregiver training experiences using count scales; more sophisticated and nuanced measurement of these variables is recommended for future studies. Also, some OnLAC variables were originally intended to be dichotomous variables but were constructed as continuous variables for

the purpose of preserving adequate power for hierarchical linear modeling (i.e., long term physical and/or mental health conditions, maltreatment exposure, and caregiving training experiences). Constructing variables may have affected the validity of results using these scales.

Two additional study limitations relate to the predictive validity and generalizability of the study findings. Firstly, the degree to which assessments of adolescents' transition readiness skills at ages 16 and 17 predicts their future adult outcomes remains unknown. Secondly, there were no available same-age population norms of adolescents' self-sufficiency skills. This lack of population data precluded (a) the creation of resilience cut-off scores for the study sample and (b) determinations of how many youth in the sample were resilient.

Implications and Directions for Future Research

This study is one of the few Canadian studies to explore ecological system factors that predict self-sufficiency skill acquisition in transition-age youth prior to exiting care. It is notable for its large sample size and inclusion of assessment information from adolescents served by Children's Aid Societies across the province of Ontario (data from 41 of the 53 Ontario CAS sites were represented in this study). These study features provided ample statistical power to study relations between all 18 exploratory predictors and adolescents' self-care and financial literacy skills and resources.

Following the results of this correlational study, a logical next step will be to examine which ecological factors predict changes in self-sufficiency skills over time. A longitudinal study could better examine the temporal order of relations between these variables. It would be ideal if a future longitudinal study covered the time period both prior to and after foster adolescents' exits from care as it would help address the question of whether early estimates of self-sufficiency skill are predictive of future self-sufficient outcomes. Longitudinal research could

also help identify internal or external "turning point" variables with the ability to alter the pathways of these young people's entries into adulthood, as well as highlight any mediating or moderating relations that may be occurring among these predictors and self-sufficiency (Drapeau, Saint Jacques, Lepine, Begin, & Bernard, 2007).

Future research could also explore the underlying reasons why factors in this study related to higher or lower self-sufficiency skill acquisition. For example, higher self-esteem has been associated with young people's greater use of approach-oriented problem-solving strategies as opposed to passive avoidance when faced with difficulties (Werner & Smith, 1992). A future study could examine the degree to which self-esteem predicts an action-oriented coping style in transition-age youth and relates to independent living success in early adulthood. Similarly, youth with special health care needs have been identified as having unique challenges during the transition to adult serving systems (Sawicki et al., 2011). It would be valuable if subsequent research could identify whether there are care leaving needs specific to this population.

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Table 1

Summary of Hypotheses for the Youth-, Placement-, and Agency-Levels of the Ecological Model

Predictor Variables	Outcome Variable (Transition Readiness)
Individual-level variables	
Sex (male = 0, female = 1)	+
Age	n/a
Black Canadian or FNMI ethnicity (no = 0, yes = 1)	-
Academic performance	+
Age at first placement	-
Contact with biological parents (no = 0, yes = 1)	+
Daily living program (no = 0, yes = 1)	n/a
Developmental assets	+
Long term conditions	-
Maltreatment exposure	-
Placement changes	-
Problematic behaviour (no = 0, yes = 1)	-
Self-esteem	+
Socioemotional difficulties	-
Placement-level variables	
Caregiver training	+
Parenting (caregiver- and youth-rated)	+
Placement type	
Foster	n/a
Kinship care	+
Group care	-
Residence area	n/a
Agency-level variables	
CAS agency site	n/a

Note. (+) Hypothesis of a positive correlation between the predictor and outcome variable.
(-) Hypothesis of a negative correlation between the predictor and outcome variable.
(n/a) No hypothesis made regarding correlation between the predictor and outcome variable (exploratory).

Table 2

Descriptive Statistics of Study Variables (n = 1026)

Variable	%	*M*	*(SD)*	Range	Cronbach's Alpha	Skewness
Outcome variables	-					
Self-care skills and resources	-	16.98	(3.56)	20	.83	-1.04
Financial literacy	-	8.37	(3.75)	14	.90	-.41
Individual-level variables						
Sex						
Male	55.7	-		-	-	-
Female	44.3	-		-	-	-
Age	-	16.86	(.55)	1.98	-	.21
Black Canadian or FNMI ethnicity						
Yes	30.4	-		-	-	-
No	69.6	-		-	-	-
Academic performance						
Poorly or very poorly	17.5	-		-	-	-
Average	58.8	-		-	-	-
Well or very well	23.7	-		-	-	-
Age at first placement	-	8.31	(4.62)	16.83	-	-.04
Contact with biological parents						
Yes	88.2	-		-	-	-
No	11.8	-		-	-	-
Daily living program						
Yes	42.2	-		-	-	-
No	57.8	-		-	-	-
Developmental assets	-	26.50	(7.46)	38	.90	-.50
Long term conditions	-	1.48	(1.30)	6	-	.67
Maltreatment exposure	-	1.47	(1.20)	5	-	.62
Placement changes	-	6.29	(3.80)	20	-	1.17
Problematic behaviour						
Yes	25.8	-		-	-	-
No	74.2	-		-	-	-
Self-esteem	-	9.87	(2.40)	11	.86	-1.01
Socioemotional difficulties	-	12.22	(7.32)	34	.87	.45
Placement-level variables						
Caregiver training		2.27	(1.21)	5	-	.41
Parenting (caregiver-rated)	-	28.45	(4.56)	24	.71	-.66
Parenting (youth-rated)	-	28.85	(5.46)	26	.75	-.62
Placement type						
Foster	68.6	-		-	-	-
Kinship care	9.1	-		-	-	-
Group care	22.3	-		-	-	-
Residence area						
Rural area, First Nations reserve, Northern remote area	23.4	-		-	-	-
Urban (< 30 000)	11.9	-		-	-	-
Urban (30 000 to 99 999)	15.4	-		-	-	-
Urban (100 000 to 499 999)	30.6	-		-	-	-
Urban (500 000+)	18.7	-		-	-	-

Note. M = mean, SD = standard deviation.

Table 3

Summary of Intercorrelations Among Predictor and Outcome Variables (n = 1,026)

	Variable	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*	*19*	*20*
1.	Self-care skills	-																			
2.	Financial literacy	.73***	-																		
3.	Sex	.07*	.04	-																	
4.	Age	.09**	.11***	<.01	-																
5.	Black Canadian or FNMI ethnicity	.03	.05	-.01	.05	-															
6.	Academic performance	.19***	.20***	.15***	-.05	-.02	-														
7.	Age at care entry	.10**	.12***	.06	<.01	-.07*	-.01	-													
8.	Biological parent contact	.08*	.05	-.04	.02	.03	<.01	.17***	-												
9.	Daily living program	.02	.05	-.05	.06	.01	<.01	.07*	<-.01	-											
10.	Developmental assets	.25***	.22***	.13***	-.01	.03	.36***	-.18***	-.03	.02	-										
11.	Long term conditions	-.37***	-.39***	-.12***	.04	-.08*	-.22***	-.14***	-.04	.04	-.20***	-									
12.	Maltreatment exposure	-.03	-.04	.08*	-.01	.04	.02	-.29***	-.06	-.06	.11**	.07*	-								
13.	Placement changes	.05	.03	.05	.02	.03	-.10**	<-.01	.05	.02	-.22***	.05	<-.01	-							
14.	Problematic behaviour	-.10**	-.08*	-.16***	-.04	-.05	-.13***	.25***	.04	.09**	-.20***	.15***	-.26***	.06	-						
15.	Self-esteem	.20***	.13***	-.12***	.09**	-.02	.18***	-.07*	-.08*	.06	.38***	-.10**	.03	-.15***	-.05	-					
16.	Socioemotional difficulties	-.29***	-.28***	.02	.05	-.06	-.32***	<.01	.04	.05	-.43***	.40***	-.02	.14***	.20***	-.29***	-				
17.	Caregiver training	.08**	.03	.04	<.01	.02	.09**	-.04	<-.01	<.01	.16***	-.06	.07*	-.07*	-.06	.12***	-.10**	-			
18.	Parenting (caregiver)	-.12***	-.07*	.04	-.02	-.07*	.16***	-.07	-.05	.02	.29***	.05	.04	-.10**	-.08*	.19***	-.23***	.04	-		
19.	Parenting (youth)	-.09**	-.09**	.09**	.01	-.08*	.20***	-.05	.06	<-.01	.37***	.06	.07*	-.08*	-.09**	.28***	-.21***	.09**	.62***	-	
20.	Residence area	.08*	.08*	-.02	<.01	.11***	-.02	.14***	.02	.11**	-.06	-.15***	-.12***	-.04	<-.01	-.02	-.06	.07*	-.17***	-.16***	-

*Note. * p < .05. ** p < .01. *** p < .001.*

Table 4

Univariate General Linear Modelling Predicting Transition Readiness (n = 1,026)

	Model 1 (7 Predictors)				Model 2 (18 Predictors)			
Predictor Variables	*B*	*SE B*	*t*	η^2	*B*	*SE B*	*t*	η^2
Academic performance	.89**	.32	2.73	.01	.89**	.32	2.74	.01
Age of entry into care	.14***	.04	3.22	.01	.12**	.05	2.70	.01
Long term health conditions	-1.37***	.16	-8.34	.07	-1.31***	.17	-7.92	.07
Parenting practices (caregiver and youth rated)	-.14***	.02	-5.96	.04	-.14***	.02	-6.09	.04
Self-esteem	.31***	.09	3.64	.02	.29**	.09	3.45	.01
Socioemotional difficulties	-.11***	.03	-3.52	.01	-.13***	.03	-4.10	.02
Total developmental assets	.11**	.03	3.44	.01	.12**	.03	3.49	.01
Caregiver training	-	-	-	-	-.07	.16	-.45	<.01
Contact with biological parents (no = 0, yes = 1)	-	-	-	-	.56	.59	.94	<.01
Current age	-	-	-	-	1.49***	.34	4.46	.02
Daily living program (no = 0, yes = 1)	-	-	-	-	.67	.39	1.72	<.01
Maltreatment exposure	-	-	-	-	-.18	.17	-1.08	<.01
Black Canadian or FNMI ethnicity (no = 0, yes = 1)	-	-	-	-	-.11	.40	-.26	<.01
Placement changes	-	-	-	-	.11*	.05	2.15	.01
Placement type (other = 0, foster care= 1)	-	-	-	-	.14	.52	.27	<.01
Placement type (other = 0, kinship care = 1)	-	-	-	-	1.56*	.78	2.01	.01
Problematic behaviour (no = 0, yes = 1)	-	-	-	-	.05	.47	.10	<.01
Residence area	-	-	-	-	-.12	.13	-.87	<.01
Sex (males = 0, females = 1)	-	-	-	-	.54	.39	1.38	<.01

*Note. * $p < .05$. ** $p < .01$. *** $p < .001$.*

Table 5

Summary of Predictor and Outcome Variable Relations When All Other Factors Accounted For

Predictor Variables	Outcome Variable (Transition Readiness)
Individual-level variables	
Sex (male = 0, female = 1)	null
Age	+
Black Canadian or FNMI ethnicity (no = 0, yes = 1)	null
Academic performance	+*
Age at first placement	+
Contact with biological parents (no = 0, yes = 1)	null
Daily living program (no = 0, yes = 1)	null
Developmental assets	+*
Long term conditions	-*
Maltreatment exposure	null
Placement changes	+
Problematic behaviour (no = 0, yes = 1)	null
Self-esteem	+*
Socioemotional difficulties	-*
Placement-level variables	
Caregiver training	null
Parenting (caregiver- and youth-rated)	-
Placement type	
Foster	-
Kinship care	+*
Group care	null
Residence area	null
Agency-level variables	
CAS agency site	null

Note. (+) Result of a positive correlation between the predictor and outcome variable.
(-) Result of a negative correlation between the predictor and outcome variable.
(null) Result of no relation or effect between the predictor and outcome variable.
(*) Result the same as hypothesized.

General Discussion

In this general discussion, I will present an overview of the two studies, synthesize the main results, and integrate the findings with the relevant existing literature. I will then review the limitations of these studies and comment on the generalizability of the findings. I will conclude by discussing implications of this research and suggestions for future study.

Dissertation Objectives

The dissertation addressed the prediction of transition readiness in adolescents living in-out-of-home care. Within the child welfare literature, the term *transition readiness* has historically been defined as synonymous with the possession of self-sufficiency skills. Increased research on this topic is sorely needed given that across North America, (a) transition readiness is a commonly stated priority of both Canadian and American child welfare systems, (b) by virtue of having adopted parental responsibility for these young people, child protection agencies have a duty to ensure their readiness for adulthood, (c) millions of jurisdictional dollars have been spent on programming efforts to increase transition readiness, (d) the majority of outcomes evaluations of these programs have demonstrated minimal effectiveness despite stakeholders' time, money, and efforts, and (e) despite existing programming, outcomes studies indicate that a substantial number of young people continue to exit the child welfare system ill-prepared for adulthood and vulnerable to experiencing significant adversities (Loman & Siegel, 2000; McMillen & Raghavan, 2009).

Despite stakeholder concern regarding the well-being of youth who age of care, relatively little is known regarding pre-transition factors that correlate with their acquisition of self-sufficiency skills (Daining & DePanfilis, 2007; Jones, 2012; Yates & Grey, 2012). Knowledge of individual and socioenvironmental factors that may predispose youth to possess adequate levels

of transition readiness skills prior to exiting care would aid both (a) the identification of youth at-risk for poor transition readiness and (b) the development of interventions to increase readiness skills (Loman & Siegel, 2000). The broad objective of the current dissertation was, therefore, to increase our knowledge of factors that hinder or promote transition readiness among this vulnerable population of young people. The two studies presented in this dissertation were designed to examine the extent to which factors present in the lives of transition-age youth predict their acquisition of self-sufficiency skills prior to exiting out-of-home care. Given that few databases were relevant and accessible to address this question, cross-sectional American data were used for the first study and cross-sectional Canadian data were used for the second study.

Overview of Study Hypotheses and Results

Study 1. Do transition-age foster youth with histories of adverse childhood experiences experience lower transition readiness? If so, do certain factors moderate this relation? The first study employed an *interaction effects model* (also known as a *protective model* and common within the resilience literature) to investigate whether adverse childhood experiences (ACEs) negatively impacted transition readiness among older youth living in out-of-home care in the state of Illinois (n = 278, age 17 years), and whether strengths and traumatic stress symptomatology moderated this relation. Transition readiness was assessed via two indicators of self-sufficiency, current life functioning and acquisition of independent living skills. These indicators were combined into a single "transition readiness" measure as they were highly correlated and related similarly to other variables in the model. I hypothesized that higher ACEs would predict lower transition readiness, and that strengths and traumatic stress symptomatology would moderate this relation (as protective and risk factors, respectively).

Hierarchical regression analyses were conducted and these hypotheses were partially supported. Overall, higher ACEs exposure predicted lower transition readiness, and traumatic stress symptomatology acted as a risk factor moderating this relation. Strengths did not act as a protective factor moderating this relation but, rather, acted as a promotive factor exerting a direct effect on transition readiness. In other words, the more strengths these adolescents possessed, the more transition readiness skills they possessed irrespective of their ACEs exposure. Traumatic stress symptomatology also exerted a small direct effect on transition readiness, thereby indicating that this variable negatively impacted readiness both in relation to and irrespective of ACEs exposure. Given that the magnitude of the relation between ACEs and transition readiness was small, post-hoc analyses were conducted to determine whether adolescents' engagement in risky behaviours mediated this relation. Results indicated that risk behaviour partially mediated the relation between ACEs and transition readiness. ACEs exposure predicted adolescents' lower transition readiness both directly and indirectly through their engagement in risky behaviours.

Study 2. Which youth-, placement-, and agency-level factors promote or impede foster adolescents' transition readiness? The second study employed an *ecological systems model* (also common within the resilience literature) to investigate factors at the youth-, placement-, and agency-level that predicted transition readiness among older youth living in out-of-home care in the province of Ontario (n = 1,026, ages 16 and 17 years). Transition readiness was assessed via two indicators of self-sufficiency, self-care and financial literacy skills and resources. These indicators were also combined into a single "transition readiness" measure as they were highly correlated and related similarly to other variables in the model. Broadly, I hypothesized that proximal factors (i.e., youth-level) would have more impact on transition readiness than distal factors (i.e., agency-level). Specifically, I hypothesized that female sex, a

younger age at entry into care, contact with biological parents, higher academic performance, higher self-esteem, a greater number of developmental assets, parenting practices, caregiver training experiences, and kinship care placement would predict higher transition readiness, and that Black Canadian, First Nations, Métis, or Inuit ethnicity, placement transitions, maltreatment exposure, behavioural problems exceeding caregiver capacity, socioemotional problems, long-term physical and/or mental health conditions, and group care placement would predict lower transition readiness. I made no hypotheses regarding whether daily living program enrollment, current age, and the size of the area of the caregiver's residence (i.e., urban, rural) would relate to transition readiness, but retained these variables in the analysis for exploratory purposes. Similarly, I made no hypothesis regarding whether CAS agency site would account for an amount of the total explained variance in transition readiness.

Hierarchical and general linear modelling (HLM and GLM) analyses were conducted and these hypotheses were partially supported. Broadly, proximal factors had more impact on transition readiness than did distal factors, with adolescents' degree of transition readiness not differing significantly by CAS agency site. Of the 18 youth- and placement-level factors that were explored, seven acted as promotive factors predicting higher transition readiness, three acted as risk factors predicting lower transition readiness, and eight did not relate to transition readiness. As hypothesized, higher academic performance, higher self-esteem, a greater number of developmental assets, and kinship care placement predicted higher transition readiness, and socioemotional difficulties and long-term mental and/or physical health conditions predicted lower transition readiness. Contrary to hypotheses, an older current age, an older age of entry into care, and a greater number of placement change predicted higher transition readiness, and parenting practices predicted lower transition readiness. Sex, Black Canadian, First Nations,

Métis, or Inuit ethnicity, birth family contact, maltreatment exposure, problematic behaviour as a reason for entry into care, group care placement, caregiver training experiences, daily living program enrollment and the size of the area of the caregiver residence (i.e., urban, rural) had no impact on transition readiness.

Integration of Main Study Findings

Taken together, the results of the dissertation research increased current knowledge of the prevalence and predictors of transition readiness skills in young care leavers (i.e., ages 16 years or 17 years). The studies indicated that several factors predicted foster adolescents' acquisition of self-sufficiency skills prior to exiting care, with a tendency for proximal factors to be more influential than distal factors. This pattern was seen in relation to *temporal proximity* (i.e., current experiences being more predictive of transition readiness than past experiences) and levels of the ecological systems model (i.e., child- and family-level factors being more impactful than community-level factors).

Across both studies, high correlations were found between the criterion variables assessing transition readiness, such that they could be combined (respectively) into single "transition readiness/self-sufficiency skill" scales (i.e., current life functioning and transition to adulthood scales were combined in the first study, self-care skills and financial literacy skills and resources scales were combined in the second study, with these scales all relating highly to common definitions of self-sufficiency). This pattern suggests that there may be a more central construct not yet identified that explains the high correlations among these criterion variables. For example, there may be higher-order brain processes warranting study that predict both current functioning and resilient functioning during life transitions (e.g., cognitive flexibility, executive functioning, memory, learning emotion regulation; Cohen et al., 2003; McMillen &

Raghavan, 2008). Future research could examine the underlying constructs of the CANS transition to adulthood scale to better determine how this scale relates to the life functioning scale. Similarly, OnLAC assessment analyses could be conducted to assess why self-care skills and financial literacy skills strongly correlate.

These studies highlight the benefits of applying different theoretical models of resilience to the question of how care leavers acquire transition readiness skills. Application of an interaction effects model enabled the detection of moderation and mediation relations between variables, and application of an ecological systems model facilitated the identification of several conceptual factors and their relation to transition readiness. Findings consistent across the studies included intrinsic and extrinsic assets being predictive of higher transition readiness (i.e., strengths and developmental assets), and externalizing symptomatology and poor health being predictive of lower transition readiness (i.e., engagement in risky behaviours, trauma stress symptomatology, socioemotional problems, long-term mental and/or physical health conditions). These findings were consistent with past research indicating that child strengths are typically associated with higher functional outcomes and adolescent needs are typically associated with lower functional outcomes (Griffin, Martinovich, Garson, & Lyons, 2009; Lyons, 2009; Lyons, Uziel-Miller, Reyes, & Sokol, 2000). The results also demonstrate the importance of stakeholders assessing for externalizing symptomatology and intrinsic and extrinsic assets in transition-age youth given their relations to transition readiness.

Limitations

There were several limitations to the studies that comprise this dissertation. First, as both studies were correlational and based on data while the youth were in care, causal statements about the directionality of relations could not be made and the degree to which transition

readiness at ages 16 years or 17 years is predictive of future self-sufficiency and adaptation in adulthood cannot be determined. Simply put, it is normal for young people's functioning, well-being, and rates of resilience on particular outcomes of interest to fluctuate over time (Kinard, 1998; Luthar et al., 2000; Murray, 2003). Second, given that the perspectives of different stakeholders were solicited during a joint interview process for both the CANS and AAR-C2-2010 assessment procedures, it is possible that some participants over- or under-reported their experiences due to the influence of response biases (e.g., social desirability bias). The extent to which these biases may have influenced the results cannot be determined. Third, given that secondary datasets were used for both studies, data were limited by the original questions asked and answered during the CANS and AAR-C2-2010 assessment interviews. This means that some potential predictors of transition readiness were not available for inclusion in the study designs (e.g., intellectual functioning, birth family characteristics, age at which children experienced ACEs). This also means that some conceptual factors of interest were measured using scales with conceptual or psychometric limitations (e.g., the AAR-C2-2010 parenting practices measure which measured the frequency of parent-child interactions rather than the quality of the caregiving relationship). Fourth, neither study had comparable same-age population norms with which to compare participants' prevalence rates of transition readiness. This precluded (a) comparisons between care leavers' and same-age peers' levels of self-sufficiency skills, (b) the creation of resilience cut-off scores for either study sample, and (c) statements regarding how many adolescents across both studies fell within an adequate (i.e., resilient) range of transition readiness. In order to truly understand the concept of transition readiness and resilience it is not sufficient to know that some youth are at the high end of functioning within a given sample (Luthar & Zelazo, 2003). As a final point, it is important to keep in mind that there are important

differences between American and Canadian child welfare systems (e.g., jurisdictional boundaries, resource allocations, policies, population demographics). It is recommended that these differences be taken into consideration when interpreting and applying these results to other populations.

Implications and Future Directions

This dissertation research contributes significantly to the care leaver literature by adding to our current knowledge of risk, promotive, and protective factors that impact foster adolescents' transition readiness skills. Findings are relevant to clinical practice, as they enable greater identification of youth at risk for poor transition readiness; moreover, knowledge of factors that relate to transition readiness can be used as possible avenues for intervention and readiness programming. Specifically, both study findings suggest that it would be appropriate to target adolescents' levels of strengths, engagement in risk behaviours, and mental health symptomatology in order to better prepare them for the transition to adulthood. The second study's finding that an older current age predicted higher transition readiness also aligns the current movement towards encouraging youth to remain in care until age 21 (rather than exit out-of-home care prior to or at age 18; e.g., Dworsky & Courtney, 2010).

The use of the traditional definition of transition readiness across both studies, whereby readiness is synonymous with self-sufficiency, also enables greater generalizability of research results both clinically and within the existing literature (Nollan et al., 2000). Few studies have examined self-sufficiency skill acquisition in young people specifically, and fewer still examine this criterion quantitatively and while youth remain under child protection service guardianship (Kerman et al., 2002). Self-sufficiency skill acquisition (i.e., transition readiness) as an outcome

of interest in the dissertation research is therefore relatively novel given the young age of participants and the quantitative study designs.

As many researchers have stated, existing research on youth who age out of care tends to be explorative, descriptive, atheoretical, and negatively oriented (i.e., focused on adult pathology and predictors of negative outcomes; Herrick & Stuart, 2005; Kerman et al., 2002; Merdinger, Hines, Osterling, & Wyatt, 2005; Stein, 2006). Qualitative studies with small sample sizes are prevalent, as are studies that interview care leavers in early adulthood to solicit their recall of earlier functioning (e.g., Dixon & Stein, 2005; Jones, 2012; Pecora et al., 2006). Participants' retroactive reporting of transition readiness can be problematic as it introduces the risk of retrospective biases affecting the accuracy of the data.

In contrast, advantages of the current studies include (a) the use of quantitative methodology, (b) analysis of large scale state and provincial secondary data, (c) a focus on positive functioning as the outcome of interest, (d) the selection of predictor variables from findings within the resilience literature, (e) study design decisions based on theoretical models used by resilience researchers, and (f) the assessment of young people's transition readiness skills prior to their emancipation from care rather than in early adulthood, which is relatively rare in the research literature. As well, the inclusion of case workers', caregivers', and adolescents' perspectives during CANS and AAR-C2-2010 interviewing (and therefore in the study data) aligns with best practices regarding including the voices of multiple stakeholders when discussing the well-being of vulnerable populations (Charlton, 1998). Lastly, the second study's focus on Canadian care leavers is noteworthy because the experiences of Canadian children in out-of-home care tend to be underrepresented in the literature relative to American and British populations (Herrick & Stuart, 2005).

Suggested future directions for this area of research include (a) longitudinal studies that track adolescents' self-sufficiency skills while in care and post-transition, (b) adopting the use of psychometrically strong transition readiness measures such as the Ansell-Casey Life Skills Assessment (ACLSA) tool, (c) using outcomes of interest for which there are population norms so that inferences about rates of resilient functioning among care leavers can be made, (d) investigating the role of older adolescent-caregiver relations on transition readiness using a range of constructs and measures, given the limitations of the second study's parenting practices measure, (e) focusing on the impact of adolescents' attachment styles on transition readiness, given the abundance of research demonstrating that children's attachment styles are predictive of future functioning, (f) focusing in greater detail on the relation between academic achievement and transition readiness, given the body of research demonstrating that academic success promotes resilient outcomes for care leavers, (g) conducting a more "fine grained" assessment of the impact of various conceptual factors on transition readiness (e.g., which ACEs are most predictive of lower transition readiness, which assets are most predictive of higher transition readiness?), (h) examining potential interactions between microsystem-level factors at the mesosystem level, (i) studying the impact of possible predictors that were beyond the scope of the current studies (e.g., intellectual functioning, poverty, birth family characteristics), and (j) using multiple outcomes of interest to ascertain how transition readiness relates to other outcomes of interest among care leavers.

A final suggested future direction warranting a more in-depth discussion is the broadening of current conceptualizations of transition readiness. Within the child welfare literature, transition readiness has historically been defined by evidence of self-reliant capabilities and independent living skills (i.e., youth must become self-sufficient soon after

leaving care, possessing self-sufficiency skills therefore constitutes transition readiness). More comprehensive models of transition readiness have been developed within the change management, sociology, and pediatric health care literatures, however. These models have delineated phases of the transition process, theorized multiple factors that may influence readiness, posited that factors influencing readiness may be more or less modifiable, and identified best practices (including a readiness assessment) to be implemented years prior to a transfer date.

Some researchers have begun testing the applicability of these models to the experiences of care leavers (e.g., Dima & Skehill, 2011; Lee & Berrick, 2014). For example, Dima and Skehill (2011) adapted an organizational change management model, Bridges' transition model (2002), to the process of leaving care. The model distinguishes transition from change. Whereas change is theorized to be a situational and sometimes sudden process that happens to people, transition is theorized to be a slower social and psychological process that coincides with change. According to this model, transition consists of an ending and letting go stage (*disengagement*), a neutral zone of deconstruction and reconstruction (*in-between transition*), and a new beginning stage (*integration*; Bridges, 2002; Dima & Skehill, 2011).

Similarly, Lee and Berrick (2014) re-examined the literature on care leavers through the lens of Côté's identity capital model (2002). According to this model, multiple human, social, financial, personal, and internal factors shape young people's transitions to adulthood. Individuals invest in tangible (e.g., education, group memberships, finances) and intangible (e.g., personal agency, adult identity) assets, and the accumulation of these assets shapes their identity. Investment in one's identity is believed to support healthy development; individuals with an

insufficient accumulation of tangible and intangible resources may lack the identity capital required to journey successfully into adulthood (Côté, 2002; Schwartz, Coté, & Arnett, 2005).

Models that have not yet been applied to the child welfare context include the social-ecological model of adolescents and young adults' readiness for transition (SMART; Schwartz et al., 2011) and guidelines from the National Alliance to Advance Adolescent Health (www.gottransition.org). The SMART model was designed for the field of pediatric medicine, yet the authors aspire for the model to be applied and tested to other populations (Mulchan, Valenzuela, Crosby, & Pow Sang, 2016). Transition readiness in this model is defined as the capacity of an adolescent, with the support of his or her caregivers and service providers, to prepare for, begin, continue, and finish the process of moving from a child-oriented to an adult-oriented system, with the goal of flourishing in the adult system. The model identifies individual and socio-environmental factors that interact to impact transition readiness, and distinguishes between distal factors that are less amenable to change (e.g., demographics, disease history) and proximal factors that are modifiable (e.g., developmental maturity, relationships, knowledge and beliefs about transition, psychosocial functioning, self-efficacy skills).

Also within the field of medicine, the National Alliance to Advance Adolescent Health (NAAAH), a federally-funded American non-profit organization, has developed a "Six Core Elements of Health Care Transition" tool aimed at improving the quality of pediatric to adult health care transitions. The tool was developed in 2009 in alignment with recommendations by the American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians, and has since been updated based on knowledge from learning collaboratives, professional reviews, and existing transition innovations (McManus et al., 2014; White, McManus, McAllister, & Cooley, 2012). The authors of the tool define transition as a

process of collaboratively planning with adolescents and their parents/caregivers to support young people's development of self-care skills, participatory decision-making, identification of adult providers, and smooth and informed system transfers. These authors have also created a Transition Readiness Assessment Questionnaire (TRAQ) to address a gap in the literature, namely the absence of a validated, patient-centred instrument to formally assess transition readiness (Sawicki et al., 2009; Scale, Evans, Blozis, Okinow, & Blum, 1999).

Conclusion

Research on the impact of multiple individual and socio-environmental factors on foster adolescents' development of self-sufficiency skills prior to exiting care has been limited in the literature. The current studies add to existing knowledge by identifying predictors of transition readiness among foster youth. Most research on the well-being of care leavers investigates their outcomes in early adulthood and, in some instances, relies on retrospective assessment of self-sufficiency skills upon exiting care. In contrast, the dissertation studies assessed transition readiness while youth remained in care, which should yield improved accuracy of the data and results. The dissertation findings increase our understanding of factors that hinder or enhance readiness, and are directly relevant to efforts to develop interventions to promote greater transition readiness among care leavers.

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Appendices

Appendix A: Scoring Sheet for the NCTSN-CANS Comprehensive

Scoring Sheet for the NCTSN CANS Comprehensive

Please complete all demographic and clinical information below at the same time the CANS Scoring Sheet is completed and send to Northwestern with the CANS Scoring Sheet.

Local ID # For NU Purposes

NICON ID # (_ _ _ _ - _ _ - _ _ _ _ _)
(Please complete for all children in the CDS):

Date of this CANS completion (dd/mm/yy):

Administered:

*If Post-CANS, please fill out form on next page.

Your Name:

Your Role:

Your Agency:

Child's Home Zip Code:

Child's DOB (dd/mm/yy):

Child's Ethnicity (select only one):

Child's Race (If multiracial, indicate all that apply):

	No	Yes
American Indian or Alaska Native	☐	☐
Asian	☐	☐
Black/African American	☐	☐
Native Hawaiian or Other Pacific Islander	☐	☐
White	☐	☐
Unknown	☐	☐

Treatment Related Questions

1. a) Are you using <u>one</u> primary practice to guide treatment with this child?

No ☐ Yes ☐

1. b) Date of 1st Treatment Session (dd/mm/yy):

1. c) Please indicate all of the practices of which you use components in your treatment with this child.

	No	Yes
None	☐	☐
Child Parent Psychotherapy (CPP)	☐	☐
Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)	☐	☐
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	☐	☐
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	☐	☐
Multi-Sensory	☐	☐
Theraplay	☐	☐
Other	☐	☐

If other, please specify:

1. d) Setting:	No	Yes
In office/Outpatient	☐	☐
Residential	☐	☐
School- or Community-based	☐	☐
Other	☐	☐

1. e) Modality:	No	Yes
Individual	☐	☐
Group	☐	☐

2. How many treatment sessions has this child received at the time of this CANS completion?
(Please note that you can count assessment sessions if they include some component of treatment)

3. Is this child receiving any clinical services other than those services listed above? No ☐ Yes ☐

Scoring Sheet for the NCTSN CANS Comprehensive

Complete This Top Section with Post-SPARCS CANS ONLY

Local ID # For NU Purposes

1. Did youth graduate from SPARCS?

No ☐ Yes ☐

2. Check here if Post-Treatment CANS cannot be collected because child dropped out of SPARCS treatment: ☐

3. In total, how many SPARCS sessions did this youth attend? ____ of ____ Total

4. Please fill in the session dates the SPARCS group met and indicate whether the youth was in attendance

		Attended: No	Attended: Yes			NA	Attended: No	Attended: Yes
Session 1		☐	☐	Session 9			☐	☐
Session 2		☐	☐	Session 10			☐	☐
Session 3		☐	☐	Session 11			☐	☐
Session 4		☐	☐	Session 12			☐	☐
Session 5		☐	☐	Session 13		☐	☐	☐
Session 6		☐	☐	Session 14		☐	☐	☐
Session 7		☐	☐	Session 15		☐	☐	☐
Session 8		☐	☐	Session 16		☐	☐	☐

Complete This Bottom Section with Post-CANS for All Other Interventions (e.g., CPP, TF-CBT, CBITS, Multi-Sensory, Theraplay)

1. Date of last treatment session (dd/mm/yy): ____

2. Did youth drop out of treatment prior to completion?

No ☐ Yes ☐

3. Check here if Post-Treatment CANS cannot be collected because child dropped out of treatment prior to completion: ☐

Scoring Sheet for the NCTSN CANS Comprehensive

Local ID # For NU Purposes

TRAUMATIC/ADVERSE CHILDHOOD EXPERIENCES

	0	1	2	3		0	1	2	3
1. Sexual Abuse	☐	☐	☐	☐	8. School Violence	☐	☐	☐	☐
2. Physical Abuse	☐	☐	☐	☐	9. Natural or Manmade Disasters	☐	☐	☐	☐
3. Emotional Abuse	☐	☐	☐	☐	10. War Affected	☐	☐	☐	☐
4. Neglect	☐	☐	☐	☐	11. Terrorism Affected	☐	☐	☐	☐
5. Medical Trauma	☐	☐	☐	☐	12. Witness to Criminal Activity	☐	☐	☐	☐
6. Family Violence	☐	☐	☐	☐	13. Parental Criminal Behavior	☐	☐	☐	☐
7. Community Violence	☐	☐	☐	☐	14. Disruption in Caregiving	☐	☐	☐	☐

TRAUMATIC STRESS SYMPTOMS

	0	1	2	3		0	1	2	3
15. Adjustment to Trauma	☐	☐	☐	☐	19. Avoidance	☐	☐	☐	☐
16. Traumatic Grief	☐	☐	☐	☐	20. Numbing	☐	☐	☐	☐
17. Re-experiencing	☐	☐	☐	☐	21. Dissociation	☐	☐	☐	☐
18. Hyperarousal	☐	☐	☐	☐	22. Affective/Physiological Dys.	☐	☐	☐	☐

CHILD STRENGTHS

KEY for Strengths Domain:

0 = Centerpiece strength
1 = Useful strength
2 = Identified strength
3 = Not yet identified strength/NO information about a strength in this area

	0	1	2	3	NA		0	1	2	3
23. Family	☐	☐	☐	☐		29. Talents/Interests	☐	☐	☐	☐
24. Interpersonal	☐	☐	☐	☐		30. Spiritual/Religious	☐	☐	☐	☐
25. Educational	☐	☐	☐	☐	☐	31. Community Life	☐	☐	☐	☐
26. Vocational	☐	☐	☐	☐	☐	32. Relationship Permanence	☐	☐	☐	☐
27. Coping/Savoring Skills	☐	☐	☐	☐		33. Resilience	☐	☐	☐	☐
28. Optimism	☐	☐	☐	☐						

LIFE DOMAIN FUNCTIONING

	0	1	2	3		0	1	2	3
34. Family	☐	☐	☐	☐	41. Physical	☐	☐	☐	☐
35. Living Situation	☐	☐	☐	☐	42. Sleep	☐	☐	☐	☐
36. Social Functioning	☐	☐	☐	☐	43. Sexual Development	☐	☐	☐	☐
37. Developmental	☐	☐	☐	☐	44. School Behavior	☐	☐	☐	☐
38. Recreational	☐	☐	☐	☐	45. School Achievement	☐	☐	☐	☐
39. Legal	☐	☐	☐	☐	46. School Attendance	☐	☐	☐	☐
40. Medical	☐	☐	☐	☐					

Scoring Sheet for the NCTSN CANS Comprehensive

Local ID # For NU Purposes

ACCULTURATION

	0	1	2	3		0	1	2	3
47. Language	☐	☐	☐	☐	49. Ritual	☐	☐	☐	☐
48. Identity	☐	☐	☐	☐	50. Cultural Stress	☐	☐	☐	☐

CHILD BEHAVIORAL/EMOTIONAL NEEDS

	0	1	2	3		0	1	2	3
51. Psychosis	☐	☐	☐	☐	58. Substance Use	☐	☐	☐	☐
52. Attention/Concentration	☐	☐	☐	☐	59. Attachment	☐	☐	☐	☐
53. Impulsivity	☐	☐	☐	☐	60. Eating Disorders	☐	☐	☐	☐
54. Depression	☐	☐	☐	☐	61. Behavioral Regression	☐	☐	☐	☐
55. Anxiety	☐	☐	☐	☐	62. Somatization	☐	☐	☐	☐
56. Oppositional	☐	☐	☐	☐	63. Anger Control	☐	☐	☐	☐
57. Conduct	☐	☐	☐	☐					

CHILD RISK BEHAVIORS

	0	1	2	3		0	1	2	3
64. Suicide Risk	☐	☐	☐	☐	70. Delinquency	☐	☐	☐	☐
65. Self-Mutilation	☐	☐	☐	☐	71. Judgement	☐	☐	☐	☐
66. Other Self-Harm	☐	☐	☐	☐	72. Fire Setting	☐	☐	☐	☐
67. Danger to Others	☐	☐	☐	☐	73. Intentional Misbehavior	☐	☐	☐	☐
68. Sexual Aggression	☐	☐	☐	☐	74. Sexually Reactive Behavior	☐	☐	☐	☐
69. Runaway	☐	☐	☐	☐					

RATINGS OF CHILDREN 6 YEARS and YOUNGER - <u>OPTIONAL DOMAIN</u>

This domain is also meant for use with developmentally delayed children of any age, and can be used with any child/youth if these are areas of relevant needs regardless of child's age.

	0	1	2	3	NA	U		0	1	2	3	NA	U
75. Motor	☐	☐	☐	☐	☐		83. Labor & Delivery	☐	☐	☐	☐	☐	☐
76. Sensory	☐	☐	☐	☐	☐		84. Parent/Sibling Problems	☐	☐	☐	☐	☐	☐
77. Communication	☐	☐	☐	☐	☐		85. Maternal Availability	☐	☐	☐	☐	☐	☐
78. Failure to Thrive	☐	☐	☐	☐	☐		86. Curiosity	☐	☐	☐	☐	☐	
79. Feeding/Elimination	☐	☐	☐	☐	☐		87. Playfulness	☐	☐	☐	☐	☐	
80. Birth Weight	☐	☐	☐	☐	☐	☐	88. Temperament	☐	☐	☐	☐	☐	
81. Prenatal Care	☐	☐	☐	☐	☐	☐	89. Day Care Preschool	☐	☐	☐	☐	☐	
82. Substance Exposure	☐	☐	☐	☐	☐	☐							

Scoring Sheet for the NCTSN CANS Comprehensive

Local ID # For NU Purposes

TRANSITION TO ADULTHOOD - OPTIONAL DOMAIN

This domain is meant primarily for youth 14 and 1/2 years or older, but can be used with any child/youth if these are areas of relevant needs regardless of child's age.

	0	1	2	3	NA
90. Independent Living Skills	☐	☐	☐	☐	☐
91. Transportation	☐	☐	☐	☐	☐
92. Parenting Roles	☐	☐	☐	☐	☐
93. Intimate Relationships	☐	☐	☐	☐	☐
94. Medication Compliance	☐	☐	☐	☐	☐
95. Education Attainment	☐	☐	☐	☐	☐
96. Victimization	☐	☐	☐	☐	☐
97. Job Functioning	☐	☐	☐	☐	☐

CAREGIVER(S) NEEDS AND STRENGTHS

Title/Role of **Caregiver #1** (relation to child)

	0	1	2	3
98. Physical	☐	☐	☐	☐
99. Mental Health	☐	☐	☐	☐
100. Substance Use	☐	☐	☐	☐
101. Developmental	☐	☐	☐	☐
102. Supervision	☐	☐	☐	☐
103. Involvement	☐	☐	☐	☐
104. Knowledge	☐	☐	☐	☐
105. Organization	☐	☐	☐	☐
106. Resources	☐	☐	☐	☐
107. Residential Stability	☐	☐	☐	☐
108. Safety	☐	☐	☐	☐
109. Marital/Partner Violence	☐	☐	☐	☐
110. Posttraumatic Reactions	☐	☐	☐	☐

CAREGIVER(S) NEEDS AND STRENGTHS

Title/Role of **Caregiver #2** (relation to child)

	0	1	2	3
98. Physical	☐	☐	☐	☐
99. Mental Health	☐	☐	☐	☐
100. Substance Use	☐	☐	☐	☐
101. Developmental	☐	☐	☐	☐
102. Supervision	☐	☐	☐	☐
103. Involvement	☐	☐	☐	☐
104. Knowledge	☐	☐	☐	☐
105. Organization	☐	☐	☐	☐
106. Resources	☐	☐	☐	☐
107. Residential Stability	☐	☐	☐	☐
108. Safety	☐	☐	☐	☐
109. Marital/Partner Violence	☐	☐	☐	☐
110. Posttraumatic Reactions	☐	☐	☐	☐

Appendix B: NCTSN-CANS Comprehensive Manual

CHILD & ADOLESCENT NEEDS & STRENGTHS (CANS) Manual

The National Child Traumatic Stress Network (NCTSN) CANS Comprehensive Version:

A Comprehensive Information Integration Tool for Children and Adolescents Exposed to Traumatic Events

DRAFT: 8/10/11

CHILD AND ADOLESCENT NEEDS AND STRENGTHS

Praed Foundation

A large number of individuals have collaborated in the development of the National Child Traumatic Stress Network (NCTSN) CANS-Comprehensive. Along with the CANS versions for developmental disabilities, juvenile justice, and child welfare, this information integration tool is designed to support individual case planning and the planning and evaluation of service systems. The trauma domains on the CANS were developed in collaboration with **Cassandra Kisiel, Ph.D., Glenn Saxe, M.D., Margaret Blaustein, Ph.D, and Heidi Ellis, Ph.D.** within the National Child Traumatic Stress Network and have been incorporated across several versions of the CANS. This NCTSN version of the CANS was refined with additional significant contributions from **Tracy Fehrenbach, Ph.D., and Gene Griffin, Ph.D**. and several other NCTSN partners. The NCTSN CANS- Comprehensive is an open domain tool for use in service delivery systems that address the mental health of children, adolescents and their families. The copyright is held by the Praed Foundation to ensure that it remains free to use. For more information about alternative versions of the CANS to use please contact John Lyons. For more information on the **NCTSN CANS Comprehensive assessment tool contact Cassandra Kisiel**.

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Praed Foundation

Table of Contents

Primary CANS Domains:

Optional CANS Domains:

If you choose not to rate these optional domains, please leave those sections of the scoring sheet blank

NOTE: For additional details or if you have specific questions on any of the items listed in this manual, please consult the CANS Comprehensive Glossary for further information.

CANS Action Levels

The way the CANS works is that each item suggests different pathways for service or treatment planning. There are four levels of each item with anchored definitions; however, these definitions are designed to translate into the following action levels (separate for needs and strengths):

For Potentially Traumatic /Adverse Childhood Experiences Domain:

0- No evidence of any trauma of this type

1- A single incident or trauma occurred or suspicion exists of this type of trauma

2- Multiple incidents or a moderate degree of trauma of this type

3- Repeated and severe incidents of trauma of this type.

For Needs Domains – Symptoms Related to Trauma/Adverse Experiences, Life Domain Functioning, Acculturation, Child Behavioral/Emotional Needs, Child Risk Behavior, Children Five and Younger, Transition to Adulthood, Caregiver Domain:

0- No evidence of a need / no need for action

1- Watchful waiting / prevention / mild need

2- Action needed / moderate need

3- Immediate / Intensive Action / severe need

For Strength Domain:

0- Centerpiece strength

1- Useful Strength

2- Strength has been identified in this area but it must be built

3- No strength is identified in this area / no information

NOTE: The majority of items on the CANS should be rated in the context of what is normative for a child's age/developmental stage.

CODING DEFINITIONS & SCORING EXAMPLES

EXPOSURE TO POTENTIALLY TRAUMATIC/ ADVERSE CHILDHOOD EXPERIENCES DOMAIN

These ratings are made based on LIFETIME exposure of trauma or adverse childhood experiences.
For **this domain,** the following categories and action levels are used:
0 = a dimension where there is **no evidence** of any trauma of this type.
1 = a dimension where a **single incident** of trauma occurred **or suspicion** exists of this trauma type.
2 = a dimension where the child has experienced **multiple incidents or moderate degree** of this trauma type.
3 = a dimension which describes **repeated and severe incidents** of trauma with **medical / physical consequences.**

1. SEXUAL ABUSE – *This rating describes the child's experience of sexual abuse.*

0	There is **no evidence** that child has experienced sexual abuse.
1	There is a **suspicion** that the child has experienced sexual abuse **with some degree of evidence or the child has experienced "mild" sexual abuse** including but not limited to **direct exposure to sexually explicit materials.** Evidence for suspicion of sexual abuse could include evidence of **sexually reactive behavior** as well as **exposure to a sexualized environment or Internet predation.** Children who have experienced secondary sexual abuse (e.g. **witnessing sexual abuse, having a sibling sexually abused**) also would be rated here.
2	Child has experienced **one or a couple of incidents** of sexual abuse that were not chronic or severe. This might include a child who has experienced **molestation without penetration on a single occasion.**
3	Child has experienced **severe or chronic** sexual abuse with **multiple episodes or lasting over an extended period of time.** This abuse may have involved **penetration, multiple perpetrators, and/or associated physical injury.**

2. PHYSICAL ABUSE - *This rating describes the child's experience of physical abuse.*

0	There is **no evidence** that child has experienced physical abuse.
1	There is a **suspicion** that child has experienced physical abuse but **no confirming evidence. Spanking** without physical harm or threat of harm also qualifies.
2	Child has experienced a **moderate level of physical abuse** and/or **repeated forms of physical punishment** (e.g. hitting, punching).
3	Child has experienced **severe and repeated physical abuse** with intent to do harm and that causes sufficient physical harm to necessitate hospital treatment.

3. EMOTIONAL ABUSE - *This rating describes the degree of severity of emotional abuse, including verbal and nonverbal forms. This item includes both "emotional abuse," which would include psychological maltreatment such as insults or humiliation towards a child and "emotional neglect" defined as the denial of emotional attention and/or support from caregivers.*

0	There is **no evidence** that child has experienced emotional abuse.
1	Child has experienced **mild** emotional abuse. For instance, child may experience some **insults or is occasionally referred to in a derogatory manner** by caregivers.
2	Child has experienced **moderate degree** of emotional abuse. For instance, child may be **consistently denied emotional attention** from caregivers, **insulted or humiliated on an ongoing basis,** or **intentionally isolated** from others.
3	Child has experienced **significant or severe** emotional abuse over an **extended period of time** (at least one year). For instance, child is **completely ignored** by caregivers, or **threatened/terrorized** by others.

4. NEGLECT - *This rating describes the severity of neglect an individual has experienced. Neglect can refer to a lack of food, shelter or supervision (physical neglect) or a lack of access to needed medical care (medical neglect) or failure to receive academic instruction (educational neglect).*

0	There is **no evidence** that child has experienced neglect.
1	Child has experienced **minor or occasional** neglect. Child may have been left at **home alone for a short period of time** with no adult supervision or there may be **occasional failure to provide adequate supervision** of child.
2	Child has experienced a **moderate level** of neglect. Child may have been left **home alone overnight** or there may be **occasional failure to provide adequate food, shelter, or clothing** with corrective action.
3	Child has experienced a **severe level of neglect** including **multiple and/or prolonged absences** by adults, without minimal supervision, and **failure to provide basic necessities of life on a regular basis**.

5. MEDICAL TRAUMA - *This rating describes the severity of medical trauma. Not all medical procedures are experienced as traumatic. Medical trauma results when a medical experience is **perceived by the child** as mentally or emotionally overwhelming. Potential medical traumas include but are not limited to the following examples: the onset of a life threatening illness; sudden painful medical events; chronic medical conditions resulting from an injury or illness or another type of traumatic event. (Please see the CANS glossary for more information on this item and/or other CANS items).*

0	There is **no evidence** that the child has experienced medical trauma.
1	Child has had a medical experience that was **mildly overwhelming** for the child. Examples include events that were **acute in nature** and **did not result in ongoing medical needs and associated distress** such as minor surgery, stitches or a bone setting.
2	Child has had a medical experience that was perceived as **moderately** emotionally or mentally **overwhelming**. Such events **might include** acute injuries and **moderately invasive medical procedures** such as major surgery that require only short term hospitalization.
3	Child has had a medical experience that was perceived as **extremely** emotionally or mentally **overwhelming**. The event itself may have been **life threatening** and may have resulted in **chronic health problems** that alter the child's physical functioning.

6. WITNESS TO FAMILY VIOLENCE - *This rating describes the severity of exposure to family violence.*

0	There is **no evidence** that child has witnessed family violence.
1	Child has witnessed **one episode** of family violence.
2	Child has witnessed **repeated episodes** of family violence but **no significant injuries** (i.e. requiring emergency medical attention) have been witnessed.
3	Child has witnessed **repeated and severe episodes** of family violence or has **had to intervene** in episodes of family violence. **Significant injuries** have occurred and have **been witnessed** by the child as a direct result of the violence.

7. COMMUNITY VIOLENCE – *This rating describes the severity of exposure to community violence.*

0	There is **no evidence** that child has witnessed or experienced violence in the community.
1	Child has **witnessed occasional fighting or other forms of violence** in the community. Child has **not been directly impacted** by the community violence (i.e. violence not directed at self, family, or friends) and exposure has been limited.
2	Child has **witnessed multiple instances** of community violence **and/or the significant injury of others** in his/her community, or has **had friends/family members injured** as a result of violence or criminal activity in the community, or is the **direct victim** of violence/criminal activity that was **not life threatening**.
3	Child has witnessed or experienced **severe and repeated instances** of community **and/or the death** of another person in his/her community as a result of violence, or is the **direct victim** of violence/criminal activity in the community that was **life threatening, or has experienced chronic/ongoing impact as a result** of community violence (e.g. family member injured and no longer able to work).

8. SCHOOL VIOLENCE – *This rating describes the severity of exposure to school violence.*

0	There is **no evidence** that child has witnessed violence in the school setting.
1	Child has witnessed **occasional fighting or other forms of violence** in the school setting. Child has **not been directly impacted** by the violence (i. e. violence not directed at self or close friends) and exposure has been limited.
2	Child has **witnessed multiple instances** of school violence **and/or the significant injury of others** in his/her school setting, or has **had friends injured** as a result of violence or criminal activity in the school setting, **or has directly experienced** violence in the school setting leading to **minor injury**.
3	Child has witnessed **repeated and severe instances** of school violence **and/or the death** of another person in his/her school setting, or has had **friends who were seriously injured** as a result of violence or criminal activity in the school setting, or has **directly experienced violence** in the school setting leading to **significant injury or lasting impact**.

9. NATURAL OR MANMADE DISASTERS - *This rating describes the severity of exposure to either natural or man-made disasters.*

0	There is **no evidence** that child has been exposed to natural or man-made disasters.
1	Child has been **exposed to disasters second-hand** (i.e. on television, hearing others discuss disasters). This would include second-hand exposure to natural disasters such as a fire or earthquake or man-made disaster, including car accident, plane crashes, or bombings.
2	Child has **been directly exposed to a disaster or witnessed the impact of a disaster on a family or friend**. For instance, a child may observe a caregiver who has been injured in a car accident or fire or watch his neighbor's house burn down.
3	Child has been directly exposed to **multiple and severe natural or manmade disasters** and/or a disaster **that caused significant harm or death to a loved one or there is an ongoing impact or life disruption** due to the disaster (e.g. house burns down, caregiver loses job).

10. WAR AFFECTED - *This rating describes the severity of exposure to war, political violence, or torture. Violence or trauma related to terrorism is not included here.*

0	There is **no evidence** that child has been exposed to war, political violence, or torture.
1	**Child did not live in war-affected region or refugee camp**, but family was affected by war. **Family** members directly related to the child **may have been exposed to war, political violence, or torture**; family may have been forcibly displaced due to the war. This **does not include children who have lost one or both parents** during the war.
2	**Child has been affected by war or political violence**. He or she may have **witnessed others being injured** in the war, may have **family members who were hurt or killed** in the war, and may have lived in an area where bombings or fighting took place. Child may have **lost one or both parents** during the war or one or both **parents may be so physically or psychologically disabled** from war so that they are not able to provide adequate caretaking of child. Child may have spent extended amount of time in **refugee camp**.
3	**Child has experienced the direct effects of war**. Child may have **feared for his/her own life** during war due to bombings or shelling very near to him/her. Child may have been **directly injured, tortured or kidnapped**. Child may have **served as soldiers, guerrilla or other combatant** in his/her home country.

11. TERRORISM AFFECTED - *This rating describes the degree to which a child has been affected by terrorism. Terrorism is defined as "the calculated use of violence or the threat of violence to inculcate fear, intended to coerce or to intimidate governments or societies in the pursuit of goals that are generally political, religious, or ideological." Terrorism includes attacks by individuals acting in isolation (e.g. sniper attacks).*

0	There is **no evidence** that child has been affected by terrorism or terrorist activities.
1	Child's **community has experienced an act of terrorism**, but the **child was not directly impacted** by the violence (e.g. child lives close enough to site of terrorism that he/she may have visited before or child recognized the location when seen on TV, but child's family and neighborhood infrastructure was not directly affected). **Exposure has been limited to pictures on television.**
2	Child has **been affected** by terrorism within his/her community, but **did not directly witness the attack**. Child may live near the area where attack occurred and be accustomed to visiting regularly in the past, infrastructure of child's **daily life may be disrupted due to attack** (e.g. utilities or school), and child may see signs of the attack in neighborhood (e.g. destroyed building). Child **may know people who were injured** in the attack.
3	Child has **witnessed the death of another person** in a terrorist attack, or **has had friends or family members seriously injured** as a result of terrorism, or has **directly been injured** by terrorism leading to significant injury or lasting impact.

12. WITNESS/VICTIM TO CRIMINAL ACTIVITY - *This rating describes the severity of exposure to criminal activity. Criminal behavior includes any behavior for which an adult could go to prison including drug dealing, prostitution, assault, or battery.*

0	There is **no evidence** that child has been victimized or witnessed significant criminal activity.
1	There is a **strong suspicion or evidence** that the child is a witness of **at least one significant criminal activity**.
2	Child has witnessed **multiple criminal activities** and/**or is a direct victim** of criminal activity **or witnessed the victimization of a family or friend.**
3	Child has been **exposed to chronic and/or severe instances of criminal activity** and/or is a **direct victim** of criminal activity that was **life threatening or caused significant physical harm** or child witnessed the **death of a loved one.**

13. PARENTAL CRIMINAL BEHAVIOR (birth parents & legal guardians only) - *This item rates the criminal behavior of both biological and stepparents, and other legal guardians, **not** foster parents.*

0	There is **no evidence** that youth's parents have ever engaged in criminal behavior.
1	**One** of youth's **parents has a history** of criminal behavior but **youth has not been in contact** with this parent for at least **one year**.
2	**One** of youth's **parents has a history** of criminal behavior **resulting in a conviction or incarceration** and **youth has been in contact** with this parent in the past year.
3	**Both of youth's parents have history of criminal behavior resulting in incarceration.**

14. DISRUPTIONS IN CAREGIVING/ATTACHMENT LOSSES - This rating describes the extent to which the child has been exposed to disruptions in caregiving involving separation from primary attachment figure(s) and/or attachment losses. Children who have had placement changes including stays in foster care, residential treatment facilities or juvenile justice settings can be rated here. Short term hospital stays or brief juvenile detention stays, during which the child's caregiver remains the same, would not be rated on this item.

0	There is **no evidence** that the child has experienced disruptions in caregiving and/or attachment losses.
1	Child may have experienced **one disruption in caregiving** but was placed **with a familiar alternative caregiver**, such as a relative (i.e., child shifted from care of biological mother to paternal grandmother). Child may or may not have had ongoing contact with primary attachment figure(s) during this disruption. Shift in caregiving may be temporary or permanent.
2	Child has been exposed to **2 or more disruptions in caregiving with known alternate caregivers, or** the child has had **at least one disruption involving placement with an unknown caregiver.** Children who have been placed in foster or other out-of-home care such as residential care facilities would be rated here.
3	Child has been exposed to multiple/repeated placement changes (i.e., **3+ placements with a known caregiver or 2+ with unknown caregiver**) **resulting in caregiving disruptions in a way that has disrupted various domains of a child's life** (i.e., loss of community, school placement, peer group). Examples would include a child in several short-term unknown placements (i.e., moved from emergency foster care to additional foster care placements and/or multiple transitions in and out of the family-of-origin (i.e., several cycles of removal and reunification).

SYMPTOMS RESULTING FROM EXPOSURE TO TRAUMA OR OTHER ADVERSE CHILDHOOD EXPERIENCES DOMAIN

These ratings describe a range of reactions that children and adolescents may exhibit to any of the variety of traumatic experiences described above. Unlike the Trauma Experiences, which are cumulative over the child's lifetime, these symptoms are rated based on how the child is doing over the past 30 days.

For **Trauma Stress Symptoms,** the following categories and action levels are used:

0 indicates a dimension where there is no evidence of any needs.
1 indicates a dimension that requires monitoring, watchful waiting, or preventive activities.
2 indicates a dimension that requires action to ensure that this identified need or risk behavior is addressed.
3 indicates a dimension that requires immediate or intensive action.

15. ADJUSTMENT TO TRAUMA - *This item covers the youth's reaction to any traumatic or adverse childhood experience. This item covers adjustment disorders, posttraumatic stress disorder and other diagnoses from DSM-IV that the child may have as a result of their exposure to traumatic/adverse childhood experiences. (Please see the CANS glossary for more information on this item and/or other CANS items.)*

THIS item should be rated as 1 – 3 for children who are exhibiting any symptoms related to a traumatic or adverse childhood experience in their past. This item allows you to rate the overall severity of the broad range of symptoms they may be experiencing. The remaining items on the CANS will allow you to rate the specific types of symptoms.

0	Child has **not experienced any significant trauma** or **has adjusted well** to traumatic/adverse child experiences.
1	Child has **some mild problems** with adjustment due to trauma that might ease with the passage of time. Child may be in the process of recovering from a more extreme reaction to a traumatic experience.
2	Child presents with a **moderate level of symptoms**. Symptoms can vary widely and may include sleeping or eating disturbances, regressive behavior, behavior problems or problems with attachment. **Child may have features of one or more diagnoses and may meet full criteria for a specific DSM diagnosis** including but not limited to diagnoses of Post-Traumatic Stress Disorder (PTSD) and adjustment.
3	Child has severe **symptoms** as a result of traumatic or adverse childhood experiences **that require intensive or immediate attention**. Child likely meets criteria for **more than one diagnosis or would meet criteria for a developmental trauma disorder or a complex trauma disorder**.

16. TRAUMATIC GRIEF- *This rating describes the level of traumatic grief the youth is experiencing due to death or loss /separation from significant caregivers, siblings, or other significant figures.*

0	There is **no evidence** that the child is experiencing traumatic grief or separation from the loss of significant caregivers. Either the child has not experienced a traumatic loss (e.g., death of a loved one) or the child has adjusted well to separation.
1	Child is experiencing a **mild level** of traumatic grief due to death or loss/separation from a significant person in a manner that is expected and/or appropriate given the **recent nature of loss or separation**.
2	Child is experiencing a **moderate level** of traumatic grief or difficulties with separation in a manner that **impairs functioning in some but not all areas**. This could include withdrawal or isolation from others or other problems with day-to-day functioning.
3	Child is experiencing **significant traumatic grief reactions**. Child exhibits **impaired functioning across several areas** (e.g. interpersonal relationships, school) for a significant period of time following the loss or separation. **Symptoms require immediate or intensive intervention.**

17. REEXPERIENCING - *These symptoms consist of intrusive memories or reminders of traumatic events, including nightmares, flashbacks, intense reliving of the events, and repetitive play with themes of specific traumatic experiences. These symptoms are part of the DSM-IV criteria for PTSD.*

0	This rating is given to a child with **no evidence** of intrusive symptoms.
1	This rating is given to a child with some **problems with intrusions**, including occasional nightmares about traumatic events.
2	This rating is given to a child with **moderate difficulties with intrusive symptoms**. This child may have **recurrent frightening dreams** with or without recognizable content or recurrent distressing thoughts, images, perceptions or memories of traumatic events. This child may exhibit **trauma-specific reenactments** through **repetitive play** with themes of trauma or **intense physiological reactions to** exposure to **traumatic cues**.
3	This rating is given to a child with **severe intrusive symptoms**. This child may exhibit **trauma-specific reenactments that include sexually or physically traumatizing other children or sexual play** with adults. This child may also exhibit **persistent flashbacks, illusions or hallucinations** that make it **difficult for the child to function**.

18. HYPERAROUSAL - *These symptoms include difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance and/or exaggerated startle response. Children may also commonly manifest physical symptoms such as stomach-aches and headaches. These symptoms are part of the DSM-IV criteria for PTSD.*

0	This rating is given to a child with **no evidence** of hyperarousal symptoms.
1	This rating is given to a child who exhibits **mild hyperarousal** that **does not significantly interfere with his or her day-to-day functioning**. Children may also occasionally manifest physical symptoms such as stomach-aches and headaches.
2	This rating is given to a child with **moderate symptoms** of hyperarousal. The child may exhibit **one significant symptom or a combination of two or more of the following symptoms**: difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance and/or exaggerated startle response. Children may also commonly manifest physical symptoms such as stomach-aches and headaches.
3	This rating is given to a child who exhibits **multiple and or severe hyperarousal symptoms** including but not limited to difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance and/or exaggerated startle response. The **intensity or frequency of these symptoms are distressing** for the child and lead to **frequent problems with day-to-day functioning**.

19. AVOIDANCE - *These symptoms include efforts to avoid stimuli associated with traumatic experiences. These symptoms are part of the DSM-IV criteria for PTSD.*

0	This rating is given to a child with **no evidence** of avoidance symptoms.
1	This rating is given to a child who **exhibits some avoidance**. This child may exhibit **one primary avoidant symptom**, including efforts to **avoid thoughts, feelings or conversations associated with the trauma**.
2	This rating is given to a child with **moderate symptoms of avoidance**. In addition to avoiding thoughts or feelings associated with the trauma, the child may also **avoid activities, places, or people** that arouse recollections of the trauma.
3	This rating is given to a child who exhibits **significant or multiple avoidant symptoms**. This child may **avoid thoughts and feelings as well as situations and people** associated with the trauma and be **unable to recall important aspects of the trauma**.

20. NUMBING - *These symptoms include numbing responses that are part of the DSM-IV criteria for PTSD. These responses were not present before the trauma. (Please see the CANS glossary for more information on this item and/or other CANS items.)*

0	This rating is given to a child with **no evidence** of numbing responses.
1	This rating is given to a child who exhibits **some problems with numbing**. This child may have a restricted range of affect or be **unable to express or experience certain emotions** (e.g., anger or sadness).
2	This rating is given to a child with **moderately severe numbing** responses. This child may have a **blunted or flat emotional state** or have **difficulty experiencing intense emotions** or feel **consistently detached or estranged** from others following the traumatic experience.
3	This rating is given to a child with **significant numbing responses or multiple symptoms of numbing**. This child may have a **markedly diminished interest** or participation in significant activities and a sense of a **foreshortened future**.

21. DISSOCIATION - *Symptoms included in this dimension are daydreaming, spacing or blanking out, forgetfulness, fragmentation, detachment, and rapid changes in personality often associated with traumatic experiences. This dimension may be used to rate dissociative disorders (e.g., Dissociative Disorder NOS, Dissociative Identity Disorder) but can also exist when other diagnoses are primary (e.g., PTSD, depression). (Please see the CANS glossary for more information on this item and/or other CANS items.)*

0	This rating is given to a child with **no evidence** of dissociation.
1	This rating is given to a child with **minor dissociative problems**, including some emotional numbing, avoidance or detachment, and some difficulty with **forgetfulness, daydreaming, spacing or blanking out**.
2	This rating is given to a child with a **moderate level** of dissociation. This can include amnesia for traumatic experiences or inconsistent memory for trauma (e.g., remembers in one context but not another), more **persistent or perplexing difficulties with forgetfulness** (e.g., loses things easily, forgets basic information), **frequent daydreaming or trance-like behavior**, depersonalization and/or derealization. This rating would be used for someone who meets criteria for **Dissociative Disorder Not Otherwise Specified or another diagnosis that is specified "with dissociative features."**
3	This rating is given to a child with **severe dissociative disturbance**. This can include significant memory difficulties associated with trauma that also **impede day to day functioning**. Child is **frequently forgetful or confused about things he/she should know about** (e.g., no memory for activities or whereabouts of previous day or hours). Child shows rapid changes in personality or evidence of distinct personalities. Child who meets criteria for **Dissociative Identity Disorder or a more severe level of Dissociative Disorder NOS would be rated here**.

22. AFFECTIVE AND/OR PHYSIOLOGICAL DYSREGULATION - *These symptoms are characterized by difficulties with arousal regulation. This can include difficulties modulating or expressing emotions and energy states such as emotional outbursts or marked shifts in emotions, overly constricted emotional responses, and intense emotional responses, and/or evidence of constricted, hyperaroused, or quickly fluctuating energy level. The child may demonstrate such difficulties with a single type or a wide range of emotions and energy states. This can also include difficulties with regulation of body functions, including disturbances in sleeping, eating, and elimination; over-reactivity or under-reactivity to touch and sounds; and physical or somatic complaints. This can also include difficulties with describing emotional or bodily states. The child's behavior likely reflects their difficulty with affective and physiological regulation, especially for younger children. This can be demonstrated as excessive and chronic silly behavior, excessive body movements, difficulties regulating sleep/wake cycle, and inability to fully engage in activities. (Please see the CANS glossary for more information on this item and/or other CANS items.)*

Reminder: This item should be rated in the context of what is normative for a child's age/developmental stage.

0	This rating is given to a child with **no difficulties** regulating emotional or physiological responses. Emotional responses and energy level are appropriate to the situation.
1	This rating is given to a child with some **minor and occasional difficulties with affect/physiological regulation**. This child could have some difficulty tolerating intense emotions and become somewhat jumpy or irritable in response to emotionally charged stimuli, or more watchful or hypervigilant in general or have some difficulties with regulating body functions (e.g., sleeping, eating or elimination). This child may also have some difficulty sustaining involvement in activities for any length of time or have some physical or somatic complaints.
2	This rating is given to a child with **moderate problems with affect/physiological regulation**. This child may be unable to modulate emotional responses or have more persistent difficulties in regulating bodily functions. This child may exhibit marked shifts in emotional responses (e.g., from sadness to irritability to anxiety) or have contained emotions with a tendency to lose control of emotions at various points (e.g., normally restricted affect punctuated by outbursts of anger or sadness). This child may also exhibit persistent anxiety, intense fear or helplessness, lethargy/loss of motivation, or have persistent physical or somatic complaints. This child's behavior likely reflects difficulties with affective or physiological over-arousal or reactivity (e.g., silly behavior, loose active limbs) or under-arousal (e.g., lack of movement and facial expressions, slowed walking and talking).
3	This rating is given to a child with **severe and chronic problems with highly dysregulated affective and/or physiological responses**. This child may have more rapid shifts in mood and an inability to modulate emotional responses (feeling out of control of their emotions or lacking control over their movement as it relates to their emotional states). This child may also exhibit tightly contained emotions with intense outbursts under stress. Alternately, this child may be characterized by extreme lethargy, loss of motivation or drive, and no ability to concentrate or sustain engagement in activities (i.e., emotionally "shut down"). This child may have more persistent and severe difficulties regulating sleep/wake cycle, eating patterns or with elimination problems.

CHILD STRENGTHS DOMAIN

These ratings describe a range of assets that children and adolescents may possess that can facilitate healthy development. An absence of a strength is not necessarily a need but an indication that strength building activities are indicated. In general strengths are more trait-like, stable characteristics; however, the 30 day rating window still applies unless over-ridden by the action levels as described below.

0 Indicates a well-developed, or centerpiece, strength. This area may be able to be used as a protective factor and a centerpiece for a strength-based plan.
1 Indicates an area where a useful strength is evident but requires some effort to maximize this strength. This is a strength that might be able to be used and built upon in treatment.
2 Indicates an area where strengths have been identified but require significant strength-building efforts.
3 Indicates an area where no current strength is identified (there is no evidence of a strength in this area).

* **When you have no information/evidence about a strength in this area, use a score of 3.**

23. FAMILY - *Family refers to all family members as defined by the youth, or biological relatives and significant others with whom the child is still in contact. Is the family (as defined by the child) a support and strength to the child?*

0	Significant family strengths. There is at least one family member who has a strong loving relationship with the child and is able to provide significant emotional or concrete support.
1	Moderate level of family strengths. There is at least one family member with a strong loving relationship who is able to provide limited emotional or concrete support.
2	Mild level of family strengths. Family members are known, but currently none are able to provide emotional or concrete support.
3	This level indicates a child with no known family strengths. There are no known family members.

24. INTERPERSONAL - *This rating refers to the interpersonal skills of the child or youth both with peers and adults.*

0	Significant interpersonal strengths. Child has close friends and is friendly with others.
1	Moderate level of interpersonal strengths. Child may have a history of forming positive relationships with peers and/or non-caregivers. Child may have at least one healthy relationship, is friendly with others.
2	Mild level of interpersonal strengths. Child has some social skills that facilitate positive relationships with peers and adults but may not have any current healthy friendships.
3	Very limited ability to make and maintain positive relationships. Child lacks social skills and has no history of positive relationships with peer and adults.

25. EDUCATIONAL SETTING - *This rating refers to the strengths of the school system or the child's preschool setting, and may or may not reflect any specific educational skills possessed by the child or youth.*

0	This level indicates a child who is in school and is involved with an educational plan (or IEP) that appears to exceed expectations. School works exceptionally well with family and caregivers to create a special learning environment that meets the child's needs. Someone at the school goes above and beyond to take a healthy interest in the educational success of the child.
1	This level indicates a child who is in school and has a plan that appears to be effective. School works fairly well with family and caregivers to ensure appropriate educational development.
2	This level indicates a child who is in school but has a plan that does not appear to be effective.
3	This level indicates a child who is either not in school or is in a school setting that does not further his/her education.
NA	This item is only rated not applicable when a child is not in a school or preschool setting

26. VOCATIONAL - *Generally this rating is reserved for adolescents and is not applicable for children 14 years and younger. Computer skills would be rated here. Scoring of this item supplements Ansell-Casey assessment.*

0	This level indicates an adolescent with vocational skills who is currently working in a natural environment.
1	This level indicates an adolescent with pre-vocational and some vocational skills but limited work experience.
2	This level indicates an adolescent with some pre-vocational skills but who is not presently working in any area related to those skills. This also may indicate a child or youth with a clear vocational preference.
3	This level indicates an adolescent with no known or identifiable vocational or pre-vocational skills and no expression of any future vocational preferences.
NA	This item can be rated not applicable when a child is under 14 years old.

27. COPING AND SAVORING SKILLS - *This rating should be based on the psychological strengths that the child or adolescent might have developed including both the ability to enjoy positive life experiences and manage negative life experiences. This should be rated independent of the child's current level of distress.*

0	This level indicates a child with exceptional psychological strengths. Both coping and savoring skills are well developed.
1	This level indicates a child with good psychological strengths. The person has solid coping skills for managing distress or solid savoring skills for enjoying pleasurable events.
2	This level indicates a child with limited psychological strengths. For example, a person with very low self-esteem would be rated here.
3	This level indicates a child with no known or identifiable psychological strengths. This may be due to intellectual impairment or serious psychiatric disorders.

28. OPTIMISM - *This rating should be based on the child or adolescent's sense of him/herself in his/her own future. This is intended to rate the child's positive future orientation.*

0	Child has a strong and stable optimistic outlook on his/her life. Child is future oriented.
1	Child is generally optimistic. Child is likely able to articulate some positive future vision.
2	Child has difficulties maintaining a positive view of him/herself and his/her life. Child may be overly pessimistic.
3	Child has difficulties seeing any positives about him/herself or his/her life.

29. TALENT/INTERESTS - *This rating should be based broadly on any talent, creative or artistic skill a child or adolescent may have including art, theatre, music, athletics, etc.*

0	This level indicates a child with significant creative/artistic strengths. A child/youth who receives a significant amount of personal benefit from activities surrounding a talent would be rated here.
1	This level indicates a child with a notable talent. For example, a youth who is involved in athletics or plays a musical instrument, etc. would be rated here.
2	This level indicates a child who has expressed interest in developing a specific talent or talents even if they have not developed that talent to date.
3	This level indicates a child with no known talents, interests, or hobbies.

30. SPIRITUAL/RELIGIOUS - *This rating should be based on the child or adolescent's and their family's involvement in spiritual or religious beliefs and activities.*

0	This level indicates a child with strong moral and spiritual strengths. Child may be very involved in a religious community or may have strongly held spiritual or religious beliefs that can sustain or comfort him/her in difficult times.
1	This level indicates a child with some moral and spiritual strengths. Child may be involved in a religious community.
2	This level indicates a child with few spiritual or religious strengths. Child may have little contact with religious institutions.
3	This level indicates a child with no known spiritual or religious involvement.

31. COMMUNITY LIFE - *This rating should be based on the child or adolescent's level of involvement in the cultural aspects of life in his/her community.*

0	This level indicates a child with extensive and substantial long-term ties with the community. For example, individual may be a member of a community group (e.g. Girl or Boy Scout etc.) for more than one year, may be widely accepted by neighbors, or involved in other community activities, informal networks, etc.
1	This level indicates a child with significant community ties although they may be relatively short term (e.g. past year).
2	This level indicates a child with limited ties and/or supports from the community.
3	This level indicates a child with no known ties or supports from the community.

32. RELATIONSHIP PERMANENCE - *This rating refers to the stability of significant relationships in the child or youth's life. This likely includes family members but may also include other individuals.*

0	This level indicates a child who has very stable relationships. Family members, friends, and community have been stable for most of his/her life and are likely to remain so in the foreseeable future. Child is involved with both parents.
1	This level indicates a child who has had stable relationships but there is some concern about instability in the near future (one year) due to transitions, illness, or age. A child who has a stable relationship with only one parent may be rated here.
2	This level indicates a child who has had at least one stable relationship over his/her lifetime but has experienced other instability through factors such as divorce, moving, removal from home, and death.
3	This level indicates a child who does not have any stability in relationships.

33. RESILIENCE - *This rating refers to the child or youth's ability to recognize his or her strengths and use them in times of need or to support his/her own development.*

0	Child is able to recognize and uses his/her strengths for healthy development and problem solving.
1	Child recognizes his/her strengths but is not yet able to use them in support of their healthy development or problem solving.
2	Child has limited ability to recognize and use his/her strengths to support healthy development and/or problem solving.
3	Child fails to recognize his/her strengths and is therefore unable to utilize them.

LIFE FUNCTIONING DOMAIN

These ratings describe how children and adolescents are doing in their various environments or life domains. The domains were identified from the children's research literature on wraparound philosophy. Functioning well in all life domains is the goal of a lifetime developmental framework.

For **Life Functioning Domains**, the following categories and action levels are used:

0 indicates a life domain in which the child has no need (and may be excelling). There is no need for action/intervention. **1** indicates a life domain in which the child may have a mild need but is generally doing OK. A score of 1 indicates that this is an areas for watchful waiting based on a mild need, a potential need for preventive action or a historical need. This is an area of potential strength.
2 indicates a life domain in which the child is having moderate problems. Action/intervention is needed to improve functioning into an area of strength.
3 indicates a life domain in which the child has significant problems. Immediate and/or intensive intervention is needed to improve functioning.

34. FAMILY - *Family ideally should be defined by the child; however, in the absence of this knowledge consider biological and adoptive relatives and their significant others with whom the child has contact as the definition of family. Foster families should only be considered if they have made a significant commitment to the child. Is the family (as defined by the child) functioning well together?*

0	Child gets along well with family members.
1	Child is doing adequately in relationships with family members although some problems may exist. For example, some family members may have some problems in their relationships with child.
2	Child is having moderate problems with parents, siblings and/or other family members. Frequent arguing, difficulties in maintaining any positive relationship may be observed.
3	Child is having severe problems with parents, siblings, and/or other family members. This would include problems of domestic violence, constant arguing, etc.

35. LIVING SITUATION - *This item refers to how the child is functioning in his/her current living arrangement, which could be with a relative, in a temporary foster home, shelter, etc.*

0	Child is functioning well in his/her current living environment. Child and caregivers feel comfortable and safe dealing with issues that come up in day-to-day life.
1	Mild problems with functioning in current living situation. Caregivers express some concern about child's behavior in living situation and/or child and caregiver have some difficulty dealing with issues that arise in daily life.
2	Moderate to severe problems with functioning in current living situation. Child and caregivers have difficulty interacting effectively with each other much of the time. Difficulties may create significant problems for others in the residence.
3	Profound problems with functioning in current living situation. Child is at immediate risk of being removed from living situation.

36. SOCIAL FUNCTIONING - *This item refers to the child's social functioning from a developmental perspective.*

0	Child interacts appropriately with others and builds and maintains relationships.
1	Child is having some difficulty interacting with others and building and/or maintaining relationships.
2	Child often has problems interacting with others and building and maintaining relationships.
3	Child consistently and pervasively has problems interacting with others and building and maintaining relationships.

37. DEVELOPMENTAL/INTELLECTUAL - *This item rates the presence of Mental Retardation or Developmental Disabilities. All developmental disabilities occur on a continuum; a child with Autism may be designated a 0, 1, 2, or 3 depending on the significance of the disability and the impairment.*

0	No evidence of developmental problems or mental retardation.
1	Documented delay, learning disability, or documented borderline intellectual disability, (i.e. FSIQ 70 to 85.)
2	Evidence of a pervasive developmental disorder including Autism, Tourette's, Down's Syndrome or other significant developmental delay or child has mild mental retardation (FSIQ 50 to 69).
3	Moderate, Severe, or Profound developmental disability or FSIQ below 50.
NA	Not applicable can be used for this item when the child's IQ is unknown and there is no evidence of a learning disability or other developmental delay.

38. RECREATIONAL - *This item is intended to reflect the child's access to and use of leisure time activities.*

0	Child makes full use of leisure time to pursue recreational activities that support his/her healthy development and enjoyment.
1	Child at times has difficulty using leisure time to pursue recreational activities.
2	Child is having moderate problems with recreational activities, and may be unable to use leisure time to enjoy recreational activities.
3	Child has no access to or interest in recreational activities. Child has significant difficulties making use of leisure time.

39. LEGAL – *This item describes the child's (**not** the family's) involvement with the legal system. This could include involvement in the Juvenile or Adult Justice Systems.*

0	Child has no known legal difficulties.
1	Child has a history of legal problems but currently is not involved with the legal system and is not currently on parole or probation.
2	Child has some legal problems, is currently involved in the legal system and may have active parole and/or probation mandates.
3	Child has serious current or pending legal difficulties that place him/her at risk for a re-arrest **or** youth is currently incarcerated.

40. MEDICAL - *This item refers to the child's physical health status.*

0	Child has no current health problems or chronic conditions.
1	Child has mild/treatable medical problems that require medical treatment.
2	Child has chronic illness that requires ongoing medical intervention.
3	Child has life threatening illness or medical condition.

41. PHYSICAL - *This item is used to identify physical limitations, including chronic conditions, that entail impairment in eating, breathing, vision, hearing, mobility, or other functions.*

0	Child has no physical limitations.
1	Child has some physical condition that places mild limitations on activities. Conditions such as impaired hearing or vision would be rated here. Also rate here treatable medical conditions that result in physical limitations (e.g. asthma).
2	Child has physical condition that notably impacts activities. Sensory disorders such as blindness, deafness, or significant motor difficulties would be rated here.
3	Child has severe physical limitations due to multiple physical conditions.

42. SLEEP – *This item rates any disruptions in sleep regardless of the cause including problems with going to bed, staying asleep, waking up early or sleeping too much.*

0	Child gets a full night's sleep each night.
1	Child has some problems sleeping. Generally, child gets a full night's sleep but at least once a week problems arise. This may include occasionally awakening or bed wetting or nightmares.
2	Child is having problems with sleep. Sleep is often disrupted and child seldom obtains a full night of sleep.
3	Child is generally sleep deprived. Sleeping is difficult for the child and s/he is not able to get a full night's sleep

43. SEXUAL DEVELOPMENT – *This item looks at broad issues of sexual development, including sexual behavior, sexual identity, sexual concerns, and the reactions of significant others to any of these factors.*

0	No evidence of any problems with sexual development.
1	Mild to moderate problems with sexual development. May include concerns about sexual identity or anxiety about the reactions of others.
2	Significant problems with sexual development. May include inappropriate or high-risk sexual behavior, distress due to gender identity issues, and/or some experience of negative reactions of others.
3	Profound problems with sexual development. This level would include prostitution, very frequent risky sexual behavior, or sexual aggression and/or the expectation of specific life-threatening reactions by others.

The following three school related items can be scored for children ages 3-5 if they are in a pre-school/day-care setting or an early intervention program such as Head Start.

44. SCHOOL BEHAVIOR - *This item rates the behavior of the child or youth in school or school-like settings (e.g. Head Start, pre-school). A rating of 3 would indicate a child who is still having problems after special efforts have been made, i.e., problems in a special education class.*

0	No evidence of behavior problems at school or day care. Child is behaving well.
1	Child is having mild behavioral problems at school. May be related to either relationships with teachers or peers. A single detention might be rated here.
2	Child is having moderate behavioral difficulties at school. He/she is disruptive and may receive sanctions including suspensions or multiple detentions.
3	Child is having severe problems with behavior in school. He/she is frequently or severely disruptive. School placement may be in jeopardy due to behavior.
NA	Not applicable for children three years and younger or for children not required/expected to be in school.

45. SCHOOL ACHIEVEMENT - *This item describes academic achievement and functioning.*

0	Child is working at grade level, passing all classes and is on track with his/her educational plan.
1	Child is doing adequately in school, although some problems with achievement exist.
2	Child is having moderate problems with school achievement. He/she may be failing some subjects and/or be at risk for failing the current grade.
3	Child is having severe achievement problems. He/she may be failing most subjects or is more than one year behind same age peers in school achievement, and/or will certainly not pass to next grade level.
NA	Not applicable for children three years and younger or any other child not expected to be in school.

46. SCHOOL ATTENDANCE - *If school is not in session, rate the last 30 days when school was in session.*

0	No evidence of attendance problems. Child attends regularly.
1	Child has some problems attending school, although he/she generally goes to school. He/she may miss up to one day per week on average. Or, he/she may have had moderate to severe problems in the past six months but has been attending school regularly in the past month.
2	Child is having problems with school attendance. He/she is missing at least two days per week on average.
3	Child is generally truant or refusing to go to school or a school-aged child not enrolled in school.
NA	Not applicable for children three years and younger or any other child not expected to be in school.

ACCULTURATION DOMAIN

All children are members of some identifiable cultural group. These ratings describe possible problems that children or adolescents may experience with the relationship between their cultural membership and the predominant culture in which they live.

For **Acculturation,** the following categories and action levels are used:
0 indicates a dimension where there is no evidence of any needs.
1 indicates a dimension that requires monitoring, watchful waiting, or preventive activities.
2 indicates a dimension that requires action to ensure that this identified need or risk behavior is addressed.
3 indicates a dimension that requires immediate or intensive action.

47. LANGUAGE - *This item includes both spoken and sign language. This item concerns any language-related needs a family might have that affect their participation in services.*

0	Child and family have no problems communicating in English and do not require the assistance of a translator.
1	Child and family speak some English but potential communication problems exist due to limits on vocabulary or understanding of the nuances of the language.
2	Child and/or significant family members do not speak English. Translator or native language speaker is needed for successful intervention but qualified individual can be identified within natural supports.
3	Child and/or significant family members do not speak English. Translator or native language speaker is needed for successful intervention and no such individual is available from among natural supports.

48. IDENTITY - *Cultural identity refers to the child's view of him/herself as belonging to a specific cultural group. This cultural group may be defined by a number of factors including race, religion, ethnicity, geography or lifestyle.*

0	Child has clear and consistent cultural identity and is connected to others who share his/her cultural identity.
1	Child is experiencing some confusion or concern regarding his/her cultural identity.
2	Child has significant struggles with his/her own cultural identity. Child may have cultural identity but is not connected with others who share this culture.
3	Child has no connection to his/her cultural identity or is experiencing significant problems due to internal conflict regarding his/her cultural identity.

49. RITUAL - *Cultural rituals are activities and traditions that are culturally specific including the celebration of holidays such as Kwanza, Cinco de Mayo, etc. Rituals also may include daily activities that are culturally specific (e.g. praying toward Mecca at specific times, eating a specific diet, access to media). Rituals include being able to speak one's primary language with others.*

0	Child is consistently able to practice rituals consistent with his/her cultural identity.
1	Child is generally able to practice rituals consistent with his/her cultural identity; however, he/she sometimes experiences some obstacles to the performance of these rituals.
2	Child experiences significant barriers and is sometimes prevented from practicing rituals consistent with his/her cultural identity.
3	Child is unable to practice rituals consistent with his/her cultural identity.

50. CULTURE STRESS - *Culture stress refers to experiences and feelings of discomfort and/or distress arising from friction (real or perceived) between an individual's own cultural identity and the predominant culture in which he/she lives. Racism would be rated here.*

0	No evidence of stress between child's cultural identity and current living situation.
1	Some evidence of mild or occasional stress resulting from friction between the child's cultural identity and his/her current living situation.
2	Child is experiencing cultural stress from friction between the child's cultural identity and current living situation and that is causing some problems with functioning.
3	Child is experiencing a high level of cultural stress between his/her cultural identity and current living situation that is making functioning very difficult under the present circumstances.

CHILD BEHAVIORAL/EMOTIONAL NEEDS DOMAIN

These ratings identify the behavioral health needs of the child or adolescent. While the CANS is not a diagnostic tool, it is designed to be consistent with diagnostic communication. In DSM-IV a diagnosis is defined by a set of symptoms that is associated with either dysfunction or distress. This definition is consistent with the ratings of '2' or '3' as defined by the action levels below:

For **Behavioral/Emotional Needs**, the following categories and symbols are used:

0 indicates a dimension where there is no evidence of any needs.
1 indicates a dimension that requires monitoring, watchful waiting, or preventive activities.
2 indicates a dimension that requires action to ensure that this identified need or risk behavior is addressed.
3 indicates a dimension that requires immediate or intensive action.

51. PSYCHOSIS - *This item is used to rate symptoms of psychiatric disorders with a known neurological base. DSM-IV disorders included on this dimension are Schizophrenia and Psychotic disorders (unipolar, bipolar, NOS). The common symptoms of these disorders include hallucinations, delusions, unusual thought processes, strange speech, and bizarre/idiosyncratic behavior.*

0	This rating indicates a child with no evidence of thought disturbances. Both thought processes and content are within normal range.
1	This rating indicates a child with evidence of mild disruption in thought processes or content. The child may be somewhat tangential in speech or evidence somewhat illogical thinking (age inappropriate). This also includes children with a history of hallucinations but none currently. The category would be used for children who are sub-threshold for one of the DSM diagnoses listed above.
2	This rating indicates a child with evidence of moderate disturbance in thought processes or content. The child may be somewhat delusional or have brief or intermittent hallucinations. The child's speech may be at times quite tangential or illogical. This level would be used for children who meet the diagnostic criteria for one of the disorders listed above.
3	This rating indicates a child with severe psychotic disorder. The child frequently is experiencing symptoms of psychosis and frequently has no reality assessment. There is evidence of ongoing delusions or hallucinations or both. Command hallucinations would be coded here. This level is used for extreme cases of the diagnoses listed above.

52. ATTENTION /CONCENTRATION - *Problems with attention, concentration and task completion would be rated here. These may include symptoms that are part of DSM-IV Attention-Deficit Hyperactivity Disorder. Inattention/distractibility not related to opposition would also be rated here.*

0	This rating is used to indicate a child with no evidence of attention or concentration problems. This child is able to stay on task in an age-appropriate manner.
1	This rating is used to indicate a child with evidence of mild problems with attention or concentration. Child may have some difficulties staying on task for an age-appropriate time period in school or play.
2	This rating is used to indicate a child with moderate attention problems. In addition to problems with sustained attention, child may become easily distracted or forgetful in daily activities, have trouble following through on activities, and become reluctant to engage in activities that require sustained effort. A child who meets DSM-IV diagnostic criteria for ADHD would be rated here.
3	This rating is used to indicate a child with severe impairment of attention or concentration. A child with profound symptoms of ADHD or significant attention difficulties related to another diagnosis would be rated here.

53. IMPULSIVITY - *Problems with impulse control, impulsive behaviors, including motoric disruptions would be rated here.*

0	This rating is used to indicate a child with no evidence of age-inappropriate impulsivity in action or thought.
1	This rating is used to indicate a child with evidence of mild levels of impulsivity evident in either action or thought. The child may behave in a fashion that suggests limited impulse control. For instance, child may yell out answers to questions or may have difficulty waiting his/her turn. Child may exhibit some motoric difficulties as well, for instance, pushing or shoving others without waiting turn.
2	This rating is used to indicate a child with moderate levels of impulsivity evident in behavior. The child is frequently impulsive and may represent a significant management problem. A child who often intrudes on others and often exhibits aggressive impulses would be rated here.
3	This rating is used to indicate a child with significant levels of impulsivity evident in behavior. Frequent impulsive behavior is observed or noted that carries considerable safety risk (e.g., running into the street, dangerous driving, or bike riding). The child may be impulsive on a nearly continuous basis. He or she endangers self or others without thinking.

54. DEPRESSION - *Symptoms included in this dimension are irritable or depressed mood, social withdrawal, sleep disturbances, weight/eating disturbances, and loss of motivation. This dimension can be used to rate symptoms of the following psychiatric disorders as specified in DSM-IV: Depressive Disorders(unipolar, dysthymia, NOS), Bipolar Disorder.*

0	This rating is given to a child with no emotional problems. No evidence of depression.
1	This rating is given to a child with mild emotional problems. Brief duration of depression, irritability, or impairment of peer, family, or academic functioning that does not lead to gross avoidance behavior.
2	This rating is given to a child with a moderate level of emotional disturbance. Any diagnosis of depression would be coded here. This level is used to rate children who meet the criteria for an affective disorder listed above.
3	This rating is given to a child with a severe level of depression. This would include a child who stays at home or in bed all day due to depression or one whose emotional symptoms prevent any participation in school, friendship groups, or family life. Disabling forms of depressive diagnoses would be coded here. This level is used to indicate an extreme case of one of the disorders listed above.

55. ANXIETY - *This item describes the child's level of fearfulness, worrying or other characteristics of anxiety.*

0	No evidence of any anxiety or fearfulness.
1	History or suspicion of anxiety problems or mild to moderate anxiety associated with a recent negative life event. This level is used to rate either a mild phobia or anxiety problem or a sub-threshold level of symptoms for the other listed disorders.
2	Clear evidence of anxiety associated with either anxious mood or significant fearfulness. Anxiety has interfered significantly in child's ability to function in at least one life domain.
3	Clear evidence of debilitating level of anxiety that makes it virtually impossible for the child to function in any life domain

56. OPPOSITIONAL BEHAVIOR (Compliance with authority) - *This item is intended to capture how the child relates to authority. Oppositional behavior is different from conduct disorder in that the emphasis of the behavior is on non-compliance with authority rather than inflicting damage and hurting others.*

0	This rating indicates that the child/adolescent is generally compliant.
1	This rating indicates that the child/adolescent has mild problems with compliance with some rules or adult instructions. Child may occasionally talk back to teacher, parent/caregiver; there may be letters or calls from school.
2	This rating indicates that the child/adolescent has moderate problems with compliance with rules or adult instructions. A child who meets the criteria for Oppositional Defiant Disorder in DSM-IV would be rated here.
3	This rating indicates that the child/adolescent has severe problems with compliance with rules or adult instructions. A child rated at this level would be a severe case of Oppositional Defiant Disorder. They would be virtually always noncompliant. Child repeatedly ignores authority.

57. CONDUCT - *These symptoms include antisocial behaviors like shoplifting, lying, vandalism, cruelty to animals, and assault. This dimension would include the symptoms of Conduct Disorder as specified in DSM-IV.*

0	This rating indicates a child with no evidence of behavior disorder.
1	This rating indicates a child with a mild level of conduct problems. The child may have some difficulties in school and home behavior. Problems are recognizable but not notably deviant for age, sex, and community. This might include occasional truancy, repeated severe lying, or petty theft from family.
2	This rating indicates a child with a moderate level of conduct disorder. This could include episodes of planned aggressive or other anti-social behavior. A child rated at this level should meet the criteria for a diagnosis of Conduct Disorder.
3	This rating indicates a child with a severe Conduct Disorder. This could include frequent episodes of unprovoked, planned aggressive or other anti-social behavior.

58. SUBSTANCE ABUSE - *These symptoms include use of alcohol and illegal drugs, the misuse of prescription medications and the inhalation of any substance for recreational purposes. This rating is consistent with DSM-IV Substance-related Disorders.*

0	This rating is for a child who has no substance use difficulties at the present time. If the person is in recovery for greater than 1 year, they should be coded here, although this is unlikely for a child or adolescent.
1	This rating is for a child with mild substance use problems that might occasionally present problems for the person (intoxication, loss of money, reduced school performance, parental concern). This rating would be used for someone early in recovery (less than 1 year) who is currently abstinent for at least 30 days.
2	This rating is for a child with a moderate substance abuse problem that impairs his/her ability to function, but does not preclude functioning in an unstructured setting while participating in treatment.
3	This rating is for a child with a severe substance dependence condition that consistently impairs his/her ability to function. Substance abuse problems may present significant complications to the coordination of care for the individual. A substance-exposed infant who demonstrates symptoms of substance dependence would also be rated here.

59. ATTACHMENT DIFFICULTIES - *This item should be rated within the context of the child's significant parental or caregiver relationships.*

0	No evidence of attachment problems. Caregiver-child relationship is characterized by mutual satisfaction of needs and child's development of a sense of security and trust. Caregiver appears able to respond to child cues in a consistent, appropriate manner, and child seeks age-appropriate contact with caregiver for both nurturing and safety needs.
1	Mild problems with attachment. There is some evidence of insecurity in the child-caregiver relationship. Caregiver may at times have difficulty accurately reading child bids for attention and nurturance; may be inconsistent in response; or may be occasionally intrusive. Child may have mild problems with separation (e.g., anxious/clingy behaviors in the absence of obvious cues of danger) or may avoid contact with caregiver in age-inappropriate way. Child may have minor difficulties with appropriate physical/emotional boundaries with others.
2	Moderate problems with attachment. Attachment relationship is marked by sufficient difficulty as to require intervention. Caregiver may consistently misinterpret child cues, act in an overly intrusive way, or ignore/avoid child bids for attention/nurturance. Child may have ongoing difficulties with separation, may consistently avoid contact with caregivers, and may have ongoing difficulties with physical or emotional boundaries with others.
3	Severe problems with attachment. Child is unable to form attachment relationships with others (e.g., chronic dismissive/avoidant/detached behavior in care giving relationships) OR child presents with diffuse emotional/physical boundaries leading to indiscriminate attachment with others. Child is considered at ongoing risk due to the nature of his/her attachment behaviors. A child who meets the criteria for an Attachment Disorder in DSM-IV would be rated here. Child may have experienced significant early separation from or loss of caregiver, or have experienced chronic inadequate care from early caregivers, or child may have individual vulnerabilities (e.g., mental health, developmental disabilities) that interfere with the formation of positive attachment relationships.

60. EATING DISTURBANCES - *These symptoms include problems with eating including disturbances in body image, refusal to maintain normal body weight, recurrent episodes of binge eating and hoarding food. These ratings are consistent with DSM-IV Eating Disorders.*

0	This rating is for a child with no evidence of eating disturbances.
1	This rating is for a child with a mild level of eating disturbance. This could include some preoccupation with weight, calorie intake, or body size or type when of normal weight or below weight. This could also include some binge eating patterns.
2	This rating is for a child with a moderate level of eating disturbance. This could include a more intense preoccupation with weight gain or becoming fat when underweight, restrictive eating habits or excessive exercising in order to maintain below normal weight, and/or emaciated body appearance. This level could also include more notable binge eating episodes that are followed by compensatory behaviors in order to prevent weight gain (e.g., vomiting, use of laxatives, excessive exercising). This child may meet criteria for a DSM-IV Eating Disorder (Anorexia or Bulimia Nervosa).
3	This rating is for a child with a more severe form of eating disturbance. This could include significantly low weight where hospitalization is required or excessive binge-purge behaviors (at least once per day).

61. BEHAVIORAL REGRESSIONS - *These ratings are used to describe shifts in previously adaptive functioning evidenced in regression in behaviors or physiological functioning.*

0	This rating is given to a child with no evidence of behavioral regression.
1	This rating is given to a child with some regressions in age-level of behavior (e.g., thumb sucking, whining when age inappropriate).
2	This rating is given to a child with moderate regressions in age-level of behavior including loss of ability to engage with peers, stopping play or exploration in environment that was previously evident, or occasional bedwetting.
3	This rating is given to a child with more significant regressions in behaviors in an earlier age as demonstrated by changes in speech or loss of bowel or bladder control.

62. SOMATIZATION - *These symptoms include the presence of recurrent physical complaints without apparent physical cause or conversion-like phenomena (e.g., pseudoseizures).*

0	This rating is for a child with no evidence of somatic symptoms.
1	This rating indicates a child with a mild level of somatic problems. This could include occasional headaches, stomach problems (nausea, vomiting), joint, limb or chest pain without medical cause.
2	This rating indicates a child with a moderate level of somatic problems or the presence of conversion symptoms. This could include more persistent physical symptoms without a medical cause or the presence of several different physical symptoms (e.g., stomach problems, headaches, backaches). This child may meet criteria for a somatoform disorder. Additionally, the child could manifest any conversion symptoms here (e.g., pseudoseizures, paralysis).
3	This rating indicates a child with severe somatic symptoms causing significant disturbance in school or social functioning. This could include significant and varied symptomatic disturbance without medical cause.

63. ANGER CONTROL - *This item captures the youth's ability to identify and manage their anger when frustrated.*

0	This rating indicates a child with no evidence of any significant anger control problems.
1	This rating indicates a child with some problems with controlling anger. He/she may sometimes become verbally aggressive when frustrated. Peers and family members are aware of and may attempt to avoid stimulating angry outbursts. Child may have a history of physical aggression arising from inability to control anger, but none within the last 3 months.
2	This rating indicates a child with moderate anger control problems. His/her temper has gotten him/her in significant trouble with peers, family, and/or school. This level may be associated with some physical violence, or increasing verbal outbursts. Others are likely quite aware of anger potential.
3	This rating indicates a child with severe anger control problems. His/her temper is likely associated with frequent fighting that is often physical. Others likely fear him/her.

CHILD RISK BEHAVIORS DOMAIN

Risk behaviors are the types of things that can get children and adolescents in trouble or put them in danger of harming themselves or others. Notice that the time frames for the ratings change, particularly for the '1' and '3' ratings away from the standard 30 day rating window.

For **Risk Behaviors,** the following categories and action levels are used:

0 indicates a dimension where there is no evidence of any needs.
1 indicates a dimension that requires monitoring, watchful waiting, or preventive activities.
2 indicates a dimension that requires action to ensure that this identified need or risk behavior is addressed.
3 indicates a dimension that requires immediate or intensive action.

64. SUICIDE RISK - *This rating describes suicidal behavior. A rating of '2' or '3' would indicate the need for a safety plan.*

0	Child has no evidence or history of suicidal ideation or behaviors.
1	History of suicidal behaviors or significant ideation but none during the past 30 days.
2	Recent, (last 30 days) but not acute (today) suicidal ideation or gesture.
3	Current suicidal ideation and intent in the past 24 hours.

65. NON-SUICIDAL SELF-INJURY - *This rating includes repetitive, physically harmful behavior that generally serves a coping or self-soothing function to the child.*

0	No evidence of any forms of self-injury (e.g. cutting, burning, face slapping, head banging)
1	History of self-injury but none evident in the past 30 days.
2	Engaged in self-injury that does not require medical attention.
3	Engaged in self-injury that requires medical attention.

66. OTHER SELF HARM - *This rating includes reckless and dangerous behaviors that, while not intended to harm self or others, place the child or others at some jeopardy. Suicidal or self-injurious behaviors are NOT rated here.*

0	No evidence of behaviors that place the child at risk of physical harm.
1	History of behavior other than suicide or self-mutilation that places child at risk of physical harm. This includes reckless and risk-taking behavior that may endanger the child.
2	Engaged in behavior other than suicide or self-mutilation that places him/her in danger of physical harm. This includes reckless behavior or intentional risk-taking behavior.
3	Engaged in behavior other than suicide or self-mutilation that places him/her at immediate risk of death. This includes reckless behavior or intentional risk-taking behavior.

67. DANGER TO OTHERS - *This rating includes actual and threatened violence. Imagined violence, when extreme, may be rated here. A rating of 2 or 3 would indicate the need for a safety plan.*

0	Child has no evidence or history of aggressive behaviors or significant verbal aggression towards others (including people and animals).
1	History of aggressive behavior or verbal aggression towards others but no aggression during the past 30 days. History of fire setting (not in past year) would be rated here.
2	Occasional or moderate level of aggression towards others including aggression during the past 30 days or more recent verbal aggression.
3	Frequent or dangerous (significant harm) level of aggression to others. Child or youth is an immediate risk to others.

68. SEXUAL AGGRESSION - *Sexually abusive behavior includes both aggressive sexual behavior and sexual behavior in which the child or adolescent takes advantage of a younger or less powerful child through seduction, coercion, or force.*

0	No evidence of problems with sexual behavior in the past year.
1	Mild problems of sexually abusive behavior. For example, occasional inappropriate sexually aggressive/harassing language or behavior.
2	Moderate problems with sexually abusive behavior, For example, frequent inappropriate sexual behavior. Frequent disrobing would be rated here only if it was sexually provocative. Frequent inappropriate touching would be rated here.
3	Severe problems with sexually abusive behavior. This would include the rape or sexual abuse of another person involving sexual penetration.

69. RUNAWAY - *In general, to classify as a runaway or elopement, the child is gone overnight or very late into the night. Impulsive behavior that represents an immediate threat to personal safety would also be rated here.*

0	This rating is for a child with no history of running away and no ideation involving escaping from the present living situation.
1	This rating is for a child with no recent history or running away but who has expressed ideation about escaping present living situation or treatment. Child may have threatened running away on one or more occasions or have a history (lifetime) of running away but not in the past year.
2	This rating is for a child who has run away from home once or run away from one treatment setting within the past year. Also rated here is a child who has run away to home (parental or relative) in the past year.
3	This rating is for a child who has (1) run away from home and/or treatment settings within the last 7 days or (2) run away from home and/or treatment setting twice or more overnight during the past 30 days. Destination is not a return to home of parent or relative.

70. DELINQUENCY - *This rating includes both criminal behavior and status offenses that may result from child or youth failing to follow required behavioral standards (e.g. truancy). Sexual offenses should be included as criminal behavior.*

0	Child shows no evidence or has no history of criminal or delinquent behavior.
1	History of criminal or delinquent behavior but none in the past 30 days. Status offenses in the past 30 days would be rated here.
2	Moderate level of criminal activity including a high likelihood of crimes committed in the past 30 days. Examples would include vandalism, shoplifting, etc.
3	Serious level of criminal or delinquent activity in the past 30 days. Examples would include car theft, residential burglary, gang involvement, etc.

71. JUDGMENT - *This item describes the child's decision-making processes and awareness of consequences.*

0	No evidence of problems with judgment or poor decision making that result in harm.
1	History of problems with judgment in which the child makes decisions that are in some way harmful (e.g. a child who has a history of hanging out with other children who shoplift.)
2	Problems with judgment in which the child makes decisions that are in some way harmful to his/her development and/or well-being that may place him/her at moderate risk of harm.
3	Problems with judgment that place the child at risk of significant imminent physical harm.

72. FIRE SETTING - *This item refers to behavior involving the intentional setting of fires or accidental fire setting that might be dangerous to the child or others. This does not include the use of candles or incense or matches to smoke.*

0	No evidence or history of fire setting behavior
1	History of fire-setting but not in past six months
2	Recent fire setting behavior (in past six months) but not of the type that has endangered the lives of others (e.g. playing with matches) OR repeated fire setting behavior over a period of at least two years even if not in the past six months.
3	Acute threat of fire setting. Intentionally set fire that endangered the lives of others (e.g. attempting to burn down a house).

73. INTENTIONAL MISBEHAVIOR - *This rating describes intentional obnoxious social behaviors that a child engages in to intentionally force adults to sanction him/her. This item should reflect problematic social behaviors (socially unacceptable behavior for the culture and community in which he/she lives) that put the child at some risk of sanctions.*

It is not necessary that the child have awareness of the purpose of his/her misbehavior (to provoke sanctions/reactions) in order to be rated here as this behavior is not always conscious/planned behavior. This item should not be rated for children who engage in such behavior solely due to developmental delays or lack of social skill.

0	Child shows no evidence of problematic social behaviors.
1	Mild level of problematic social behaviors that force adults to sanction the child. Provocative comments or behavior in social settings aimed at getting a negative response from adults might be included at this level.
2	Moderate level of problematic social behaviors. Child may be intentionally getting in trouble in school or at home and the sanctions or threat of sanctions that result are causing problems in the child's life.
3	Severe level of problematic social behaviors. This would be indicated by frequent seriously inappropriate social behavior that force adults to seriously and/or repeatedly sanction the child. Social behaviors are sufficiently severe (cause harm to others) that they place the child at risk of significant sanctions (e.g. expulsion, removal from the community).

74. SEXUALLY REACTIVE BEHAVIORS - *Sexually reactive behavior includes both age-inappropriate sexualized behaviors that may place a child at risk for victimization or risky sexual practices.*

0	No evidence of problems with sexually reactive behaviors or high-risk sexual behaviors.
1	Some evidence of sexually reactive behavior. Child may exhibit occasional inappropriate sexual language or behavior, flirts when age-inappropriate, or engages in unprotected sex with single partner. This behavior does not place child at great risk. A history of sexually provocative behavior would be rated here.
2	Moderate problems with sexually reactive behavior that place child at some risk. Child may exhibit more frequent sexually provocative behaviors in a manner that impairs functioning, engage in promiscuous sexual behaviors or have unprotected sex with multiple partners.
3	Significant problems with sexually reactive behaviors. Child exhibits sexual behaviors that place child or others at immediate risk.

CHILD AND ADOLESCENT NEEDS AND STRENGTHS

RATINGS OF CHILDREN FIVE YEARS OLD AND YOUNGER

The following items are required for any child who is five years old or younger or developmentally disabled (DD); however, they may be rated for any child if they represent a need for a specific youth. The N/A option is generally used for items in this domain when a child is older than five years old AND the item does not represent a specific need for the youth.

75. MOTOR - *This rating describes the child's fine (e.g. hand grasping and manipulation) and gross (e.g. sitting, standing, walking) motor functioning.*

0	Child's fine and gross motor functioning appears normal. There is no reason to believe that the child has any problems with motor functioning.
1	The child has mild fine (e.g. using scissors) or gross motor skill deficits. The child may have exhibited delayed sitting, standing, or walking, but has since reached those milestones.
2	The child has moderate motor deficits. A non-ambulatory child with fine motor skills (e.g. reaching, grasping) or an ambulatory child with severe fine motor deficits would be rated here. A full-term newborn who does not have a sucking reflex in the first few days of life would be rated here.
3	The child has severe or profound motor deficits. A non-ambulatory child with additional movement deficits would be rated here, as would any child older than 6 months who cannot lift his or her head.
NA	Not applicable

76. SENSORY - *This rating describes the child's ability to use all senses including vision, hearing, smell, touch, taste, and kinesthetics.*

0	The child's sensory functioning appears normal. There is no reason to believe that the child has any problems with sensory functioning.
1	The child has mild impairment on a single sense (e.g. mild hearing deficits, correctable vision problems).
2	The child has moderate impairment on a single sense or mild impairment on multiple senses (e.g. difficulties with sensory integration, diagnosed need for occupational therapy).
3	The child has significant impairment on one or more senses (e.g. profound hearing or vision loss).
NA	Not applicable

77. COMMUNICATION - *This rating describes the child's ability to communicate through any medium including all spontaneous vocalizations and articulations.*

0	Child's receptive and expressive communication appears developmentally appropriate. There is no reason to believe that the child has any problems communicating.
1	Child's receptive abilities are intact, but child has limited expressive capabilities (e.g. if the child is an infant, he or she engages in limited vocalizations; if older than 24 months, he or she can understand verbal communication, but others have unusual difficulty understanding child).
2	Child has limited receptive and expressive capabilities.
3	Child is unable to communicate in any way, including pointing or grunting.
NA	Not applicable

78. FAILURE TO THRIVE - *Symptoms of failure to thrive focus on normal physical development such as growth and weight gain.*

0	The child does not appear to have any problems with regard to weight gain or development. There is no evidence of failure to thrive.
1	The child has mild delays in physical development (e.g. is below the 25th percentile in terms of height or weight).
2	The child has significant delays in physical development that could be described as failure to thrive (e.g. is below the 10th percentile in terms of height or weight).
3	The child has severe problems with physical development that puts his/her life at risk (e.g. is at or beneath the 1st percentile in height or weight).
NA	Not applicable

79. FEEDING/ELIMINATION - *This category refer to all dimensions of eating and/or elimination. Pica would be rated here.*

0	Child does not appear to have any problems with feeding or elimination.
1	Child has mild problems with feeding and/or elimination (e.g. picky eating).
2	Child has moderate to severe problems with feeding and/or elimination. Problems are interfering with functioning in at least one area.
3	Child has profound problems with feeding and/or elimination.
NA	Not applicable

80. BIRTH WEIGHT - *This dimension describes the child's weight as compared to normal development.*

0	Child is within normal range for weight and has been since birth. A child with a birth weight of 2500 grams (5.5 pounds) or greater would be rated here.
1	Child was born under weight but is now within normal range or child is slightly beneath normal range. A child with a birth weight of between 1500 grams (3.3 pounds) and 2499 grams would be rated here.
2	Child is considerably under weight to the point of presenting a development risk to the child. A child with a birth weight of 1000 grams (2.2 pounds) to 1499 grams would be rated here.
3	Child is extremely under weight to the point where the child's life is threatened. A child with a birth weight of less than 1000 grams (2.2 pounds) would be rated here.
U	Unknown
NA	Not applicable

81. PRENATAL CARE - *This dimension refers to the health care and birth circumstances experienced by the child in utero.*

0	Child's biological mother had adequate prenatal care (e.g. 10 or more planned visits to a physician) that began in the first trimester. Child's mother did not experience any pregnancy-related illnesses.
1	Child's biological mother had some short-comings in prenatal care, or had a mild form of a pregnancy-related illness. A child whose mother had 6 or fewer planned visits to a physician would be rated here (her care must have begun in the first or early second trimester). A child whose mother had a mild or well-controlled form of pregnancy-related illness such as gestational diabetes, or who had an uncomplicated high-risk pregnancy, would be rated here.
2	Child's biological mother received poor prenatal care, initiated only in the last trimester, or had a moderate form of pregnancy-related illness. A child whose mother had 4 or fewer planned visits to a physician would be rated here. A mother who experienced a high-risk pregnancy with some complications would be rated here.
3	Child's biological mother had no prenatal care, or had a severe form of pregnancy-related illness. A mother who had toxemia/preeclampsia would be rated here.
U	Unknown
NA	Not applicable

82. SUBSTANCE EXPOSURE - *This dimension describes the child's exposure to substance use and abuse both before and after birth.*

0	Child had no in utero exposure to alcohol or drugs, and there is currently no exposure in the home.
1	Child had either mild in utero exposure (e.g. mother ingested alcohol or tobacco in small amounts fewer than four times during pregnancy), or there is current alcohol and/or drug use in the home.
2	Child was exposed to significant alcohol or drugs in utero. Any ingestion of illegal drugs during pregnancy (e.g. heroin, cocaine, methamphetamine), or use of alcohol or tobacco, would be rated here.
3	Child was exposed to alcohol or drugs in utero and continues to be exposed in the home. Any child who evidenced symptoms of substance withdrawal at birth (e.g. crankiness, feeding problems, tremors, weak and continual crying) would be rated here.
U	Unknown
NA	Not applicable

83. LABOR AND DELIVERY - *This dimension refers to conditions associated with, and consequences arising from complications in labor and delivery of the child.*

0	Child and biological mother had normal labor and delivery. A child who received an Apgar score of 7-10 at birth would be rated here.
1	Child or mother had some mild problems during delivery, but child does not appear to be affected by these problems. An emergency C-Section or a delivery-related physical injury (e.g. shoulder displacement) to the child would be rated here.
2	Child or mother had problems during delivery that resulted in temporary functional difficulties for the child or mother. Extended fetal distress, postpartum hemorrhage, or uterine rupture would be rated here. A child who received an Apgar score of 4-7, or who needed some resuscitative measures at birth, would be rated here.
3	Child had severe problems during delivery that have long-term implications for development (e.g. extensive oxygen deprivation, brain damage). A child who received an Apgar score of 3 or lower, or who needed immediate or extensive resuscitative measures at birth, would be rated here.
U	Unknown
NA	Not applicable

84. PARENT OR SIBLING PROBLEMS - *This dimension describes how this child's parents and older siblings have done/are doing in their respective developments.*

0	The child's parents have no developmental disabilities. The child has no siblings, or existing siblings are not experiencing any developmental or behavioral problems
1	The child's parents have no developmental disabilities. The child has siblings who are experiencing some mild developmental or behavioral problems (e.g. Attention Deficit, Oppositional Defiant, or Conduct Disorders). It may be that child has at least one healthy sibling.
2	The child's parents have no developmental disabilities. The child has a sibling who is experiencing a significant developmental or behavioral problem (e.g. a severe version of any of the disorders cited above, or any developmental disorder).
3	One or both of the child's parents have been diagnosed with a developmental disability, or the child has multiple siblings who are experiencing significant developmental or behavioral problems (all siblings must have some problems).
U	Unknown
NA	Not applicable

85. MATERNAL AVAILABILITY - *This dimension addresses the primary caretaker's emotional and physical availability to the child in the weeks immediately following the birth. Rate maternal availability up until 3 months (12 weeks) post-partum.*

0	The child's mother/primary caretaker was emotionally and physically available to the child in the weeks following the birth.
1	The primary caretaker experienced some minor or transient stressors which made her slightly less available to the child (e.g. another child in the house under two years of age, an ill family member for whom the caretaker had responsibility, a return to work before the child reached six weeks of age).
2	The primary caretaker experienced a moderate level of stress sufficient to make him/her significantly less emotionally and physically available to the child in the weeks following the birth (e.g. major marital conflict, significant post-partum recuperation issues or chronic pain, two or more children in the house under four years of age).
3	The primary caretaker was unavailable to the child to such an extent that the child's emotional or physical well-being was severely compromised (e.g. a psychiatric hospitalization, a clinical diagnosis of severe Post-Partum Depression, any hospitalization for medical reasons which separated caretaker and child for an extended period of time, divorce or abandonment).
U	Unknown
NA	Not applicable

86. CURIOUSITY - *This rating describes the child's self-initiated efforts to discover his/her world.*

0	This level indicates a child with exceptional curiosity. Infants display mouthing and banging of objects within grasp; older children crawl or walk to objects of interest.
1	This level indicates a child with good curiosity. An ambulatory child who does not walk to interesting objects, but who will actively explore them when presented to him/her, would be rated here.
2	This level indicates a child with limited curiosity. Child may be hesitant to seek out new information or environments, or reluctant to explore even presented objects.
3	This level indicates a child with very limited or no observable curiosity. Child may seem frightened of new information or environments.
NA	Not applicable

87. PLAYFULNESS - *This rating describes the child's enjoyment of play alone and with others.*

0	This level indicates a child with substantial ability to play with self and others. Child enjoys play, and if old enough, regularly engages in symbolic and means-end play. If still an infant, child displays changing facial expressions in response to different play objects.
1	This level indicates a child with good play abilities. Child may enjoy play only with self or only with others, or may enjoy play with a limited selection of toys.
2	This level indicates a child with limited ability to enjoy play. Child may remain preoccupied with other children or adults to the exclusion of engaging in play, or may exhibit impoverished or unimaginative play.
3	This level indicates a child who has significant problems with play both by his/her self and with others. Child does not engage in symbolic or means-end play, although he or she will handle and manipulate toys.
NA	Not applicable

88. TEMPERAMENT *This rating describes the child's general mood state and ability to be soothed.*

0	This level indicates a child with an easy temperament. S/he is easily calmed or distracted when angry or upset
1	This level indicates a child with some mild problems being calmed, soothed, or distracted when angry or upset. Child may have occasional episodes or extended crying or tantrums.
2	This level indicates a child with a difficult temperament. Child has difficulty being calmed, soothed, or distracted. Persistent episodes of crying, tantrums, or other difficult behaviors are observed.
3	This level indicates a child who has significant difficulties being calmed, soothed, or distracted when angry or upset. Repeated and extreme persistent episodes of crying, tantrums, or other difficult behaviors are observed when the child is angry or upset.
NA	Not applicable

89. DAY CARE PRESCHOOL

0	This level indicates a child with no problems in day care or preschool environments.
1	This level indicates a child with mild problems in day care of school environments.
2	This level indicates a child who has difficulties in day care or preschool environments. These problems may include things such as separation anxiety or difficult behavior.
3	This level indicates a child who has significant problems in day care or preschool environments. Child may have recently been asked to stop attending.
NA	Not applicable

TRANSITION TO ADULTHOOD

The following items are required for youth 14 years, 6 months and older. However, any of these items can be rated regardless of age if they represent a need for a specific youth. The N/A option is generally used for items in this domain when a child is younger than 14 years, 6 months AND the item does not represent a specific need for the youth.

90. INDEPENDENT LIVING SKILLS - *This rating focuses on the presence or absence of skills and impairments in independent living abilities or the readiness to take on those responsibilities.*

0	This level indicates a person who is fully capable of independent living. No evidence of any deficits or barriers that could impede maintaining own home.
1	This level indicates a person with mild impairment of independent living skills. Some problems exist with maintaining reasonable cleanliness, diet and so forth. Problems with money management may occur at this level. These problems are generally addressable with training or supervision.
2	This level indicates a person with moderate impairment of independent living skills. Notable problems with completing tasks necessary for independent living are apparent. Difficulty with cooking, cleaning, and self-management when unsupervised would be common at this level. Problems are generally addressable with in-home services and supports.
3	This level indicates a person with profound impairment of independent living skills. This individual would be expected to be unable to live independently given their current status. Problems require a structured living environment.
NA	Not applicable

91. TRANSPORTATION - *This item is used to rate the level of transportation required to ensure that the individual could effectively participate in his/her own treatment and in other life activities. Only unmet transportation needs should be rated here.*

0	The individual has no unmet transportation needs.
1	The individual has occasional unmet transportation needs (e.g., appointments). These needs would be no more than weekly and not require a special vehicle. The needs can be met with minimal support, for example, assistance with bus routes to facilitate independent navigation, or provision of a bus card.
2	The individual has occasional transportation needs that require a special vehicle or frequent transportation needs (e.g., daily to work or therapy) that do not require a special vehicle. Individual can self-transport with a med-van service.
3	The individual requires frequent (e.g., daily to work or therapy) transportation in a special vehicle. He or she is completely reliant on others for transportation and cannot self-transport.
NA	Not applicable

92. PARENTING ROLES - *This item is intended to rate the individual in any caregiver roles. For example, an individual with a son or daughter or an individual at least partially responsible for caring for an elderly parent or grandparent would be rated here. Include pregnancy as a parenting role.*

0	Individual has a parenting/caregiving role and he/she is functioning appropriately in that role.
1	The individual has responsibilities as a parent/caregiver but occasionally experiences difficulties with this role.
2	The individual has responsibilities as a parent/caregiver and either the individual is struggling with these responsibilities or these issues are currently interfering with the individual's functioning in other life domains.
3	The individual has responsibilities as a parent/caregiver and the individual is currently unable to meet these responsibilities or these responsibilities are making it impossible for the individual to function in other life domains. Individual has the potential of abuse or neglect in his/her parenting.
NA	Not applicable. Individual is not a caregiver/parent.

93. INTIMATE RELATIONSHIPS - *This item is used to rate the individuals current status in terms of romantic/intimate relationships. Note, if the individual has never had a romantic/intimate partner relationship and this is not causing significant personal or interpersonal/environmental stress, then they would receive a 0 on this item.*

0	Adaptive partner relationship. Individual has a strong, positive, partner relationship with another adult, or they have maintained a positive partner relationship in the past but are not currently in an intimate relationship.
1	Mostly adaptive partner relationship. Individual has a generally positive partner relationship with another individual. This relationship may, at times, impede the individual's healthy development.
2	Limited adaptive partner relationship. For example, the individual has a recent history of being in a domestically violent relationship or a recent history of being in a relationship where he/she was overly dependent on his/her partner. Individual may or may not be currently involved in any partner relationship with another individual.
3	Significant difficulties with partner relationships. For example, individual is currently involved in a negative or domestically violent relationship or a relationship where he/she is totally dependent on his/her partner.
NA	Not applicable

94. MEDICATION COMPLIANCE - *This rating focuses on the level of the individual's willingness or ability to participate in taking prescribed medications.*

0	This level indicates a person who self-administers any prescribed medications as prescribed and without reminders, or a person who is not currently on any medication.
1	This level indicates a person who will take prescribed medications routinely, but who sometimes needs reminders to maintain compliance. Also, a history of medication noncompliance but no current problems would be rated here.
2	This level indicates a person who is sporadically non-compliant. This person may be resistant to taking prescribed medications or this person may tend to overuse his or her medications. He/she might comply with prescription plans for periods of time (1-2 weeks) but generally does not sustain taking medication in prescribed dose or protocol. This would include youth who are sporadically noncompliant with medications for physical helath that may place youth at medical risk.
3	This level indicates a person who has refused to take prescribed medications during the past 30-day period or a person who has abused his or her medications to a significant degree (i.e., overdosing or over using medications to a dangerous degree).
NA	Not applicable

95. EDUCATIONAL ATTAINMENT - *This rates the degree to which the individual has completed his/her planned education.*

0	Individual has achieved all educational goals OR has no educational goals and educational attainment has no impact on lifetime vocational functioning.
1	Individual has set educational goals and is currently making progress towards achieving them.
2	Individual has set educational goals but is currently not making progress towards achieving them.
3	Individual has no educational goals and lack of educational attainment is interfering with individual's lifetime vocational functioning.
NA	Not applicable

96. VICTIMIZATION - *This item is used to examine a history and level of current risk for victimization.*

0	This level indicates a person with no evidence of recent victimization and no significant history of victimization within the past year. The person may have been robbed or burglarized on one or more occasions in the past, but no pattern of victimization exists. Person is not presently at risk for re-victimization.
1	This level indicates a person with a history of victimization but who has not been victimized to any significant degree in the past year. Person is not presently at risk for re-victimization.
2	This level indicates a person who has been recently victimized (within the past year) but is not in acute risk of re-victimization. This might include physical or sexual abuse, significant psychological abuse by family or friend, extortion or violent crime.
3	This level indicates a person who has been recently victimized and is in acute risk of re-victimization. Examples include working as a prostitute or living in an abusive relationship.
NA	Not applicable

97. JOB FUNCTIONING - *This item is intended to describe functioning in vocational settings.*

0	Youth is gainfully employed in a job and experiencing no problems in attendance, performance or relationships at work.
1	Youth is gainfully employed but may have some difficulties at work with attendance, performance or relationships
2	Youth has significant job-related problems with attendance, performance, or relationships.
3	Youth is experiencing severe problems in an employment situation with performance or relationships. Youth may have recently been fired.
NA	Not applicable as the child is not employed.

CAREGIVER NEEDS AND STRENGTHS

These ratings should be done with a focus on permanency plan caregivers. However, when a temporary placement is impacting a child's functioning the temporary caregivers can be scored. Caregiver ratings should be completed by household. If multiple households are involved in the permanency planning, then this section should be completed once for each household under consideration.

For Caregiver Needs and Strengths the following definitions and action levels apply:

0 indicates a dimension where there is no evidence of any needs. This is a strength.
1 indicates a dimension that requires monitoring, watchful waiting, or preventive activities.
2 indicates a dimension that requires action to ensure that this identified need or risk behavior is addressed.
3 indicates a dimension that requires immediate or intensive action.

98. PHYSICAL HEALTH - *Physical health includes medical and physical challenges faced by the caregiver(s).*

0	Caregiver(s) has no physical health limitations that impact assistance or attendant care.
1	Caregiver(s) has some physical health limitations that interfere with provision of assistance or attendant care.
2	Caregiver(s) has significant physical health limitations that prevent them from being able to provide some needed assistance or make attendant care difficult.
3	Caregiver(s) is physically unable to provide any needed assistance or attendant care.
NA	Rate non applicable when the child has no known caregiver and/or when child is living in a residential or group home setting.

99. MENTAL HEALTH - *This item refers to the caregiver's mental health status. Serious mental illness would be rated as a '2' or '3' unless the individual is in recovery.*

0	Caregiver(s) has no mental health limitations that impact assistance or attendant care.
1	Caregiver(s) has some mental health limitations that interfere with provision of assistance or attendant care.
2	Caregiver(s) has significant mental health limitations that prevent them from being able to provide some needed assistance or make attendant care difficult.
3	Caregiver(s) is unable to provide any needed assistance or attendant care due to serious mental illness.
NA	Rate non applicable when the child has no known caregiver and/or when child is living in a residential or group home setting.

100. SUBSTANCE USE - *This item rates the caregiver's pattern of alcohol and/or drug use. Substance-related disorders would be rated as a '2' or '3' unless the individual is in recovery.*

0	Caregiver(s) has no substance-related limitations that impact assistance or attendant care.
1	Caregiver(s) has some substance-related limitations that interfere with provision of assistance or attendant care.
2	Caregiver(s) has significant substance-related limitations that prevent them from being able to provide some needed assistance or make attendant care difficult.
3	Caregiver(s) is unable to provide any needed assistance or attendant care due to serious substance dependency or abuse.
NA	Rate non applicable when the child has no known caregiver and/or when child is living in a residential or group home setting.

101. DEVELOPMENTAL - *This item describes the caregiver's developmental status in terms of low IQ, mental retardation or other developmental disabilities.*

0	Caregiver(s) has no developmental limitations that impact assistance or attendant care.
1	Caregiver(s) has some developmental limitations that interfere with provision of assistance or attendant care.
2	Caregiver(s) has significant developmental limitations that prevent them from being able to provide some needed assistance or make attendant care difficult.
3	Caregiver(s) is unable to provide any needed assistance or attendant care due to serious developmental disabilities.
NA	Rate non applicable when the child has no known caregiver and/or when child is living in a residential or group home setting.

102. SUPERVISION - *This rating is used to determine the caregiver's capacity to provide the level of monitoring and discipline needed by the child.*

0	This rating is used to indicate a caregiver circumstance in which supervision and monitoring are appropriate and functioning well.
1	This level indicates a caregiver circumstance in which supervision is generally adequate but inconsistent. This may include a placement in which one member is capable of appropriate monitoring and supervision but others are not capable or not consistently available.
2	This level indicates a caregiver circumstance in which appropriate supervision and monitoring are very inconsistent and frequently absent.
3	This level indicates a caregiver circumstance in which appropriate supervision and monitoring are nearly always absent or inappropriate.
NA	Rate non applicable when the child has no known caregiver and/or when child is living in a residential or group home setting.

103. INVOLVEMENT WITH CARE - *This rating should be based on the level of involvement the caregiver(s) has in the planning and provision of child welfare and related services.*

0	This level indicates a caregiver(s) who is actively involved in the planning and/or implementation of services and is able to be an effective advocate on behalf of the child or adolescent.
1	This level indicates a caregiver(s) who is consistently involved in the planning and/or implementation of services for the child or adolescent but is not an active advocate on behalf of the child or adolescent.
2	This level indicates a caregiver(s) who is minimally involved in the care of the child or adolescent. Caregiver may visit individual when in out of home placement, but does not become involved in service planning and implementation.
3	This level indicates a caregiver(s) who is uninvolved with the care of the child or adolescent. Caregiver may want individual out of home or fails to visit individual when in residential placement.
NA	Rate non applicable when the child has no known caregiver and/or when child is living in a residential or group home setting.

104. KNOWLEDGE - *This rating should be based on caregiver's knowledge of the specific strengths of the child and any problems experienced by the child and their ability to understand the rationale for the treatment or management of these problems.*

0	This level indicates that the present caregiver is fully knowledgeable about the child's psychological strengths and weaknesses, talents and limitations.
1	This level indicates that the present caregiver, while being generally knowledgeable about the child, has some mild deficits in knowledge or understanding of either the child's psychological condition or his/her talents, skills and assets.
2	This level indicates that the caregiver does not know or understand the child well and that significant deficits exist in the caregiver's ability to relate to the child's problems and strengths.
3	This level indicates that the present caregiver has little or no understanding of the child's current condition. The placement is unable to cope with the child given his/her status at the time, not because of the needs of the child but because the caregiver does not understand or accept the situation.
NA	Rate non applicable when the child has no known caregiver and/or when child is living in a residential or group home setting.

105. ORGANIZATION - *This rating should be based on the ability of the caregiver to participate in or direct the organization of the household, services, and related activities.*

0	Caregiver(s) is well organized and efficient.
1	Caregiver(s) has minimal difficulties with organizing or maintaining household to support needed services. For example, may be forgetful about appointments or occasionally fails to call back case manager.
2	Caregiver(s) has moderate difficulty organizing or maintaining household to support needed services.
3	Caregiver(s) is unable to organize household to support needed services.
NA	Rate non applicable when the child has no known caregiver and/or when child is living in a residential or group home setting.

106. RESOURCES - *This item refers to the financial and social assets (extended family) and resources that the caregiver(s) can bring to bear in addressing the multiple needs of the child and family.*

0	Caregiver(s) has sufficient resources so that there are few limitations on what can be provided for the child.
1	Caregiver(s) has the necessary resources to help address the child's major and basic needs but those resources might be stretched.
2	Caregiver(s) has limited resources (e.g. a grandmother living in same town who is sometimes available to watch the child).
3	Caregiver(s) has severely limited resources that are available to assist in the care and treatment of the child.
NA	Rate non applicable when the child has no known caregiver and/or when child is living in a residential or group home setting.

107. RESIDENTIAL STABILITY - *This item rates the caregiver's current and likely future housing circumstances.*

0	This rating indicates a family/caregiver in stable housing with no known risks of instability.
1	This rating indicates a family/caregiver who is currently in stable housing but there are significant risks of housing disruption (e.g. loss of job).
2	This rating indicates a family/caregiver who has moved frequently or has very unstable housing.
3	This rating indicates a family/caregiver who is currently homeless.
NA	Rate non applicable when the child has no known caregiver and/or when child is living in a residential or group home setting.

108. SAFETY - *This rating refers to the safety of the assessed child. It does not refer to the safety of other family or household members based on any danger presented by the assessed child.*

0	This level indicates that the present placement is as safe or safer for the child (in his or her present condition) as could be reasonably expected.
1	This level indicates that the present placement environment presents some mild risk of neglect, exposure to undesirable environments (e.g. drug use or gangs in neighborhood, etc.) but that no immediate risk is present.
2	This level indicates that the present placement environment presents a moderate level of risk to the child, including such things as the risk of neglect or abuse or exposure to individuals who could harm the child.
3	This level indicates that the present placement environment presents a significant risk to the well being of the child. Risk of neglect or abuse is imminent and immediate. Individuals in the environment offer the potential of significantly harming the child.
NA	Rate non applicable when the child has no known caregiver and/or when child is living in a residential or group home setting.

109. MARITAL/PARTNER VIOLENCE - *This rating describes the degree of difficulty or conflict in the caregiver relationship.*

0	Caregivers appear to be functioning adequately. There is no evidence of notable conflict in the caregiver relationship. Disagreements are handled in an atmosphere of mutual respect and equal power.
1	Mild to moderate level of family problems including marital difficulties and caregiver arguments. Caregivers are generally able to keep arguments to a minimum when child is present. Occasional difficulties in conflict resolution or use of power and control by one partner over another.
2	Significant level of caregiver difficulties including frequent arguments that often escalate to verbal aggression or the use of verbal aggression by one partner to control the other. Child often witnesses these arguments between caregivers or the use of verbal aggression by one partner to control the other.
3	Profound level of caregiver or marital violence that often escalates to mutual attacks or the use of physical aggression by one partner to control the other. These episodes may exacerbate child's difficulties or put the child at greater risk.
NA	Rate non applicable when the child has no known caregiver and/or when child is living in a residential or group home setting.

110. CAREGIVER POSTTRAUMATIC REACTIONS - *This rating describes posttraumatic reactions faced by caregiver(s), including emotional numbing and avoidance, nightmares and flashbacks that are related to their child's or their own traumatic experiences.*

0	Caregiver has adjusted to traumatic experiences without notable posttraumatic stress reactions.
1	Caregiver has some mild adjustment problems related to their child's or their own traumatic experiences. Caregiver may exhibit some guilt about their child's trauma or become somewhat detached or estranged from others.
2	Caregiver has moderate adjustment difficulties related to traumatic experiences. Caregiver may have nightmares or flashbacks of the trauma.
3	Caregiver has significant adjustment difficulties associated with traumatic experiences. Symptoms might include intrusive thoughts, hypervigilance, and constant anxiety.
NA	Rate non applicable when the child has no known caregiver and/or when child is living in a residential or group home setting.

Appendix C: Definition of Broad Placement Categories (Adapted from Havlicek, 2010)

Placement Category	Description
Kinship Care	"Any placement with a biological relative. States have considerable flexibility in defining kin for the purposes of foster care policy. In Illinois, only those related by blood marriage or adoption are considered to be kin."
Regular Foster Care	"Care in one of two types of foster homes: (1) regular boarding homes, which are supervised by the state child welfare agency, and (2) private agency homes, which are supervised by outside agencies that are contracted by the state child welfare agency. In the absence of any indication of difference, this study considers placements in both types of homes to be in the same category."
Treatment Foster Care	"Care by professional caregivers with specialized training. Caregivers provide support to youth with high-level emotional, behavioral, developmental, or health needs."
Congregate Care	"Any institutional setting (e.g., a group home, residential treatment center, or congregate care setting). The term *congregate care* refers to any facility that provides 24-hour care to a group of youth that is supervised by unrelated adults who work in shifts."
Emergency Care	"Events that are not technically foster placements but include care in locked facilities deemed necessary to stabilize foster youth who are at risk of harming themselves or others or who exhibit serious problems. This category includes any psychiatric hospitalization as well as placement in a detention center or juvenile lockup facility."

Appendix D: OnLAC AAR (AAR-C2-2010) for ages 16-17 years

Draft

PLEASE NOTE: Use only this AAR-C2 form from June 1, 2011 to May 31, 2012 for 16 and 17 year olds.

LOOKING AFTER CHILDREN:
Assessment and Action Record

(Second Canadian Adaptation - AAR-C2-2010)
Good Parenting, Good Outcomes
Ages 16 and 17 years

ID

Note to young people:

- ***What has happened in the last year?***
- ***Have you had the care, guidance, and opportunities you need to give you a good start in adult life?***
- ***What else needs to be done?***

This form is meant to help you, your child welfare worker, and caregivers to answer these questions. By now you will want to take a major part in making decisions about your life. We strongly encourage you to fill out this form with your worker and one of your caregivers so that together, you may make future plans and decide who is going to carry them out.

The Assessment and Action Record is confidential once completed. Only authorized persons are allowed access to the document.

Note to the child welfare worker: PLEASE COMPLETELY FILL OUT THE QUESTIONS ON THIS PAGE.

This information is necessary to help us link this AAR conversation with last year's AAR conversation (if there was one). The linking of AARs from one year to the next will allow us to follow the developmental progress of the young person while respecting the confidentiality of all those taking part in the AAR conversations.

Young person's initials of first and last name: dmc1

Young person's official agency file number: dmc2

Young person's gender: 0 Male 1 Female dmc3

Young person's date of birth: Day / Month / Year dmc4

This assessment was completed by:

Child welfare worker's initials of first and last name: dmw1

agency

Agency or organization: dmw3

Assessment approved by:
Initials of first and last name of supervisor: dmw4

Date signed: Day / Month / Year dmw5

Date begun: Day / Month / Year dmw6

Date completed: Day / Month / Year dmw7

Looking After Children AAR-C2-2010 - Introduction (16-17 yrs)

INTRODUCTION: How to get the best from the Assessment and Action Record (AAR)

This record is in a format that allows it to be read by a computer scanner, for rapid processing. The **purposes** of the Assessment and Action Record (AAR) are to assess a young person's yearly progress, monitor the quality of care he/she is receiving, and serve as the basis for preparing or revising his/her annual Plan of Care. The AAR covers seven developmental dimensions: **health, education, identity, family and social relationships, social presentation, emotional and behavioural development,** and lastly, **self-care skills.**

These data are collected annually to assess the individual child's or youth's needs in order to provide information to update the child's or youth's Plan of Care and to monitor the child's or youth's developmental progress. The information collected is used to relieve any hardship faced by young people in care and to monitor and prevent any discrimination against the child or youth, ameliorate any disadvantage and promote equality for all children and youth in care.

It is to be completed by the child welfare worker in a series of conversations with the young person and the caregiver who knows the young person best. Some questions are addressed to the young person, some to the caregiver, and others to the child welfare worker.

Throughout the AAR, the acronym **FNMI** refers to First Nations, Métis, and Inuit, and includes status/eligible for status and First Nations heritage (non-status).

Note to the child welfare worker: In completing the AAR,

PLEASE DO:

- Think about who is the best person to complete the Assessment and Action Record with you and the young person.This person should be someone who knows the young person best.
- Try to have conversations about the topics raised by the AAR rather than question and answer sessions. Feel free to use a form of speaking which is familiar and comfortable for you and the people with whom you are working.
- Complete the AAR with young people with disabilities as best you can.
- Recognize the importance of having FNMI Band representatives or Community members present to assist.
- Be respectful of cultural diversity.
- Plan ahead and read through each section before you complete it with the main caregiver and the young person. Some questions ask about sensitive issues which need to be thought through in advance.
- Consider talking to significant others such as teachers and healthcare professionals as part of the process.
- Make use of the space available on the right hand page to start preparing the plan of care.
- Aim to make the sessions enjoyable for all concerned.
- Use your own judgement and discuss issues more fully when you find the sections do not include details which are important.
- Give a copy of the AAR to the young person and another to his/her caregiver. This will allow them to follow along easily and permit the conversation to proceed smoothly and quickly.
- Note the details on the right hand page if anyone disagrees with some of the answers.
- Provide a copy of the completed AAR to the youth or caregiver if he/she wishes to have one.
- Please be prepared to find out the missing information or plan action for the future. Please indicate the reason(s) for gaps in the notes section on the right hand page.

PLEASE DO NOT:

- Try to complete it all in one sitting.
- Re-interpret the young person's or the caregiver's answers. Please respect his/her opinion.
- Say that you are doing "it" because "they" have told you it has to be done.
- Try to complete the AAR without involving the young person (if appropriate) or the caregiver.
- Answer questions for the young person or the caregiver.

Looking After Children AAR-C2-2010 - Background information (16-17 yrs) A

Draft

Looking After Children
Assessment and Action Record
Second Canadian Adaptation (AAR-C2-2010)

Main language of AAR conversation: bgfq41
[1] English [2] French [4] First Nations or Inuit language [3] Other

The AAR is written in: aarq4
1 [X] English [2] French

Age-group of this AAR is: aarq5
[10] 18-21 years [8] 12-15 years [3] 5-9 years [5] 1-2 years
7 [X] 16-17 years [9] 10-11 years [4] 3-4 years [6] 0-11 months

Province or territory of young person's placement: aarq6
[1] Alberta [6] Northwest Territories [11] Québec
[2] British Columbia [7] Nova Scotia [12] Saskatchewan
[3] Manitoba [8] Nunavut [13] Yukon
[4] New Brunswick [9] Ontario [14] Other
[5] Newfoundland and Labrador [10] Prince Edward Island

Province or territory with legal guardianship of the young person (if different from province or territory of young person's placement): aarq7
[1] Alberta [6] Northwest Territories [10] Prince Edward Island
[2] British Columbia [7] Nova Scotia [11] Québec
[3] Manitoba [8] Nunavut [12] Saskatchewan
[4] New Brunswick [9] Ontario [13] Yukon
[5] Newfoundland and Labrador

BACKGROUND INFORMATION

The purpose of this background information section is to gather basic information on three key persons in the Looking After Children approach: the young person, the child welfare worker responsible for the young person, and the caregiver who knows the young person best.

Notes to the child welfare worker:

- ***In many cases, much of this background information section can probably be completed by you before the AAR conversation with the caregiver and young person.***
- *For each item, please put a **dark mark** (i.e. an **X**, a **check mark**, or a **line**, or, as required, **a number or letter**) in the appropriate box or boxes, so that the computer will be able to scan the questionnaire properly.*
- *The symbol of three dots in a row [...] always refers to the young person for whom the AAR is being completed.*
- *At the beginning of the conversation, please give a copy of the AAR to the caregiver and young person. This will allow them to follow along easily and permit the conversation to proceed smoothly and quickly. Only your copy of the AAR is to be filled out.*

Looking After Children — AAR-C2-2010 - Background information (16-17 yrs) B

Draft

During the AAR conversation, the **CHILD WELFARE WORKER** is to answer the following section with assistance, as needed, from the caregiver.

1. BACKGROUND INFORMATION ON THE YOUNG PERSON FOR WHOM THE AAR IS TO BE COMPLETED

BG1A: CURRENT PLACEMENT: Which of the following best describes ...'s current placement? **(Mark one only.)** bgcq8

- [2] Kinship in care
- [1] Foster home operated by child welfare organization
- [3] Group home operated by child welfare organization
- [4] Foster home - outside purchased care
- [5] Group home - outside purchased care
- [6] Children's mental health residential facility
- [7] Hospital
- [17] Customary care (in the case of aboriginal children)
- [15] Other
- [8] Psychiatric facility
- [10] With birth parent(s)
- [11] Adoption probation
- [12] With relatives (not in foster care)
- [19] Whereabouts unknown or unapproved
- [13] Independent living
- [18] Shelter
- [16] Custody/Detention facility

BG1B: *NOTE*: **IF** you answered in question BG1A that the young person's current placement is a **FOSTER HOME, THEN** please indicate what **TYPE** of foster home this is: **(Mark one only.)** bgcq9

- [2] Regular foster care
- [3] Specialized foster care
- [4] Treatment foster care
- [5] Other foster care

BG1C: Whom does the current placement serve (whether foster care or another type of placement)? bgcq6c

- [1] Males only
- [2] Females only
- [3] Both genders

BG2: Does ... have his/her own bedroom? bgcq17

- [1] Yes
- [0] No

BG3A: What is the size of the area of residence in which this dwelling is situated? bgcq13

- [1] Urban, population 500,000 or over
- [2] Urban, population 100,000 to 499,999
- [3] Urban, population 30,000 to 99,999
- [4] Urban, population < 30,000
- [7] Northern remote area
- [5] Rural area
- [6] First Nations reserve

BG3B: In what postal code is this dwelling is situated? bgcq13a

[ ][ ][ ][ ][ ][ ]

BG4: What is ...'s (e.g., the young person) current age? bgcq4a

[ ][ ] **Years**

BG5: What is ...'s current legal status as a client of the local child welfare agency or organization? **(Mark only one.)** bgcq5

- [1] Temporary care agreement
- [2] Interim care and custody
- [11] Customary care
- [10] Society ward
- [4] Crown ward, with access
- [8] Crown ward
- [7] Extended care and maintenance
- [5] Other

Looking After Children — AAR-C2-2010 - Background information (16-17 yrs) C

Draft

FIRST NATION YOUNG PEOPLE: IF ... is a *First Nations young person*, **THEN** please answer questions BG6 to BG8. **If not, go to question BG9.**

BG6: Is ... registered with a First Nation? bgcq75a

[1] Yes [0] No [3] Don't know

BG7: Does ... have his/her Band Status Card? bgcq75b

[1] Yes [0] No [3] Don't know

BG8: What is ...'s status eligibility? bgcq75c

[1] Status [2] Non-Status [3] Bill C-31 [4] Eligible but not registered [5] Don't know

BG9: PRIMARY REASONS FOR CURRENT ADMISSION TO SERVICE: Young person came into care because of: **(Mark all that apply.)** bgcq7

[b] **Physical harm** (i.e., the young person has been or is at risk of being physically harmed as a result of an act or action by a caregiver [commission] or is at risk of being harmed as a result of caregiver's failure to take actions to protect him/her [omission].)

[c] **Sexual harm** (i.e., the young person has been or is at risk of being sexually harmed as a result of an act or action by a caregiver [commission] or is at risk of being harmed as a result of the caregiver's failure to take actions to protect him/her [omission].)

[d] **Neglect** (i.e., the young person has been or is at risk of neglect as a result of the caregiver's failure to provide adequate care for him/her. This may be by commission or omission.)

[e] **Emotional harm** (i.e., the young person has been or is at risk of being emotionally harmed as a result of specific behaviours of the caregiver towards him/her [commission] or is at risk of being harmed as a result of the caregiver's failure to take actions to protect him/her [omission].)

[i] **Domestic violence** (i.e., the young person has been exposed to domestic violence.)

[f] **Abandonment/separation** (i.e., the young person has been abandoned or is at risk of being separated from the family as a result of intentional or unintentional actions of the caregiver.)

[g] **Problematic behaviour** (i.e., the young person's behaviour is so problematic that it exceeds the birth family's capacity to care for the young person.)

[h] **Other**

BG10: How old was ... when he/she was placed in out-of-home care for the **very first time** (at this or another child welfare agency)? **(If less than one year of age indicate age in months.)** bgcq6

6a [ ] **Years** 6b [ ] **Months (If less than one year.)**

ONTARIO CHILD BENEFIT equivalent (OCBe): Through the implementation of OCBe funding, young people (in care) can receive access to recreational, educational, cultural, and social opportunities that support their achievement of higher educational outcomes, higher degree resiliency, social skills and relationship development, and a smoother transition to adulthood.

BG11A: Have any funds been accessed from the Ontario Child Benefit equivalent program? bgcq10

[1] Yes [0] No

BG11B: If yes, please describe:

bgcq10b

Looking After Children AAR-C2-2010 - Background information (16-17 yrs) D

Draft

2. INFORMATION ON THE CURRENT PLACEMENT SETTING.

BG12: Total number of children or youths **not in care** (aged 17 or younger) who usually live in this dwelling

[ ][ ] **Total number of children or youths not in care** bgfq53

BG13: Total number of children or youths **in care** besides young person who usually live in this dwelling.

[ ][ ] **Total number of children or youths in care besides young person** bgfq54

BG14: Total number of **siblings** of young person who usually live in this dwelling with him/her.

[ ][ ] **Total number of siblings** bgfq55

3. BACKGROUND INFORMATION ON THE YOUNG PERSON'S CHILD WELFARE WORKER

BG15: Child welfare worker's gender: bgwq19

[0] Male [1] Female

BG16: Total length of time child welfare worker has worked with this young person, not counting interruptions: bgwq21c

[1] Less than 1 year [2] 1-3 years [3] 4-9 years [4] 10 years and over

BG17: Total length of time child welfare worker has worked in child welfare: bgwq22c

[1] Less than 1 year [2] 1-3 years [3] 4-9 years [4] 10 years and over

BG18: The child welfare worker's team is: bgwq37

[1] A generic team (i.e., composed of mixed cases including intake, protection/ongoing, children-in-care, permanent wards, adoption, etc.)

[2] A specialized team (i.e., composed of one type of case, that is exclusively intake or protection/ongoing or children-in-care or permanent wards or adoption, etc.)

[3] A FNMI team

BG19: Has the child welfare worker received formal training in the Looking After Children (LAC) program? bgwq41

[1] Yes [0] No

BG20: HIGHEST LEVEL OF EDUCATION: Highest degree, certificate, or diploma the child welfare worker has ever attained in **any field**: bgwq31

[10] Less than a high school diploma

[9] High school diploma

[2] Trades certificate - Vocational school - Apprenticeship training

[3] Non-university certificate or diploma from a community college, CEGEP, school of nursing, etc.

[4] University certificate or diploma below bachelor level

[5] Bachelor degree

[6] University certificate or diploma above bachelor level

[7] Master's degree

[8] Doctoral degree

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BG21: FIELD OF HIGHEST LEVEL OF EDUCATION : What was the specific field of the child welfare worker's highest degree, certificate, or diploma (i.e., the one identified in BG20?) **(Mark one only.)**

bgwq32

- [1] Social work
- [2] Child & youth care
- [5] Native Studies
- [4] Other

BG22: LANGUAGE: Does the child welfare worker usually speak with the young person in his/her primary language?

bgwq40

- [1] Yes
- [0] No

BG23: In general, how often do you discuss information contained in the AAR with your supervisor (e.g., developing and/or reviewing plan of care)?

bgwq28a

- [4] Not applicable, this is my first AAR
- [2] Sometimes
- [1] Very often
- [3] Almost never

4. BACKGROUND INFORMATION ON THE YOUNG PERSON'S CAREGIVER (to be completed by the child welfare worker in conjunction with the caregiver, as needed.)

Note to the child welfare worker: *Here, the term* ***caregiver*** *refers to the person who is considered the most knowledgeable about the young person, usually because he/she is the caregiver most actively involved in the young person's care. He/she is to participate in the AAR conversation. (**If two or more** caregivers know the young person equally well and are equally involved in his/her care, they are asked to **nominate one person as the main respondent**.)*

BG24: Initials of first and last name of main respondent:

[ ] [ ] [ ] [ ]

bgfq61

BG25: Main respondent's gender:

bgfq63

- [0] Male
- [1] Female

BG26: If ... is in a **foster home**, for how many years in total have the caregivers been providing foster care to children or youths (i.e., including but not limited to ...)?

bgcq10c

- [1] Less than 1 year
- [2] 1-3 years
- [3] 4-9 years
- [4] 10 years and over

BG27: LANGUAGE: What language(s) are spoken most often in the caregiver's home? **(Mark all that apply.)**

bgfq43

- [a] English
- [b] French
- [c] First Nations or Inuit language
- [d] Other

BG28: RELIGION(S) / SPIRITUAL AFFILIATION(S): What, if any, is the caregiver's religion or spiritual affiliation(s)? **(Mark no more than two.)**

bgfq45

- [a] No religion or spiritual affiliation
- [b] Anglican
- [c] Baptist
- [d] Buddhist
- [e] Eastern Orthodox
- [f] FNMI (traditional)
- [u] FNMI (other)
- [m] Mormon
- [g] Hindu
- [h] Islam (Muslim)
- [i] Jehovah's Witness
- [j] Jewish
- [k] Lutheran
- [l] Mennonite
- [o] Pentecostal
- [p] Presbyterian
- [q] Roman Catholic
- [r] United Church
- [s] Sikh
- [t] Other

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BG29: The ethnic/cultural background of at least one caregiver and that of the young person is:

[1] The same [2] Similar [3] Neither the same nor similar idcq13

BG30: **HEALTH:** In general, the caregiver would say that his/her own health is:

[4] Excellent [3] Very good [2] Good [1] Fair [0] Poor bgfq47

BG31: **DISABILITY:** Because of a long-term physical or mental condition, or a health problem (lasting or expected to last 6 months or more), is the caregiver limited in the kind or amount of activity he/she can do at home, in caring for children, or in leisure activities?

[1] Yes [0] No bgfq48

BG32: **SMOKING:** At present, does anyone in the household smoke cigarettes inside the home?

[1] Daily [2] Occasionally [3] Not at all bgfq49

BG33 **CAREGIVER TRAINING:** Has the caregiver received any formal training in the Looking After Children (LAC) program?

[1] Yes [0] No bgfq72

BG34: Has the caregiver completed or is he/she currently attending one or more of the following caregiver training programs (**other than** Looking After Children)? **(Mark as many as apply.)** bgfq67

[a] PRIDE pre-service (Parenting Resources for Information, Development & Education program)

[c] Agency-specific program (i.e., PRIDE in-service)

[f] Foster parenting techniques (training offered by a CEGEP or college)

[d] Other program

The following two questions apply only to young people residing in group homes and are to be answered by the **CHILD WELFARE WORKER** with assistance, if needed, from the group home worker(s). **(If not a group home, go to question BG37)**

BG35: What is the model of the group home? bgfq70

[1] Parent model (i.e., presence of 1 or 2 main caregivers who define this dwelling as their own primary residence.)

[2] Staff model (i.e., presence of several caregivers who define other dwellings as their own primary residence.)

[3] Other

BG36: If the group home is based on the staff model, who is mainly responsible for the young person? bgfq71

[4] Not applicable [1] A team of group home workers [2] A key group home worker

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5. INFORMATION ON THE LAST ASSESSMENT (IF APPLICABLE) OF THIS YOUNG PERSON WITH THE ASSESSMENT AND ACTION RECORD (AAR).

BG37: Was the young person previously assessed with the AAR? bgfq56

[0] No **(IF NO, PLEASE GO SECTION 6 - question BG42)**

[1] Yes (If yes, the **child welfare worker** is to answer questions BG38 to BG41.)

BG38: Was the young person living in the same placement at the last AAR assessment as he/she is in this year? bgfq57

[1] Yes [0] No

BG39: Did the young person have the same child welfare worker at the last AAR assessment as he/she has this year? bgfq58

[1] Yes [0] No

BG40: Did the young person have the same caregiver at the last AAR assessment as he/she has this year? bgfq59

[1] Yes [0] No

BG41: Is it the same caregiver who was the main respondent at the last AAR assessment and this year's AAR assessment? bgfq60

[1] Yes [0] No

6. BACKGROUND INFORMATION RELATING TO THE YOUNG PERSON'S HEALTH

BG42: HEIGHT: How tall is ...? hlcq3

[3a] **Feet and** [3b] **Inches OR** [3c] **Metres and** [3d] **Centimetres**

BG43: WEIGHT: How much does ... weigh? hlcq4

[4a] **Pounds OR** [4b] **Kilograms**

BG44: FNMI YOUNG PEOPLE (If not an FNMI young person, go to question BG46): When did ... last see a Traditional Healer? hlcq6a

[1] Less than a year ago [2] More than a year ago [3] Never **(Go to question BG46)**

BG45: Has everything the Healer recommended been done? hlcq6b

[1] Yes [0] No [3] Uncertain [4] No recommendation(s)

BG46: MEDICAL EXAM: When did ... last have a medical exam? hlcq6

[1] Less than a year ago [2] More than a year ago [3] Never had one **(Go to question BG48)**

BG47: Has everything the doctor recommended been done? hlcq7

[1] Yes [0] No [3] Uncertain [4] No recommendation(s)

BG48: DENTAL EXAM: When did ... last visit the dentist? hlcq8

[1] Less than a year ago [2] More than a year ago [3] Never **(Go to question BG50)**

BG49: Have all treatments the dentist recommended been carried out? hlcq9

[1] Yes [0] No [3] Uncertain [4] No recommendation(s)

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BG50: Is ... taking any psychotropic and/or behaviour altering medication(s) prescribed by a physician (e.g., Ritalin, tranquilizers, anti-convulsants, etc.)? hlcq67

[1] Yes [0] No **(Go to question BG52)** [3] Uncertain

BG51: If ... is taking psychotropic and/or behaviour altering medication(s) prescribed by a physician, is this being monitored by an appropriate health care professional? hlcq68

[1] Yes [0] No [3] Uncertain

BG52: HOSPITALIZATIONS: In the past 12 months, was ... ever an overnight patient in the hospital? hlcq19

[1] Yes [0] No

BG53: IMMUNIZATIONS: Are all of ...'s immunizations up-to-date? hlcq21

[1] Yes [0] No

BG54: LONG-TERM CONDITIONS: In this question "long-term conditions" refer to conditions that have lasted or are expected to last 6 months or more and have been diagnosed by a health professional. Does ... have any of the following long-term conditions? **(Mark all that apply.)** hlcq10

- [o] None
- [a] Food or digestive allergies
- [b] Respiratory allergies such as hay fever
- [c] Any other allergies
- [d] Asthma
- [e] Bronchitis
- [f] Heart condition or disease
- [g] Epilepsy
- [r] Diabetes
- [q] Fetal alcohol spectrum disorder
- [h] Cerebral palsy
- [i] Kidney condition or disease
- [s] Blood disorder (i.e., Von Willebrand, hemophilia, etc.)
- [t] Developmental disability
- [k] Learning disability
- [l] Attention deficit disorder
- [m] Emotional, psychological, or nervous difficulties
- [n] Any other long-term condition

BG55: HEALTH SERVICES RECEIVED BY THE YOUNG PERSON DURING THE LAST 12 MONTHS:
For each of the service providers listed, please indicate whether ... has received services from such a provider during **the last 12 months.**

1. Family physician [1] Yes [0] No ds1a	**6. Dentist** [1] Yes [0] No ds7a	**11. Speech therapist** [1] Yes [0] No ds11a
2. Pediatrician [1] Yes [0] No ds2a	**7. Orthodontist** [1] Yes [0] No ds8a	**12. Physiotherapist** [1] Yes [0] No ds13a
3. Ophthalmologist [1] Yes [0] No ds3a	**8. FNMI Traditional Healer** [1] Yes [0] No ds34a	**13. Occupational therapist** [1] Yes [0] No ds14a
4. Other MD [1] Yes [0] No ds5a	**9. Optometrist** [1] Yes [0] No ds9a	**14. Nurse practitioner** [1] Yes [0] No ds37a
5. Nurse [1] Yes [0] No ds6a	**10. Audiologist** [1] Yes [0] No ds10a	**15. Other health service provider** [1] Yes [0] No ds38a

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7. BACKGROUND INFORMATION RELATING TO THE YOUNG PERSON'S EDUCATION

edcq1

BG56: TYPE OF SCHOOL: What type of school is ... (i.e., the young person in care) currently enrolled in? (Or, if this conversation takes place during the summer, what type of school was ... enrolled in during the last school year?)

- [4] Not currently in school **(Go to question BG58)**
- [1] Public school
- [2] Catholic school (publicly funded)
- [3] Private school
- [25] FNMI school
- [6] Taught in an institution (e.g., hospital, young offender facility, child welfare facility)
- [5] Taught at home (home schooling)
- [8] Post-secondary
- [7] Other

BG57: In what language is ... mainly taught? edcq4

[1] English [2] French [5] First Nations or Inuit language [4] Other

BG58: What is the highest grade that ... has completed? edcq100

- [1] Grade 8 (Secondaire II in QC)
- [2] Grade 9 (Secondaire III in QC)
- [3] Grade 10 (Secondaire IV in QC)
- [4] Grade 11 (Secondaire V in QC)
- [5] Grade 12 (Ontario Secondary School Diploma)
- [6] Grade 12 (Ontario Certificate of Accomplishment)
- [7] First year of post-secondary
- [8] Other

BG59: Has ... repeated a grade at school (including kindergarten)? edcq3

[1] Yes [0] No

BG60: CHANGES IN SCHOOLS: Other than the natural progression through the school system, how many times (if any) has ... changed schools since birth? edcq29

- [1] No changes in school (other than natural progression through the school system)
- [2] 1 or 2 changes
- [3] 3 or 4 changes
- [4] 5-7 changes
- [5] 8 or more changes

LEVEL OF DIFFICULTY: The next few questions concern levels of difficulty of different subjects that may be offered at the school currently or last attended by the young person in care. The terms used may not be the same as those used in your community. The **advanced/enriched** level includes courses targeting those with stronger abilities/performance in their grade and allows them to progress more rapidly. The **general** level includes courses targeting those with average abilities/performance and allows students to progress normally. The **basic** level includes courses targeting students with lower abilities/school performance and allows them to accomplish different educational or occupational plans. For each of the following subjects, please indicate the level at which the young person in care is enrolled (or was enrolled during the last year that he/she was enrolled in school):

BG61: Reading and other language arts (spelling, grammar, composition)? edcq90

[1] Advanced/Enriched [2] General [3] Basic [4] Does not take it

BG62: Mathematics? edcq81

[1] Advanced/Enriched [2] General [3] Basic [4] Does not take it

BG63: Science? edcq105

[1] Advanced/Enriched [2] General [3] Basic [4] Does not take it

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BG64: EDUCATIONAL AND RECREATIONAL SERVICES RECEIVED BY THE YOUNG PERSON DURING THE LAST 12 MONTHS: Has ... received services from the following providers in the last 12 months?

	Yes	No	
1. Teacher (regular class)	1	0	ds22a
2. Teacher (special education)	1	0	ds23a
3. Teacher's aide	1	0	ds24a
4. Educational tutor	1	0	ds25a
5. Other educational or recreational service provider	1	0	ds39a
6. Paid recreation/sports instructor or coach	1	0	ds28a
7. Volunteer (unpaid) recreation/sports instructor or coach	1	0	ds29a
8. Volunteer/paid driver	1	0	ds19a
9. Summer camp staff	1	0	ds27a
10. FNMI Traditional Elder or Cultural Teacher	1	0	ds35a
11. FNMI cultural recreational service provider	1	0	ds49a

8. BACKGROUND INFORMATION RELATING TO THE YOUNG PERSON'S FAMILY AND SOCIAL RELATIONSHIPS

BG65: How long has ... been living with his/her current caregiver? **(If less than one year indicate months.)**

2a ☐☐ **Years** 2b ☐☐ **Months (If less than one year.)** fscq2

BG66: Is there a permanency plan for ...? fscq133

1 Yes 3 Uncertain 0 No

BG67: The permanency plan for the young person is to: fscq161

1 Remain in current placement
2 Move to adoption
3 Move to kinship
4 Status change to legal custody
5 Move to customary care
6 Move to independent living
7 Move to adult services
8 Discharge from care
9 Other
10 Permanency plan is not yet determined

BG68: Is it the caregiver's intention to have this young person in the current placement into adulthood? fscq163

1 Yes 0 No 3 Uncertain

BG69: How many changes in main caregivers has ... experienced since birth? **(A main caregiver is a person who has acted in that capacity for one month or more. If care was shared by two or more people, select only one of these people as a main caregivers for that period.) Try to give an estimate of the number, even if you are not certain.**

☐☐ **Changes in main caregiver(s) (write in total number)** fscq5

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BG70: CHANGES IN PLACE OF RESIDENCE: How many times in ...'s life has he/she moved, that is, changed his/her **usual** place of residence? **(Write in the number of times.)**

[ ][ ] No. of times (00 = none; 01 = once; 02 = twice; etc.) edcq34

BG71: CONTACT WITH BIRTH FAMILY: What main type of contact does ... have with his/her birth family (i.e. birth mother, birth father, siblings he/she is not living with, extended birth family)? fscq162

[1] At least once a month
[2] Less than once a month
[3] Telephone or letter contact only
[4] No contact at all
[5] Crown ward, with no access
[6] Deceased

BG72: If ... is not living with all of his/her sibling(s), is ... receiving all necessary assistance to remain in contact with his/her sibling(s)? fscq135

[1] Yes [0] No [3] Not applicable

BG73: Is ... receiving all necessary assistance to remain in contact with his/her birth family? fscq10

[1] Yes [0] No [3] Not applicable

BG74: PREVIOUS CAREGIVERS: What main type of contact does ... have with his/her previous caregivers? fscq11

[1] At least once a month
[2] Less than once a month
[3] Telephone or letter contact only
[4] No contact at all
[7] Has not had any previous foster parents or other adult caregivers

BG75: Is ... receiving all necessary assistance to remain in contact with his/her previous supportive caregiver(s)? fscq113

[1] Yes [0] No [3] Not applicable

BG76: PLACEMENT SETTING(S) IN WHICH THE YOUNG PERSON HAS LIVED DURING THE LAST 12 MONTHS: Please indicate whether the young person has lived in one or more of the following placement settings during the last 12 months.

1. Foster care
[1] Yes [0] No rs31a

2. Group home
[1] Yes [0] No rs32a

3. Residential treatment
[1] Yes [0] No rs33a

4. Independent living
[1] Yes [0] No rs37a

5. Respite/relief home (young person leaves foster home)
[1] Yes [0] No rs38a

6. Hospital
[1] Yes [0] No rs34a

7. Custody/detention facility
[1] Yes [0] No rs36a

8. Kinship in care
[1] Yes [0] No rs41a

9. Customary care home
[1] Yes [0] No rs50a

10. Other residential placement setting
[1] Yes [0] No rs35a

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BG77: SERVICES RECEIVED BY THE YOUNG PERSON DURING THE LAST 12 MONTHS:
For each of the service providers listed please indicate whether ... has received services from such a provider in the **last 12 months**.

1. Child welfare worker [1] Yes [0] No ds16a ds20a

2. Social worker (not from child welfare agency) [1] Yes [0] No ds17a ds42a

3. Child & youth care worker [1] Yes [0] No ds36a ds57a

4. Lawyer [1] Yes [0] No ds15a ds43a

5. Police officer [1] Yes [0] No

6. Child access worker [1] Yes [0] No

7. Probation Officer [1] Yes [0] No

8. Adoption worker [1] Yes [0] No

9. FNMI Traditional Healer [1] Yes [0] No ds51a

10. FNMI Cultural Teacher [1] Yes [0] No ds52a

11. Volunteer Driver [1] Yes [0] No ds44a

12. Other child welfare service provider [1] Yes [0] No ds30a

9. BACKGROUND INFORMATION RELATING TO THE YOUNG PERSON'S EMOTIONAL AND BEHAVIOURAL DEVELOPMENT

BG78: MENTAL HEALTH SERVICES RECEIVED BY THE YOUNG PERSON DURING THE LAST 12 MONTHS: For each of the service providers listed please indicate whether ... has received services from such a provider during the **last 12 months**.

1. Psychiatrist [1] Yes [0] No ds4a

2.Other mental health service provider [1] Yes [0] No ds40a

3. Psychologist/counsellor [1] Yes [0] No ds12a

BG79: ADVERSITIES: Which of the following family-related adversities has ... experienced in the last year? **(Mark all that apply).** becq81

- [a] Death of his/her birth or step parent
- [b] Death of his/her brother or sister
- [c] Death of his/her relative or close friend
- [d] Divorce or separation of his/her birth or step parents
- [e] Serious physical illness of his/her birth or step mother
- [f] Serious physical illness of his/her birth or step father
- [g] Serious psychiatric disturbance of his/her birth or step mother
- [h] Serious psychiatric disturbance of his/her birth or step father
- [i] Abuse of drugs or alcohol by his/her birth or step mother
- [j] Abuse of drugs or alcohol by his/her birth or step father
- [k] Violence between his/her birth or step parents
- [s] His/her birth or step mother spent time in jail
- [l] His/her birth or step father spent time in jail
- [m] Severe poverty
- [n] Physical abuse
- [o] Sexual abuse
- [p] Emotional abuse
- [q] Neglect

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BG80: **ADVERSITIES:** Which of the following self-related adversities has ... experienced in the last year? **(Mark all that apply.)**

becq81

- [r] **A change in caregivers because of ...'s behaviour problems**
- [t] **Serious arguments with his/her birth or step parents**
- [v] **Skipping school (truancy)**
- [w] **Suspension from school (temporary or not)**
- [x] **Failed a grade and was held back**
- [z] **Was beaten up by school mates**
- [aa] **Changed schools for reasons other than planned progress through the school system**
- [bb] **Ran away from home multiple times**
- [cc] **Became pregnant**
- [dd] **Spent time in a detention centre**
- [y] **Received treatment for substance abuse**
- [ee] **Was hopitalized for depression**

Looking After Children AAR-C2-2010 - Health dimension (16-17 yrs) 1

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DEVELOPMENTAL DIMENSION 1: HEALTH

This dimension is about the health of the young person and the help he/she is getting to be and remain well. The questions in this section are designed to make sure that the young person is getting all necessary preventive medical care, including immunizations, that any health problems or disabilities are being properly treated, and that he/she is learning to keep in shape. This section also asks questions about things that affect the young person's health such as diet and safety issues.

Note to the child welfare worker: *Please use the right-hand page for each item on which you judge that further action needs to be taken during the coming year.* ***For each such item, note the action to be taken, the person responsible, and the target date, for inclusion in the updated individualized Plan of Care.***

During the AAR conversation, the **YOUNG PERSON** is to answer the following section with assistance, as needed.

H1: GENERAL HEALTH: In general, would you say your health is: hlcq1
[5] Excellent? [4] Very good? [3] Good? [2] Fair? [1] Poor?

H2: Do you have problems with any of the following activities? **(Mark all that apply.)** hlcq72
[a] Seeing [c] Speaking [e] Climbing [g] Using hands and fingers
[b] Hearing [d] Walking [f] Bending [i] No problems

H3: Are you receiving all the help and resources you require to treat the above health conditions/problems? hlcq73a
[3] None identified [1] Yes [0] No

Young people sometimes experience health problems that may or may not be related to stress and may affect other areas in their life. Your answers to the following questions will help build a picture of your general health.

During the past 6 months, how often have you had or felt the following?

H4: Headache hlcq64a
[0] Seldom/never [1] About once a month [2] About once a week [3] More than once a week [4] Most days

H5: Stomachache hlcq64b
[0] Seldom/never [1] About once a month [2] About once a week [3] More than once a week [4] Most days

H6: Backache hlcq64c
[0] Seldom/never [1] About once a month [2] About once a week [3] More than once a week [4] Most days

H7: Difficulties in getting to sleep hlcq64d
[0] Seldom/never [1] About once a month [2] About once a week [3] More than once a week [4] Most days

H8: PAIN AND DISCOMFORT: Are you usually free of pain or discomfort? huiq28
[1] Yes [0] No

H9: MEMORY: How would you describe your usual ability to remember things? **(Mark one only.)** huiq26
[3] Able to remember most things [1] Very forgetful
[2] Somewhat forgetful [0] Unable to remember anything at all

H10: THINKING: How would you describe your usual ability to think and solve day-to-day problems? **(Mark one only.)** huiq27
[4] Able to think clearly and solve problems [1] Having a great deal of difficulty
[3] Having a little difficulty [0] Unable to think or solve problems
[2] Having some difficulty

H11: CAR SAFETY: How often do you use a seat belt when you ride in a car? hlcq65
[4] Always [3] Often [2] Sometimes [1] Seldom or never [0] Usually there is no seatbelt where I sit

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Draft

H12: Are you aware of the laws pertaining to cellular phone usage while driving? hlcq90

[1] Yes [0] No

H13: BICYCLE SAFETY: How often do you wear a helmet when you ride your bicycle? hlcq66

[4] Always [3] Often [2] Sometimes [1] Seldom or never [0] I do not ride a bicycle

H14: Are you taking precautions to minimize your exposure to the sun (i.e., wearing sunblock)? hlcq100

[1] Yes [0] No

***Note to the young person*:** The following questions will help build a picture of your overall health.

H15: DISABILITY: Do you have any long-term conditions or health problems which prevent or limit your participation in school, at play, in sports, or in any other activity for a young person of your age? hlcq11

[1] Yes [0] No **(Go to question H17)**

H16: SPECIAL HELP OR EQUIPMENT: Do you have all the special help or equipment you may need for any long-term conditions or disabilities you may have? hlcq12

[1] Yes [0] No [3] No special help or equipment needed

H17: SERIOUS INJURIES: The following questions refer to injuries, such as a broken bone, bad cut or burn, head injury, poisoning, or a sprained ankle, which occurred in the past 12 months, and were serious enough to require medical attention by a doctor, nurse, or dentist. In the past 12 months were you injured? hlcq13

[1] Yes [0] No **(Go to question H19)**

H18: For the most serious injury, what type of injury did you have? **(Mark one only.)** hlcq15

[12] Not applicable - no serious injuries	[4] Sprain or strain	[9] Dental injury
[1] Broken or fractured bones	[11] Multiple injuries	[7] Poisoning by substance or liquid
[2] Burn or scald	[5] Cut, scrape, or bruise	[8] Internal injury
[3] Dislocation	[6] Concussion	[10] Other

H19: DIET: Do you have a special diet for health, weight-control, religious, or cultural reasons? hlcq22

[1] Yes [0] No

H20: DIETARY ASSISTANCE: Are you receiving all the help you require to maintain a healthy daily diet, whether special or not? hlcq23

[1] Yes [0] No

H21: BREAKFAST: During a school week (Monday to Friday), how many days do you normally eat breakfast? hlcq24

[0] Never [1] 1 or 2 days a week [2] Most school days

H22: WEIGHT: Would you say you are....: hlcq25

[4] Not trying to do anything about your weight? [1] Trying to lose weight?

[3] Trying to stay the same weight? [2] Trying to gain weight?

H23: MEDICATIONS: Are you taking any medication(s)? hlcq81a

[1] Yes [0] No **(Go to question H25)**

H24: Do you have all the information you need about the medication(s) and why you need to take it/them? hlcq81b

[1] Yes [0] No

H25: PUBERTY: Do you have any questions related to body changes (e.g., acne, menstruation, voice, hair growth)? hlcq37

[1] Yes [0] No

H26: Are you getting all the information you need with questions you may have related to body changes? hlcq38

[1] Yes [0] No

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H27: FNMI YOUNG PEOPLE: Are you getting guidance from a FNMI Traditional Elder or Cultural Teacher as you are entering into this new stage of life?

[1] Yes [0] No [3] Not Applicable — hlcq99

H28: SEXUALITY: Do you have any questions related to sexuality? (i.e., sexual relations, contraception, pregnancy, HIV, and other sexually transmitted diseases?)

[1] Yes [0] No [3] Not sure — hlcq39

H29: Are you receiving all the information you need with questions related to sexuality?

[1] Yes [0] No — hlcq40

H30: CIGARETTES: Do you smoke cigarettes (or use other tobacco products)?

[3] Not at all **(Go to question H32)** [2] Have tried it [1] Occasionally [0] Daily — hlcq26

H31: Are you getting all the help you need to quit smoking?

[1] Yes [0] No [4] I smoke but I do not want to quit — hlcq28

How many of your close friends do the following:

	None	A Few	Most	All	
H32: Smoke cigarettes?	[3]	[2]	[1]	[0]	hlcq27
H33: Drink alcohol?	[3]	[2]	[1]	[0]	hlcq30
H34: Break the law by stealing, hurting someone, or damaging property?	[3]	[2]	[1]	[0]	hlcq47
H35: Have tried marijuana?	[3]	[2]	[1]	[0]	hlcq48
H36: Have tried drugs other than marijuana?	[3]	[2]	[1]	[0]	hlcq49

H37: ALCOHOL: Which of the following best describes your experience with drinking alcohol **in the past 12 months?**

[0] Not at all **(Go to question H39)** [1] Have tried it [2] Occasionally [3] Daily — hlcq82a

H38: Are you getting all the help you need to quit drinking alcohol?

[1] Yes [0] No [4] I drink but I do not want to stop — hlcq31

H39: DRUGS: Have you ever used drugs?

[1] Yes **(Go to H40)** [0] No **(Go to H46)** — hlcq140

Questions regarding the young person's experiences with the following drugs are to be asked only if it pertains to this young person. ***Which of the following best describes your experience with the following drugs during the past 12 months:***

	Not at all	Tried it	Occasionally	Daily	
H40: Marijuana and cannabis products (also known as a joint, pot, grass, or hash):	[3]	[2]	[1]	[0]	hlcq83a
H41: Drugs like crack, cocaine, heroin, speed, or ecstacy, etc.:	[3]	[2]	[1]	[0]	hlcq83b
H42: Glue, gasoline, hair spray, or other solvents:	[3]	[2]	[1]	[0]	hlcq83c
H43: Drugs without a prescription or advice from a doctor (e.g., downers, uppers, tranquilizers, Ritalin, etc.):	[3]	[2]	[1]	[0]	hlcq83d
H44: Hallucinogens like LSD/acid, magic mushrooms:	[3]	[2]	[1]	[0]	hlcq83e

H45: Are you getting all the help you need to quit using drugs?

[1] Yes [0] No [4] I use drugs, but I do not want to quit — hlcq36

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During the AAR conversation, the **CHILD WELFARE WORKER** is to answer the following section based on the information obtained on the entire developmental dimension of health.

ATTAINMENT OF HEALTH OBJECTIVES OF THE CHILD WELFARE SYSTEM

H46: Objective 1: The young person is normally well.
(**Note:** "Unwell" here means ill enough to be in bed or take some time off school.)

- [3] Normally well (i.e., unwell for 1 week or less in the last 6 months)
- [2] Sometimes ill (i.e., unwell between 8 and 14 days in the last 6 months)
- [1] Often ill (i.e., unwell between 15 and 28 days in the last 6 months)
- [0] Frequently ill (i.e., unwell for more than 28 days in the last 6 months)

hlcq41

H47: Objective 2: The young person's weight is within normal limits for his/her height.

- [1] Within normal limits
- [2] Slightly underweight
- [4] Slightly overweight
- [3] Seriously underweight
- [5] Seriously overweight

hlcq42

H48: Objective 3: All necessary preventive health measures, including immunizations, are being taken.

[3] All [2] Most [1] A few [0] None

hlcq43

H49: Objective 4: All necessary attention, including support and monitoring of medication for the young person, is being provided.

- [3] Not on medication
- [1] Is receiving some attention
- [2] Is receiving appropriate attention
- [0] Needs attention

hlcq84a

H50: Objective 5: All ongoing health conditions and disabilities are being dealt with.

- [3] No health condition or disability
- [1] Some being adequately dealt with
- [2] All being adequately dealt with
- [0] Needs attention

hlcq44

H51: Objective 6: The young person does not put his/her health at risk.

[3] No risks taken [2] Some risks taken [1] Considerable risks taken [0] Health placed seriously at risk

hlcq45

Note to the child welfare worker: *If anyone disagrees with these answers to the Health objectives, please note the details on the right hand page.*

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DEVELOPMENTAL DIMENSION 2: EDUCATION

This dimension is about the young person's experiences at school. The questions in this section are designed to find out if the young person is getting the help he/she needs to make sure that he/she does as well at school as possible and that his/her education is being properly planned. The questions are also meant to find out if the young person has opportunities to learn special skills and to take part in a wide range of activities both in and out of school.

During the AAR conversation, the **CAREGIVER** is to answer the following section with assistance, as needed.

E1: GRADE: What grade is ... in? edcq2

- [23] Not currently enrolled in school
- [12] Grade 9 (Secondaire III in QC)
- [13] Grade 10 (Secondaire IV in QC)
- [14] Grade 11 (Secondaire V in QC)
- [15] Grade 12
- [17] Ungraded (i.e., special education)
- [24] Apprenticeship
- [25] College of Applied Arts and Techonolgy
- [26] CEGEP
- [20] Private career college
- [21] University
- [22] Other

E2: Does ... have possible learning-related difficulties? edcq172

[1] Yes [0] No

E3: LEARNING-RELATED DIFFICULTIES: Has ... been assessed for possible learning-related difficulties (e.g., attention-deficit and hyperactivity disorder [ADHD]; learning disability; unsatisfactory progress; fetal alcohol spectrum disorder)? edcq5

[1] Yes [0] No [3] He/she is currently on a waiting list for an assessment

E4: Has ... been identified by Identification Placement Review Committee (IPRC) as exceptional? edcq170

[1] Yes [0] No **(Go to question E6A)**

E5: If yes, check applicable area(s) of identification **(if MULTIPLE check all that apply)**: edcq32

[a] Behaviour [b] Communication [c] Intellectual [d] Physical

E6A: Does the young person have an Individual Education Plan (IEP)? edcq124

[1] Yes [0] No **(Go to question E7)**

E6B: Is the Individual Education Plan being satisfactorily implemented? edcq126

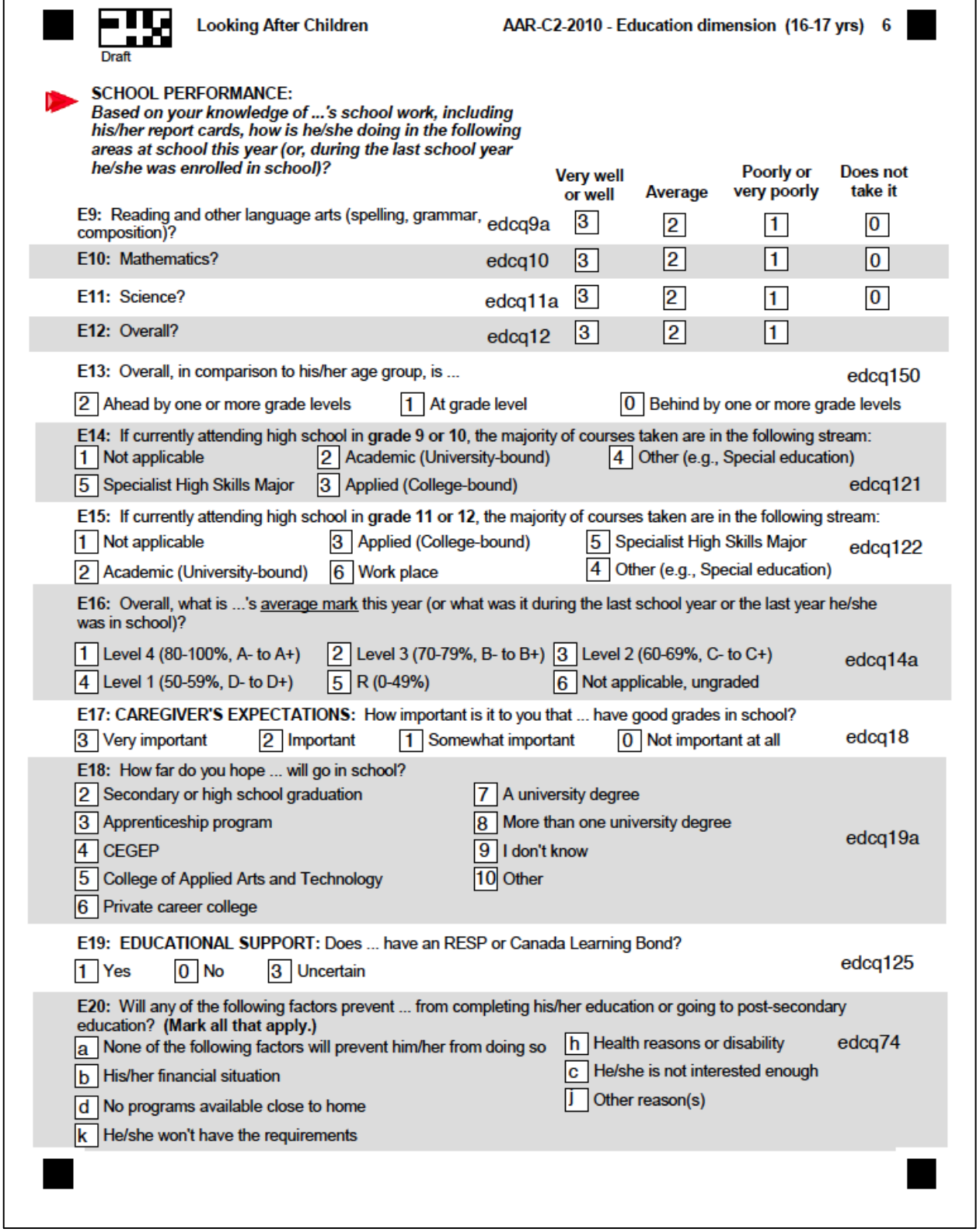
[1] Yes [0] No [3] Uncertain

E7: Does ... receive special/resource help at school because of a physical, emotional, behavioural, or some other learning-related difficulty that limits the kind or amount of school work he/she can do? edcq6

[1] Yes [0] No [4] On a waitlist [3] Not attending school

E8: TRANSPORTATION: Does ... have ready access to transportation (including any special equipment or assistive devices that may be needed) for getting to and from school? edcq8

[1] Yes [0] No [3] Not applicable



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SCHOOL PERFORMANCE:
Based on your knowledge of ...'s school work, including his/her report cards, how is he/she doing in the following areas at school this year (or, during the last school year he/she was enrolled in school)?

		Very well or well	Average	Poorly or very poorly	Does not take it
E9: Reading and other language arts (spelling, grammar, composition)?	edcq9a	3	2	1	0
E10: Mathematics?	edcq10	3	2	1	0
E11: Science?	edcq11a	3	2	1	0
E12: Overall?	edcq12	3	2	1	

E13: Overall, in comparison to his/her age group, is ... edcq150

2 Ahead by one or more grade levels 1 At grade level 0 Behind by one or more grade levels

E14: If currently attending high school in **grade 9 or 10**, the majority of courses taken are in the following stream:

1 Not applicable 2 Academic (University-bound) 4 Other (e.g., Special education)
5 Specialist High Skills Major 3 Applied (College-bound) edcq121

E15: If currently attending high school in **grade 11 or 12**, the majority of courses taken are in the following stream:

1 Not applicable 3 Applied (College-bound) 5 Specialist High Skills Major edcq122
2 Academic (University-bound) 6 Work place 4 Other (e.g., Special education)

E16: Overall, what is ...'s <u>average mark</u> this year (or what was it during the last school year or the last year he/she was in school)?

1 Level 4 (80-100%, A- to A+) 2 Level 3 (70-79%, B- to B+) 3 Level 2 (60-69%, C- to C+) edcq14a
4 Level 1 (50-59%, D- to D+) 5 R (0-49%) 6 Not applicable, ungraded

E17: CAREGIVER'S EXPECTATIONS: How important is it to you that ... have good grades in school?

3 Very important 2 Important 1 Somewhat important 0 Not important at all edcq18

E18: How far do you hope ... will go in school?

2 Secondary or high school graduation
3 Apprenticeship program
4 CEGEP
5 College of Applied Arts and Technology
6 Private career college
7 A university degree
8 More than one university degree
9 I don't know
10 Other
edcq19a

E19: EDUCATIONAL SUPPORT: Does ... have an RESP or Canada Learning Bond?

1 Yes 0 No 3 Uncertain edcq125

E20: Will any of the following factors prevent ... from completing his/her education or going to post-secondary education? **(Mark all that apply.)**

a None of the following factors will prevent him/her from doing so
b His/her financial situation
d No programs available close to home
k He/she won't have the requirements
h Health reasons or disability
c He/she is not interested enough
J Other reason(s)
edcq74

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E21: How often do you and ... talk about his or her plans for the future? edcq27

[3] Daily [2] One or more times a week [1] One or more times a month [0] Less than once a month or rarely

E22: ABSENCES FROM SCHOOL: How many days, if any, was ... absent from school during the last 12 months? edcq30

[1] 0 days
[2] 1-3 days
[3] 4-6 days
[4] 7-10 days
[5] 11-20 days
[6] More than 20 days
[7] Not in school during the last 12 months

E23: What were the **main reasons** for... being absent from school? **(Mark all that apply.)** edcq31

[a] Illness
[b] Appointments with doctor or dentist
[c] Appointments with mental health professional
[d] Meeting with social worker or child welfare worker
[e] Transportation issue
[f] Access visits
[g] Family vacation
[h] Completing AAR/plan of care
[x] Attending FNMI ceremonies
[i] Problem with the teacher
[j] Problem with weather
[k] Problem with children/youths at school
[l] Fear of school
[m] Supension
[o] Court appearance
[p] Other

E24: SUSPENSIONS FROM SCHOOL: During the last 12 months, how many times, if any, has ... been temporarily suspended from school? edcq32

[1] Never [2] Once or twice [3] 3 or 4 times [4] 5 times or more

During the AAR conversation, the **YOUNG PERSON** is to answer the following section with assistance, as needed.

Note to the young person: The following section is about your experience of school during the current year (or during the last year you were enrolled in school).

E25: SCHOOL: How do you feel about school? edcq35

[1] I like school very much
[2] I like school quite a bit
[3] I like school a bit
[4] I don't like school very much
[5] I hate school

E26: How well do you think you are doing in your school work? edcq103

[2] Well or very well [1] Average [0] Poorly or very poorly

	Yes	No	
E27: Do you have access to a computer at home?	1	0	edcq23
E28: Do you have access to the internet at home?	1	0	edcq24
E29: Do you understand the importance of internet safety?	1	0	edcq24a
E30: Does you have access to a cellular phone?	1	0	edcq24b
E31: Do you understand the importance of appropriate cellular phone use?	1	0	edcq25a

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LEVEL OF IMPORTANCE: *How important is it to you to do the following in school?*	Very important	Somewhat important	Not important	
E32: Make friends	2	1	0	edcq45a
E33: Get good grades	2	1	0	edcq40
E34: Participate in extra-curricular activities	2	1	0	edcq41
E35: Learn new things	2	1	0	edcq43
E36: Always show up for class on time	2	1	0	edcq42
E37: Express your opinion in class	2	1	0	edcq44
E38: Take part in student council or other similar groups	2	1	0	edcq45b
E39: Hand in assignments on time	2	1	0	edcq41a

E40: Have you started the volunteer hours required by the school curriculum? edcq123
1 Yes 0 No 3 Not required 4 Not applicable

E41: Have you received a high school diploma or its equivalent? edcq101
1 Yes 2 No, but I plan on doing so 3 No, and I do not plan on doing so

ACTIVITIES: *In the last 12 months, how often have you:*	4 or more times a week	1 to 3 times a week	Less than once a week	Never	
E42: Played sports or done physical activities without a coach or an instructor (e.g., biking, skate boarding, etc.)?	3	2	1	0	edcq46
E43: Played sports with a coach or instructor, other than for gym class (e.g., swimming lessons, baseball, hockey, etc.)?	3	2	1	0	edcq47
E44: Taken part in dance, gymnastics, karate, traditional dance, or other groups or lessons, other than in gym class?	3	2	1	0	edcq48
E45: Taken part in art, drama, or music groups (including traditional drumming), clubs or lessons, outside of class?	3	2	1	0	edcq49
E46: Taken part in clubs or groups such as Guides or Scouts, 4-H club, community, church, or other religious or cultural groups?	3	2	1	0	edcq50
E47: Done a hobby or craft (drawing, model building, traditional hunting, trapping, etc.)?	3	2	1	0	edcq51

SCHOOL SUBJECTS: *How do you like the following subjects:*	I like it a lot	I like it a little	I don't like it very much	I hate it	I don't take it	
E48: Math	4	3	2	1	0	edcq36
E49: English	4	3	2	1	0	edcq38
E50: French	4	3	2	1	0	edcq39
E51: Science	4	3	2	1	0	edcq37
E52: Gym/Phys. Ed.	4	3	2	1	0	edcq37a
E53: Arts (art, music, drama)	4	3	2	1	0	edcq106

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TEACHERS: ***The next statements are about teachers and homework during the current year at school (or during the last year that you were enrolled in school).***

	All the time	Most of the time	Some of the time	Rarely	Never	
E54: In general, how often do your teachers treat you fairly?	4	3	2	1	0	edcq52
E55: How often do your teachers provide extra help if you need it?	4	3	2	1	0	edcq53
E56: When your teachers give you homework, do you do it?	4	3	2	1	0	edcq54
E57: How often do your caregivers check your homework or provide help with homework?	4	3	2	1	0	edcq55

E58: How often do you talk to a teacher outside of class about class matters?

1 Daily — 4 A few times a month — 5 Less than once a month

2 A few times a week — 7 Once a month — 8 Rarely

3 Once a week

edcq110

E59: How often do you talk to a teacher outside of class about social matters?

1 Daily — 4 A few times a month — 5 Less than once a month

2 A few times a week — 7 Once a month — 8 Rarely

3 Once a week

edcq111

E60: SCHOOL PERFORMANCE: In the last 2 years, have you repeated a grade?

1 Yes — 0 No

edcq112

E61: In the last 2 years, have you failed a course at school? **(Mark all that apply)**

a No, I have not failed any courses in the last 2 years — d Yes, I failed French

b Yes, I failed Math — e Yes, I failed Science

c Yes, I failed English — f Yes, I failed another type of course

edcq113

E62: CAREGIVER'S ACADEMIC SUPPORT: How often were your caregivers ready to help you if you had problems at school?

2 All or most of the time — 1 Some of the time — 0 Rarely or never — 3 No problems at school

edcq57

E63: My caregivers encourage me to do well at school.

2 All or most of the time — 1 Some of the time — 0 Rarely or never

edcq58

E64: How often do you feel that your caregivers expect too much from you with regard to your performance at school?

0 All of the time — 2 Some of the time — 4 Never

1 Most of the time — 3 Rarely

edcq59

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E65: CHANGE IN SCHOOLS: For your most recent change in schools (even if it happened more than 2 years ago), what is/are the main reason(s) for changing? **(Mark all that apply.)**

- [a] Regular progression through school system
- [b] You wanted a specific program
- [c] You changed your place of residence (e.g., you or your foster family moved, etc.)
- [d] Your marks were too low or you were not progressing well in your previous school
- [e] You were not getting along with others in your previous school
- [f] Other

edcq116

E66: MY ASPIRATION: How far do you hope to go in school? I hope to complete:

- [2] Secondary or high school graduation
- [12] Apprenticeship program
- [11] CEGEP
- [10] College of Applied Arts and Technology
- [3] Private career college
- [5] A university degree
- [6] More than one university degree
- [8] I don't know
- [9] Other

edcq56a

FAIR TREATMENT: ***During the past 12 months have you personally been treated unfairly because of:***

	Yes	No	I don't know	
E67: Your sex/gender?	[1]	[0]	[3]	edcq117
E68: Your race, skin colour, or ethnic group?	[1]	[0]	[3]	edcq118
E69: Your religion?	[1]	[0]	[3]	edcq119
E70: Another reason?	[1]	[0]	[3]	edcq120

SCHOOL SAFETY:
For each of the following statements, choose the answer that best describes how you feel.

	Most or all of the time	Some of the time	Rarely or never	
E71: I feel safe at school.	[2]	[1]	[0]	edcq94
E72: I feel safe on my way to and from school.	[2]	[1]	[0]	edcq95
E73: Other young people say mean things to me at school.	[0]	[1]	[2]	edcq96
E74: I am bullied at school.	[0]	[1]	[2]	edcq97
E75: I feel my culture is respected at school.	[2]	[1]	[0]	edcq99
E76: I am bullied on my way to and from school.	[0]	[1]	[2]	edcq98

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During the AAR conversation, the **CHILD WELFARE WORKER** is to answer the following section based on the information obtained on the entire developmental dimension of education.

ATTAINMENT OF GENERAL EDUCATION OBJECTIVES OF THE CHILD WELFARE SYSTEM

E77: Objective 1: The young person's educational performance matches his/her ability. edcq61

[2] Performance matches ability [1] Performance somewhat below ability [0] Performance seriously below ability

E78: Objective 2: The young person is acquiring special skills and interests. edcq62

[3] Many [2] Some [1] Few [0] None

E79: Objective 3: Adequate attention is being given to planning the young person's education. edcq63

[2] Satisfactory planning [1] Some planning, but not enough [0] Little or no planning

Note to the child welfare worker: *If anyone disagrees with these answers to the Education objectives, please note the details on the opposite page.*

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DEVELOPMENTAL DIMENSION 3: IDENTITY

This dimension is about the identity of the young person. The questions in this section are designed to make sure that the young person knows something about his/her birth family and his/her culture, understands and accepts the reasons why he/she is in care, and is being helped to feel increasingly confident about himself/herself and about the way he/she makes decisions.

During the AAR conversation, the **YOUNG PERSON** is to answer this section with assistance, as needed. If you were **adopted** and have had no contact with your birth family since then, questions in this section apply to your adoptive family or your birth family.

ID1: Would you like to find out more about your birth family? idcq2

[1] Yes [3] Uncertain [0] No

ID2: BEING IN CARE: Would you like more information about why you are in care? idcq3

[1] Yes [3] Uncertain [0] No

ID3: Would you like any assistance dealing with questions about your birth family, where you live, or why you are in care? idcq4

[1] Yes [0] No [3] No assistance required

ID4: LIFE BOOK: Do you have a personal album, containing photographs and mementos about people and events that were important to you? idcq5

[1] Yes [0] No

ID5: RELIGION(S) / SPIRITUAL AFFILIATION(S): What, if any, is your religion or spiritual affiliation(s)? **(Mark no more than two.)** idcq6

[a] No religion	[f] FMNI (traditional)	[j] Jewish	[p] Presbyterian
[b] Anglican	[u] FNMI (other)	[k] Lutheran	[q] Roman Catholic
[c] Baptist	[g] Hindu	[l] Mennonite	[r] United Church
[d] Buddhist	[h] Islam (Muslim)	[m] Mormon	[s] Sikh
[e] Eastern Orthodox	[i] Jehovah's Witnesses	[o] Pentecostal	[t] Other

ID7: Do you have enough opportunities to practice your religion (including religious services, festivals and holidays, prayers, clothing, diet, fasting, traditional sweat lodge, pow wow, drumming,etc.)? idcq7

[3] No religious or spiritual affiliation [1] Yes [0] No

ID8: Other than on special occasions (such as weddings or funerals), how often did you voluntarily attend religious services or meetings in the past 12 months? idcq88

[1] About once a week [2] About once a month [3] 3 or 4 times [4] Once [5] Never

ID9: FIRST LANGUAGE: What is the language that you first learned at home in childhood and can still understand? (If you can no longer understand the first language learned, choose the second language learned.) **(Mark all that apply.)** idcq8

[a] English [b] French [o] First Nations or Inuit language [s] Other

ID10: Overall, do you have enough opportunities to speak your own first language (at home, at school, with friends, etc.)? idcq10

[1] Yes [0] No

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ID11: ETHNICITY: To which ethnic or cultural group(s) did your ancestors belong? (For example: French, British, Chinese) **(Mark all that apply.)** idcq11

[a] Canadian	[j] Italian	[s] Latin American
[b] French	[k] Jewish	[t] Portugese
[c] English	[l] Ukranian	[u] African (e.g., Somalian, South African)
[d] First Nations	[m] Dutch (Netherlands)	[z] Caribbean (e.g., Haitian, Jamaican)
[e] Inuit	[n] Chinese	[v] South Asian (e.g., East Indian, Pakistani, Punjabi, Sri Lankan)
[f] Métis	[o] Filipino	[w] South East Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese)
[g] German	[p] Japanese	[x] Arab/West Asian (e.g., Armenian, Egyptian, Lebanese, Moroccan)
[h] Irish	[q] Korean	[y] Other Specify: _____
[i] Scottish	[r] Polish	

ID12: Overall, do you have enough opportunities to meet people from your own ethnic or cultural background (including, for First Nations young people, people from your own band or community)? idcq12

[1] Yes [0] No

ID13: Overall, do you have enough opportunities to learn about traditions, customs, ceremonies, or events related to your ethnic or cultural background? idcq101

[1] Yes [9] No

ID14: Overall, do you have enough opportunities to participate in traditions, customs, ceremonies, or events related to your ethnic or cultural background? idcq13b

[1] Yes [0] No

NOTE TO THE CHILD WELFARE WORKER: *While it is essential for those who are providing child welfare services in ethnically diverse communities to consider the unique traditions and heritage of all cultures, the Child and Family Services Act emphasizes the importance of paying particular attention to the provision of services to FNMI young people.*

FNMI YOUNG PEOPLE : IF you are a *First Nations, Métis, or Inuit young person*, **THEN** please answer questions ID15 to ID21. **If not, go to question ID22.**

ID15: If your ancestors were members of a First Nation, to which band, community, or nation did they belong?

idcq83

ID16: Do you visit or meet with people from your own FNMI community? idcq84a

[2] Often [1] Sometimes [0] Rarely/Never

ID17: Do you learn about traditional teachings, customs, or ceremonies? idcq85a

[2] Often [1] Sometimes [0] Rarely/Never

ID18: Do you participate in your own FNMI community events, activities, traditional meals/foods, and ceremonies? idcq86a

[2] Often [1] Sometimes [0] Rarely/Never

ID19: How often do you speak your own First Nations or Inuit language? idcq100

[2] Often [1] Sometimes [0] Rarely/Never [4] Don't know my First Nations or Inuit language

ID20: Do you have a personal connection with an Elder, Healer, and/or Cultural Teacher? idcq87

[1] Yes [0] No

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ID21: Do you have a native Spirit Name?
[1] Yes [0] No [3] Not yet [4] Don't know — idcq90a

ABOUT ME:
For each of the following statements, choose the answer that best describes how you feel.

	Most of the time/Always	Sometimes	Rarely/Never	
ID22: I have a lot to be proud of.	2	1	0	idcq15
ID23: I can do things as well as most people.	2	1	0	idcq15a
ID24: I am as good as most other people.	2	1	0	idcq15b
ID25: Other people think I am a good person.	2	1	0	idcq15c
ID26: When I do something, I do it well.	2	1	0	idcq17
ID27: A lot of things about me are good.	2	1	0	idcq15d

QUESTIONS ABOUT YOUR GOALS: The six sentences below describe how young people think about themselves and how they do things in general. Read each sentence carefully. For each sentence, please think about how you are in most situations. Choose the answer that describes **YOU** the best. **There are no right or wrong answers.**

		Most of the time	Often	Sometimes	Never
ID28: I think I am doing pretty well.	idcq55	3	2	1	0
ID29: I can think of many ways to get the things in life that are most important to me.	idcq56	3	2	1	0
ID30: I am doing just as well as other kids my age.	idcq57	3	2	1	0
ID31: When I have a problem, I can come up with lots of ways to solve it.	idcq58	3	2	1	0
ID32: I think the things I have done in the past will help me in the future.	idcq59	3	2	1	0
ID33: Even when others want to quit, I know that I can find ways to solve the problem.	idcq60	3	2	1	0

HOW YOU DEAL WITH PROBLEMS: Sometimes young people have problems or feel upset about things. When this happens, they may do different things to solve the problem or to make themselves feel better. For each item, choose the answer that best describes how often you do this to solve your problems or make yourself feel better. **There are no right or wrong answers.** Just indicate how often **YOU** do each thing.

When I have a problem:		Most of the time	Often	Sometimes	Never
ID34: I do things to make my problem better.	idcq63	3	2	1	0
ID35: I think about different ways of solving my problem.	idcq74	3	2	1	0
ID36: I take action to improve the situation.	idcq68	3	2	1	0
ID37: I try to learn more about what is causing my problem.	idcq81	3	2	1	0

Note: This is meant to be a discussion with the young person. He/she has the coice as to whether or not he/she would like to disclose.
Now we're going to talk about sexual orientation and gender identity, which is part of who we are. Sexual orientation refers to gay, lesbian, bisexual, and heterosexual. Gender identity refers to whether you identify yourself as a boy, a girl, or both (including two-spirit for First Nations young people).

ID38: Do you have any questions or want further information about sexual orientation or gender identity?

[1] Yes [0] No idcq25

During the AAR conversation, the **CHILD WELFARE WORKER** is to answer the following section based on the information obtained on the entire developmental dimension of identity.

ATTAINMENT OF GENERAL IDENTITY OBJECTIVES OF THE CHILD WELFARE SYSTEM

ID39: Objective 1: The young person has knowledge of his/her family of origin.

[2] Clear knowledge [1] Some knowledge [0] Little or no knowledge idcq21

ID40: Objective 2: The young person identifies with and is proud of his/her racial or ethnic background.

[2] To a great extent [1] To some extent [0] To little or no extent idcq22

ID41: Objective 3: The young person has a good level of self-esteem.

[2] High self-esteem [1] Moderate self-esteem [0] Low self-esteem idcq23

ID42: Objective 4: The young person has a clear understanding of his/her current situation.

[2] Clear understanding [1] Some understanding [0] Little or no understanding idcq24

Note to the child welfare worker: *If anyone disagrees with these answers to the Identity objectives, please note the details on the opposite page.*

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DEVELOPMENTAL DIMENSION 4: FAMILY AND SOCIAL RELATIONSHIPS

This dimension is about the young person's relationship with friends, family, and others. The questions in this section are meant to find out if he/she has a close relationship with a parent or someone who acts as his/her parent, if he/she has a home where he/she is welcomed, and if he/she knows an adult who will help out if something goes wrong.

During the AAR conversation, the **CAREGIVER** is to answer the following section with assistance, as needed.

F1: What is the permanency plan for ...? **(Please specify.)**

fscq134

F2: CURRENT FRIENDSHIPS: About how many days a week does ... do things with friends outside of school hours?

[1] Never [2] 1 day a week [3] 2-3 days a week [4] 4-5 days a week [5] 6-7 days a week fscq12

SHARED ACTIVITIES: ***How often do you do the following activities with the young person?***

	Every day	3-6 days per week	1-2 days per week	1-2 times per month	Rarely or never	
F3: How often do you eat together?	[4]	[3]	[2]	[1]	[0]	fscq49
F4: How often do you have a discussion together?	[4]	[3]	[2]	[1]	[0]	fscq53
F5: How often do you have a family outing/ entertainment together?	[4]	[3]	[2]	[1]	[0]	fscq55
F6: How often do you participate in activities, ceremonies, practices, etc. that are culturally relevant to the young person?	[4]	[3]	[2]	[1]	[0]	fscq121

	Always	Often	Sometimes	Almost never	Never	
F7: You let ... know when he/she is doing a good job with something.	[4]	[3]	[2]	[1]	[0]	fscq75a
F8: You warn ... that you will discipline him/her and then do not actually discipline him/her.	[4]	[3]	[2]	[1]	[0]	fscq75b
F9: ... fails to leave a note or to let you know where he/she is going.	[4]	[3]	[2]	[1]	[0]	fscq75c
F10: ... talks you out of being disciplined after he/she has done something wrong.	[4]	[3]	[2]	[1]	[0]	fscq75d
F11: ... stays out in the evening past the time he/she is supposed to be home.	[4]	[3]	[2]	[1]	[0]	fscq75e
F12: You compliment ... when he/she does something well.	[4]	[3]	[2]	[1]	[0]	fscq75f
F13: You praise ... if he/she behaves well.	[4]	[3]	[2]	[1]	[0]	fscq75g
F14: ... is out with friends you don't know.	[4]	[3]	[2]	[1]	[0]	fscq75h
F15: You let ... out of a discipline consequence early (like lift restrictions earlier than you originally said).	[4]	[3]	[2]	[1]	[0]	fscq75i

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During the AAR conversation, the **YOUNG PERSON** is to answer the following sections with assistance, as needed.

Note to the young person: This section is about your relationships with friends, family, and others. The questions ask about your relationship with your caregiver(s), your contacts with members of your birth family, your ability to get along well with adults and other young people, and whether you have any close friends.

The next few questions have to do with friends. *Would you say:*

F16: I have many friends.

[2] True or mostly true [1] Sometimes true/Sometimes false [0] False or mostly false fscq61

F17: I get along easily with others my age.

[2] True or mostly true [1] Sometimes true/Sometimes false [0] False or mostly false fscq62

In this next section, by "close friends", we mean the people that you trust and confide in. They are friends that you see or hang out with at school or outside of school.

F18: How many close friends do you have?

fscq [120] Number of close friends [1] None fscq13

F19: Other than your close friends, do you have anyone else in particular you can talk to about yourself or your problems?

[1] Yes **(Go to question F20)** [0] No **(Go to question F21)** fscq68

F20: If you have someone else or other people you can talk to, what is their relationship to you? **(Mark every person that you feel you can talk to about yourself or your problems.)** fscq69

[a] Foster mother	[r] Elder	[i] Birth parent's partner
[b] Foster father	[s] Cultural Teacher	[k] Teacher
[c] Birth mother	[t] Healer	[m] Child welfare worker
[d] Birth father	[u] First Nation, Métis, or Inuit community member	[n] Sitter or baby sitter
[e] Brother	[q] Foster sibling(s)	[o] Other (e.g., family doctor, etc.)
[f] Sister	[j] A friend of the family or a friend's parent	
[g] Grandparents	[p] Boyfriend or girlfriend	
[h] Other relative	[l] Coach or leader (e.g., Scout, Guide, or religious leader)	

F21: If you don't have anyone like this, would you like to be put in touch with someone who could give you support when you need it?

[1] Yes [3] Not sure [0] No fscq70

Thinking of your caregiver(s):

Caregiver 1 Gender: [0] Male [1] Female fscq164

	A great deal	Some	Very little	
F22: How well do you feel he/she understands you?	[2]	[1]	[0]	fscq166
F23: How much fairness do you receive from him/her?	[2]	[1]	[0]	fscq167
F24: How much affection do you receive from him/her?	[2]	[1]	[0]	fscq168

F25: Overall, how would you describe your relationship with him/her?

[2] Very close [1] Somewhat close [0] Not very close fscq169

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Caregiver 2 Gender: [0] Male [1] Female fscq165

	A great deal	Some	Very little	
F26: How well do you feel he/she understands you?	[2]	[1]	[0]	fscq170
F27: How much fairness do you receive from him/her?	[2]	[1]	[0]	fscq171
F28: How much affection do you receive from him/her?	[2]	[1]	[0]	fscq172

E29: Overall, how would you describe your relationship with him/her?
[2] Very close [1] Somewhat close [0] Not very close fscq173

F30: How well do you feel your caregivers support your cultural needs.
[2] A great deal [1] Some [0] Very little fscq175

F31: How often do your caregivers participate in your cultural ceremonies, traditions, and events?
[2] Very often [1] Sometimes [0] Never [3] Not applicable fscq176

	Always	Often	Sometimes	Almost never	Never	
F32: Your caregiver tells you that you are doing a good job.	[4]	[3]	[2]	[1]	[0]	fscq76a
F33: Your caregiver warns you that he/she will discipline you and then does not do it.	[4]	[3]	[2]	[1]	[0]	fscq76b
F34: You fail to leave a note or let your caregiver know where you are going.	[4]	[3]	[2]	[1]	[0]	fscq76c
F35: You talk your caregiver out of disciplining you after you have done something wrong.	[4]	[3]	[2]	[1]	[0]	fscq76d
F36: You stay out in the evening past the time you are supposed to be home.	[4]	[3]	[2]	[1]	[0]	fscq76e
F37: Your caregiver compliments you when you have done something well.	[4]	[3]	[2]	[1]	[0]	fscq76f
F38: Your caregiver praises you for behaving well.	[4]	[3]	[2]	[1]	[0]	fscq76g
F39: Your caregiver does not know the friends you are with.	[4]	[3]	[2]	[1]	[0]	fscq76h
F40: Your caregiver lets you out of a discipline consequence early (like lift restrictions earlier than he/she originally said).	[4]	[3]	[2]	[1]	[0]	fscq76i

CURRENT PLACEMENT: The next few questions have to do with your current living situation.

Would you say that:	A great deal	Some	Very little	
F41: You like living here?	[2]	[1]	[0]	fscq84
F42: You feel safe living in this home?	[2]	[1]	[0]	fscq85
F43: You would be pleased if you were to live here for a long time?	[2]	[1]	[0]	fscq88
F44: You are satisfied with the amount of privacy you have here?	[2]	[1]	[0]	fscq89
F45: You have a good relationship with other people with whom you are living?	[2]	[1]	[0]	fscq91
F46: Overall, you are satisfied with your current living situation here?	[2]	[1]	[0]	fscq93

F47: What improvements, if any, in your current living situation would you like to see happen in the coming year?
Specify:

fscq93a

During the AAR conversation, the **CHILD WELFARE WORKER** is to complete the following section based on the information obtained on the entire developmental dimension of family and social relationships.

ATTAINMENT OF GENERAL SOCIAL AND FAMILY RELATIONSHIP OBJECTIVES OF THE CHILD WELFARE SYSTEM:

F48: Objective 1: The young person has had continuity of care.
[2] Much continuity of care (i.e., no change of placement in the last 12 months)
[1] Some disruptions (i.e., one change of placement in the last 12 months)
[0] Serious disruptions (i.e., two or more changes of placement in the last 12 months)
fscq94

F49: Objective 2: The young person is definitely attached to at least one caregiver.
[2] Definitely attached [1] Some attachment [0] Little or no attachment
fscq95

F50: Objective 3: The young person's contact with his/her birth family strengthens his/her relationship with them.
[2] Most contacts are helpful [1] Most contacts are unhelpful [0] No contacts
fscq96

F51: Objective 4: The young person has a strong sense of belonging in his/her cultural identity through his/her family and social relationships..
[2] A great deal [1] Some [0] Very little
fscq102

F52: Objective 5: The young person has had a stable relationship with at least one adult over a number of years.
[3] Stable relationship throughout life
[2] Fairly long-term relationship (i.e., more than 3 years)
[1] Short-term relationship (i.e., 1-3 years)
[0] No stable relationship
fscq97

F53: Objective 6: The young person has a relationship with a person who is prepared to help him/her in times of need.
[2] A good relationship with someone he/she can call on regularly
[1] A fairly good relationship with someone he/she can call on in times of crisis
[0] No support of this kind
fscq98a

F54: Objective 7: The young person is able to make friendships with others of the same age.
[3] Several friends [2] Some friends [1] Few friends [0] No friends
fscq99

F55: Objective 8: All feasible action is being taken to create or maintain a permanent placement for him/her.
[1] Yes [0] No
fscq101

Note to the child welfare worker: *If anyone disagrees with these answers to the Family and Social Relationships objectives, please note the details on the opposite page.*

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DEVELOPMENTAL DIMENSION 5: SOCIAL PRESENTATION

This dimension is about making sure that the young person is being helped to understand what sort of impression he/she makes on other people and how he/she needs to adapt to different situations.

During the AAR conversation, the **CAREGIVER** is to answer the following section with assistance, as needed.

	Always	Often	Sometimes	Never/rarely	
P1: Does ... keep himself/herself clean (i.e., body, hair, teeth)?	3	2	1	0	spcq1
P2: Does ... take adequate care of his/her skin?	3	2	1	0	spcq2
P3: Overall, does ...'s personal appearance give people the impression that he/she takes care of himself/herself properly?	3	2	1	0	spcq3
P4: Does ... wear suitable clothes (e.g., at school, home, or parties, etc.)?	3	2	1	0	spcq4
P5: Can people understand what he/she is saying?	3	2	1	0	spcq5
P6: Is ... polite with friends and adults?	3	2	1	0	spcq14

During the AAR conversation, the **YOUNG PERSON** is to answer the following section.

	True	Mostly true	Sometimes true/ sometimes false	Mostly false	False	
P7: I like the way I look:	4	3	2	1	0	spcq20
P8: I like the way I dress:	4	3	2	1	0	spcq21

During the AAR conversation, the **CHILD WELFARE WORKER** is to answer the following section based on the information obtained on the entire developmental dimension of social presentation.

ATTAINMENT OF SOCIAL PRESENTATION OBJECTIVES OF THE CHILD WELFARE SYSTEM:

P9: Objective 1: The young person's appearance is acceptable to young people and adults. spcq11

3 Usually acceptable to young people and adults
1 Usually acceptable to adults only
2 Usually acceptable to young people only
0 Usually not acceptable to either young people or adults

P10: Objective 2: The young person's manners are acceptable to young people and adults. spcq12

3 Usually acceptable to young people and adults
1 Usually acceptable to adults only
2 Usually acceptable to young people only
0 Usually not acceptable to either young people or adults

P11: Objective 3: The young person can communicate easily with others. spcq13

3 Very easily 2 Easily 1 With some difficulty 0 With great difficulty

P12: Objective 4: The young person has a positive physical self-image. spcq60

2 Good physical self-image 1 Fair physical self-image 0 Poor physical self-image

Note to the child welfare worker: *If anyone disagrees with these answers to the Social Presentation objectives, please note the details on the opposite page.*

DEVELOPMENTAL DIMENSION 6: EMOTIONAL AND BEHAVIOURAL DEVELOPMENT

This dimension is designed to assess how the young person in care has been feeling and how this may have affected the way he/she behaves.

During the AAR conversation, the **YOUNG PERSON** is to answer the following section with assistance, as needed.

During the past MONTH, how often did you feel:		Every day	Almost every day	2 or 3 times a week	About once a week	Once or twice a month	Never
B1: happy	becq150	5	4	3	2	1	0
B2: interested in life	becq151	5	4	3	2	1	0
B3: satisfied	becq152	5	4	3	2	1	0
B4: that you had something important to contribute to society	becq153	5	4	3	2	1	0
B5: that you belonged to a community (like a social group, your school, or your neighbourhood)	becq154	5	4	3	2	1	0
B6: that our society is becoming a better place for people like you	becq155	5	4	3	2	1	0
B7: that people are basically good	becq156	5	4	3	2	1	0
B8: that the way our society works made sense to you	becq157	5	4	3	2	1	0
B9: that you liked most parts of your personality	becq158	5	4	3	2	1	0
B10: good at managing the responsiblities of your daily life	becq159	5	4	3	2	1	0
B11: that you had warm and trusting relationships with other children/youth	becq160	5	4	3	2	1	0
B12: that you had experiences that challenged you to grow and become a better person	becq161	5	4	3	2	1	0
B13: confident to think or express your own ideas and opinions	becq162	5	4	3	2	1	0
B14: that your life has a sense of direction or meaning to it	becq163	5	4	3	2	1	0

Now, we have a few questions to ask **you** (i.e., the **YOUNG PERSON**) about suicide. Some of them might be hard for you to answer, but please answer them as well as you can. If you feel you need support, please talk to your caregiver, your child welfare worker, your family doctor, your FNMI Traditional Healer, an Elder, or Cultural Teacher.

B15: Has anyone in your school or someone else you know ever committed suicide? becq98

1 Yes, within the last year 2 Yes, more than a year ago 3 No, never 4 I don't know

B16: During the past 12 months have you ever attempted to hurt yourself? becq97

1 Yes 0 No

B17: During the past 12 months, did you seriously consider attempting suicide? becq46

1 Yes 0 No

B18: If you attempted suicide during the past 12 months, did you have to be treated by a doctor, nurse, or other health professional (for a physical injury or counseling)? becq48

3 I did not attempt suicide within the past 12 months 1 Yes 0 No


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During the AAR conversation, the **CAREGIVER** is to answer the following section.

B19: STRENGTHS AND DIFFICULTIES QUESTIONNAIRE: For each item, please mark the box for Not True, Somewhat True or True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of this young person's behaviour over the last six months or this school year.

	True	Somewhat true	Not True	
1. Considerate of other people's feelings.	2	1	0	sdq1
2. Restless, overactive, cannot stay still for long.	2	1	0	sdq2
3. Often complains of headaches, stomachaches, or sickness.	2	1	0	sdq3
4. Shares readily with other youth, for example books, games, food.	2	1	0	sdq4
5. Often loses temper.	2	1	0	sdq5
6. Would rather be alone than with other youth.	2	1	0	sdq6
7. Generally well behaved, usually does what adults request.	0	1	2	sdq7
8. Many worries or often seems worried.	2	1	0	sdq8
9. Helpful if someone is hurt, upset, or feeling ill.	2	1	0	sdq9
10. Constantly fidgeting or squirming.	2	1	0	sdq10
11. Has at least one good friend.	0	1	2	sdq11
12. Often fights with other youth or bullies them.	2	1	0	sdq12
13. Often unhappy, depressed, or tearful.	2	1	0	sdq13
14. Generally liked by other youth.	0	1	2	sdq14
15. Easily distracted, concentration wanders.	2	1	0	sdq15
16. Nervous in new situations, easily loses confidence.	2	1	0	sdq16
17. Kind to younger children.	2	1	0	sdq17
18. Often lies or cheats.	2	1	0	sdq18
19. Picked on or bullied by other youth.	2	1	0	sdq19
20. Often offers to help others (parents, teachers, youth).	2	1	0	sdq20
21. Thinks things out before acting.	0	1	2	sdq21
22. Steals from home, school, or elsewhere.	2	1	0	sdq22
23. Gets along better with adults than with other youth.	2	1	0	sdq23
24. Many fears, easily scared.	2	1	0	sdq24
25. Good attention span, sees work through to the end.	0	1	2	sdq25


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During the AAR conversation, the **YOUNG PERSON** is to answer the following section with assistance, as needed.

B20: ADVERSE LIFE EXPERIENCES: Would you like to discuss any events or situations that caused you, or continue to cause you, a great amount of worry or unhappiness? **Specify:**

negexp

B21: POSITIVE LIFE EXPERIENCES: Which of the following positive experiences have you had during the last year? **(Mark as many as apply.)**

becq99

- [a] I have caregivers who care about me.
- [b] I have had someone in my life who really listens to me.
- [c] I have had enough stability in my living arrangements.
- [d] I have been included in my caregivers' family activities and outings.
- [e] I have enjoyed the fact that my caregivers have spent time with me.
- [f] I have felt trusted by my caregivers.
- [g] I have had a strong relationship with a supportive adult other than my caregiver.
- [h] I have had a say in things that affect my life.
- [i] I have had a comforting sense of routine in my life (for example, supper time, bed time, etc.).
- [j] I have made new friends at school or elsewhere.
- [k] I have kept in touch with friends who live elsewhere.
- [l] I have had good contact with my birth mother (if applicable).
- [n] I have had good contact with my birth father (if applicable).
- [p] I have had good contact with my birth sibling(s) (if applicable).
- [q] I have enjoyed participating in a school or community club, or sports team.
- [r] I have gone to a fun summer or weekend camp.
- [s] I have gone on a trip.
- [t] I have received a medal, trophy, or certificate (for example, sports, music, scouts, guides, etc.).
- [u] I have had good grades in school.
- [v] I have enjoyed school.
- [w] I have had good teachers at school.
- [x] I have learned a new skill (for example, guitar, hobby, language, etc.).
- [y] I have enjoyed participating in cultural ceremonies, activities, or other cultural events.

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B22: POSITIVE LIFE EXPERIENCES: What are the most positive life experiences you have had during the last 12 months? **Specify:**

posexp

During the AAR conversation, the **CHILD WELFARE WORKER** is to answer the following section based on the information obtained on the entire developmental dimension of emotional and behavioural development.

ATTAINMENT OF EMOTIONAL AND BEHAVIOURAL DEVELOPMENT OBJECTIVES OF CHILD WELFARE SYSTEM:

B23: Objective 1: The young person displays behaviours appropriate to his/her age in a range of situations.

[3] Always [1] Sometimes

[2] Most of the time [0] Infrequently

becq83

B24: Objective 2: The young person displays emotional reactions appropriate for his/her age in a range of situations.

[3] Always [1] Sometimes

[2] Most of the time [0] Infrequently

becq84

B25: Objective 3: The young person is free of serious emotional and behavioural problems.

[3] No problems [1] Problems exist that need remedial action

[2] Minor problems [0] Serious problems exist which need specialized assistance

becq79

B26: Objective 4: The young person is receiving effective treatment for all persistent problems.

[3] Does not need treatment [1] Is receiving some treatment

[2] Is receiving effective treatment [0] Is not receiving effective treatment

becq80

Note to the child welfare worker: *If anyone disagrees with these answers to the Emotional and Behavioural objectives, please note the details on the opposite page.*

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DEVELOPMENTAL DIMENSION 7: SELF-CARE SKILLS & TRANSITION TO YOUNG ADULTHOOD

The questions in this dimension are designed to find out whether the young person is learning to care for himself/herself at a level appropriate to his/her age, whether s/he is gaining the experience of volunteer or paid work, and whether s/he is getting prepared to make the transition to young adulthood.

This section is to be answered by the **YOUNG PERSON** with assistance, as needed.

LIFE SKILLS:

Do you know how to:	Yes	No	Not Applicable	
S1: Research information?	1	0	3	sccq81
S2: Give a presentation?	1	0	3	sccq82
S3: Meet project deadlines?	1	0	3	sccq83
S4: Work with other people on projects?	1	0	3	sccq84
S5: Lead others in a project or task?	1	0	3	sccq85
S6: Write a report, essay, or business letter?	1	0	3	sccq86
S7: Talk with people you don't know at all?	1	0	3	sccq87
S8: Help others with their concerns or problems?	1	0	3	sccq88
S9: Search for a suitable apartment?	1	0	3	sccq91
S10: Negotiate a lease for an apartment?	1	0	3	sccq92
S11: Apply for a passport, expired health card, social insurance card, birth certificate, etc.?	1	0	3	sccq93
S12: Apply for post-secondary education/training (i.e., college, university, trade school)?	1	0	3	sccq94
S13: Prepare a meal?	1	0	3	scc100v
S14: Use the vacuum cleaner?	1	0	3	scc100i
S15: Use the washer and the dryer?	1	0	3	scc100j
S16: Manage your time (i.e., get up on time, be ready for school/work, etc.)?	1	0	3	scc100f
S17: Undertake simple first aid?	1	0	3	scc100k
S18: Utilize public transportation?	1	0	3	scc100s

Do you have:	Yes	No	
S19: A valid driver's license?	1	0	sccq95
S20: A valid health card?	1	0	sccq96
S21: A valid social insurance card?	1	0	sccq97
S22: A valid birth certificate?	1	0	sccq98
S23: A valid passport?	1	0	sccq102

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FINANCIAL LITERACY: At age 18, young people are eligible to access savings from the Ontario Child Benefit equivalent savings program. In order to access these fungs, young people must demonstrate certain financial literacy competencies.

Do you:

	Yes	No	Not Applicable	
S24: Save money for things you want to buy?	1	0	3	scc100n
S25: Use a bank machine?	1	0	3	scc100q
S26: Use a bank account?	1	0	3	scc100r
S27: Know how to write a resumé or a summary of your job qualifications?	1	0	3	sccq35
S28: Know how to prepare yourself for a job interview?	1	0	3	sccq36
S29: Know how to find out what kinds of jobs are available for people your age?	1	0	3	sccq89
S30: Know how to find information on different types of jobs you may be interested in when you have completed your post-secondary education?	1	0	3	sccq90
S31: Know how to prepare a budget?	1	0	3	sccq37
S32: Know how to keep track of what you earn and spend in a month?	1	0	3	scc100z
S33: Know about the requirement to file a tax return?	1	0	3	sccq38
S34: Understand interest paid on credit cards, loans, and other debts?	1	0	3	sccq39
S35: Know about different types of investments (i.e., RRSP, GIC, mutual fund, Canada Savings Bond, etc.)?	1	0	3	sccq40
S36: Know how to access various funds available to you (i.e., RESP, OCBe, OSAP, Victim's Compensation, etc.)?	1	0	3	sccq41
S37: Understand terms of contracts, including fine print (i.e., cellular phone, internet, cable, rental agreements, etc.)?	1	0	3	sccq42

S38: Have you developed a budget based on your monthly income and monthly expenses?

1 Yes 0 No 3 Not Applicable sccq43

COMMUNITY INVOLVEMENT: The following questions ask about your community involvement.
In the past 12 months, have you volunteered or helped without pay (excluding chores around the house) by:

	Yes	No	
S39: Supporting a cause (such as a food bank, environmental group, political group, etc.)?	1	0	sccq55
S40: Fundraising (for example, for a charity)?	1	0	sccq56
S41: Helping in your community (for example, hospital volunteering, work in a community organization, or coaching)?	1	0	sccq57
S42: Helping neighbours or relatives (for example, cutting grass, babysitting, or shovelling snow)?	1	0	sccq58
S43: Doing another volunteer activity?	1	0	sccq59

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S44: During the past 12 months, how often have you volunteered or helped without pay?

[1] Everyday [4] A few times a month [6] Less than once a month

[2] A few times a week [5] Once a month [7] Never

[3] Once a week

sccq60

EMPLOYMENT: The next questions are about jobs or employment. These questions are about all types of work, paid or unpaid, full-time or part-time.

S45: Did you work at a job or business for pay at any time in the past 12 months (for example, at a store or a restaurant)?

[1] Yes [0] No

sccq61

S46: Did you do any odd jobs (or jobs on the side) for pay (for example, babysitting, mowing a neighbour's lawn, or delivering flyers)?

[1] Yes [0] No

sccq62

S47: Did you do any work as part of a co-op program or work placement organized by your school in the past 12 months?

[1] Yes [0] No

sccq63

S48: How many weeks did you work in the past 12 months?

[ ][ ] **No. of total weeks**

sccq64

Thinking about all of the jobs you have had during the last 12 months, how many hours did you usually work per week?

S49: When you were in school:

[ ][ ] **Hours per week**

sccq65

S50: When you were not in school (for example, during the summer):

[ ][ ] **Hours per week**

sccq66

S51: Do you have a job at the present time?

[1] Yes [0] No

sccq67

S52: If you have a job at present, how many hours a week do you usually work?

sccq69 [ ][ ] **Hours per week** [1] I do not have a job at the present time

sccq70

S53: If you have a job at the present time, does working cause you to do less school work than you would like?

[5] Not applicable - I do not have a job at present, or I am not in school [2] Yes, somewhat less

[1] Yes, a great deal less [3] No, not at all less

sccq76

Draft

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S54: Considering all aspects of the paid or unpaid jobs you have had in the **last 12 MONTHS**, would you say you were: sccq68

- [4] Very satisfied?
- [3] Satisfied?
- [2] Dissatisfied?
- [1] Very dissatisfied?
- [0] Not applicable - I haven't had any paid or unpaid jobs in the past 12 months

S55: Have you done any of the following things to find out about future careers or work? **(Mark all that apply.)** edcq71

- [a] Talked to a guidance counsellor at school?
- [b] Talked to someone working in a job you might like?
- [k] Talked to a FNMI Elder or Cultural Teacher or other Community member?
- [c] Completed a questionnaire to find out about your interests and abilities?
- [d] Read information about different types of work or careers?
- [e] Attended an organized visit to a workplace?
- [f] Taken a school course where you spent time with an employer (such as a co-op program)?
- [g] Attended a presentation by people working in different types of jobs?
- [h] Volunteered in an area you are interested in?
- [i] None of the above?

S56: CAREER GOALS: What kind of career or work would you be most interested in having when you are about 30 years old?

sccq75

S57: What is the minimum level of education you think is needed for this type of work? sccq72

- [1] Less than high school graduation
- [2] High school diploma or graduation equivalency
- [3] Trade/vocational certificate
- [4] College diploma
- [7] Don't know
- [8] Private career college diploma
- [9] CEGEP certificate
- [5] One university degree (for example, Bachelor's)
- [6] More than one university degree (Master's, PhD, more than 1 Bachelor's)

S58: During the past 12 months, what was your <u>total income (before deductions) from all sources</u> (including income from odd jobs, income from employers, an allowance from the Children's Aid Society, money from your family or caregivers, or any income from other sources)? sccq73

- [1] Less than $1000
- [2] $1000 to $2499
- [3] $2500 to $4999
- [4] $5000 to $7499
- [5] $7500 to $9999
- [6] $10000 to $14999
- [7] $15000 to $19999
- [8] $20000 to $24999
- [9] $25000 to $29999
- [10] $30000 to $34999
- [11] $35000 to $39999
- [12] $40000 or more

S59: Is there anything standing in your way of going as far in school as you WOULD LIKE to go? **(Mark up to 3 answers.)** edcq77

- [a] No **(Go to question S60)**
- [b] Your financial situation (for example, you would need to work or it would cost too much)
- [c] You are not interested enough or lack the necessary motivation
- [d] You would like to stay close to home
- [e] It would take too long
- [f] You would like to work (for pay)
- [g] You need to care for your own children
- [h] Your health
- [i] You are not sure what you would like to do later on in life
- [j] Other

S60: Each month, how much of the money that you receive (from all sources) do you save? sccq77

[1] None [2] Less than half [3] About half [4] More than half [5] Almost all

S61: Of the money that you save, is some of it for your education after high school? sccq79

[3] I don't save any [1] Yes [0] No

S62: DAILY LIVING PROGRAM: Are you following a formal daily living program that teaches independent living skills? sccq52

[1] Yes [0] No

S63: Are you receiving all the assistance you need to learn to live independently? sccq53

[1] Yes [0] No

S64: What kind of help do you need most, at the present time, to prepare to live independently?

sccq80a

Looking After Children AAR-C2-2010 - **Self-care skills & transition to adulthood (16-17 yrs) 30**

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During the AAR conversation, the **CAREGIVER** is to answer the following section.

S65: I help... maintain a budget of his/her expenses and income. sccq50

2 Always or often 1 Sometimes 0 Rarely or Never

S66: I help ... to answer his/her questions about money management. sccq51

2 Always or often 1 Sometimes 0 Rarely or Never

S67: I am involved in helping ... prepare for his/her transition to independent living. sccq54

2 Always or often 1 Sometimes 0 Rarely or Never

S68: I talk to ... about his/her financial planning for the future. sccq81a

2 Always or often 1 Sometimes 0 Rarely or Never

During the AAR conversation the **CHILD WELFARE WORKER** is to answer the following section based on the information obtained on the entire developmental dimension of self-care skills.

ATTAINMENT OF SELF-CARE OBJECTIVES OF THE CHILD WELFARE SYSTEM:

S69: Objective 1: The young person is learning to care for himself/herself at a level appropriate to his/her age and ability when given the necessary resources and support. sccq18

2 Already competent 1 Learning to care for himself/herself 0 Not learning to care for himself/herself

S70: Objective 2: The young person is learning money management skills? sccq19

2 Already competent 1 Learning money management skills 0 Not learning money management skills

S71: Objective 3: The young person has a Learning Plan to build financial literacy skills? sccq20

2 Has a plan and it is implemented 0 No action

1 A plan is under development 4 Not applicable

Note to the child welfare worker: *If anyone disagrees with these answers to the Self-Care Skills objectives, please note the details on the opposite page.*

Looking After Children AAR-C2-2010 - Asset profile (16-17 yrs) 31

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The **CHILD WELFARE WORKER** is to answer the following section based on the information obtained from the entire Assessment and Action Record. **"Yes" should only be answered if you are very certain that the young person truly possesses the asset.**

SUMMARY PROFILE OF YOUNG PERSON'S ASSETS. The Search Institute has identified the following assets as building blocks that help young people grow up healthy, caring, and responsible.

Asset Category, Name, and Definition:

SUPPORT	Yes	Uncertain	No	
A1: *Caregiver support:* Caregivers provide high levels of love and support.	1	0	a	apq1
A2: *Positive communication:* Young person and caregivers communicate positively, and young person is willing to seek advice and counsel from caregivers.	1	0	a	apq2
A3: *Other adult relationships:* Young person receives support from other adults besides caregivers.	1	0	a	apq3
A4: *Caring neighbourhood:* Young person experiences caring neighbours.	1	0	a	apq4
A5: *Caring school environment:* School provides a caring, encouraging environment.	1	0	a	apq5
A6: *Caregiver involvement:* Caregivers are actively involved in helping young person succeed in school.	1	0	a	apq6

EMPOWERMENT	Yes	Uncertain	No	
A7: *Community values youth:* Young person perceives that adults in the community value youth.	1	0	a	apq7
A8: *Youth as resources:* Young person is given useful roles in the community.	1	0	a	apq8
A9: *Service to others:* Young person serves others in the community on a regular basis.	1	0	a	apq9
A10: *Safety:* Young person feels safe at home, school, and in neighbourhood.	1	0	a	apq10

BOUNDARIES AND EXPECTATIONS	Yes	Uncertain	No	
A11: *Caregiver boundaries:* Caregivers have clear rules and consequences and monitor the young person's whereabouts.	1	0	a	apq11
A12: *School boundaries:* School provides clear rules and consequences.	1	0	a	apq12
A13: *Neighbourhood boundaries:* Neighbours take responsibility for monitoring the young person's behaviour.	1	0	a	apq13
A14: *Adult role models:* Caregivers and other adults model positive, responsible behaviour.	1	0	a	apq14
A15: *Positive peer observations:* Young person's best friends model responsible behaviour.	1	0	a	apq15
A16: *High expectations:* Both caregivers and teachers encourage young person to do well.	1	0	a	apq16

CONSTRUCTIVE USE OF TIME	Yes	Uncertain	No	
A17: *Creative activities:* Young person spends time regularly in lessons or practice in music, theater, or other arts.	1	0	a	apq17
A18: *Youth programs:* Young person spends time regularly in sports, clubs, or organizations at school and/or in the community.	1	0	a	apq18
A19: *Religious or spiritual community:* Young person spends time regularly in religious or spiritual activities.	1	0	a	apq19
A20: *Time at home:* Young person is out with friends "with nothing special to do" two or fewer nights per week.	1	0	a	apq20

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COMMITMENT TO LEARNING		Yes	Uncertain	No
A21: ***Achievement motivation:*** Young person is motivated to do well in school.	apq21	1	0	a
A22: ***School engagement:*** Young person is actively engaged in learning.	apq22	1	0	a
A23: ***Homework:*** Young person reports doing homework regularly.	apq23	1	0	a
A24: ***Bonding to school:*** Young person cares about his/her school.	apq24	1	0	a
A25: ***Reading for pleasure:*** Young person reads for pleasure regularly.	apq25	1	0	a

POSITIVE VALUES		Yes	Uncertain	No
A26: ***Caring:*** Young person places high value on helping other people.	apq26	1	0	a
A27: ***Equality and social justice:*** Young person places high value on promoting equality and reducing hunger and poverty.	apq27	1	0	a
A28: ***Integrity:*** Young person acts on convictions and stands up for his/her beliefs.	apq28	1	0	a
A29: ***Honesty:*** Young person "tells the truth even when it is not easy".	apq29	1	0	a
A30: ***Responsiblity:*** Young person accepts and takes personal responsibility.	apq30	1	0	a
A31: ***Restraint:*** Young person believes it is important not to be sexually active or to use alcohol or other drugs.	apq31	1	0	a

SOCIAL COMPETENCIES		Yes	Uncertain	No
A32: ***Planning and decision making:*** Young person knows how to plan ahead and make choices.	apq32	1	0	a
A33: ***Interpersonal competence:*** Young person has empathy, sensitivity, and friendship skills.	apq33	1	0	a
A34: ***Cultural competence:*** Young person has knowledge and comfort with people of different cultural, racial, and/or ethnic backgrounds.	apq34	1	0	a
A35: ***Resistance skills:*** Young person can resist negative peer pressure and dangerous situations.	apq35	1	0	a
A36: ***Peaceful conflict resolution:*** Young person seeks to resolve conflict nonviolently.	apq36	1	0	a

POSITIVE IDENTITY		Yes	Uncertain	No
A37: ***Personal power:*** Young person feels that he/she has control over "things that happen to me".	apq37	1	0	a
A38: ***Self-esteem:*** Young person reports having high self-esteem.	apq38	1	0	a
A39: ***Sense of purpose:*** Young person reports that "my life has a purpose".	apq39	1	0	a
A40: ***Positive view of personal future:*** Young person is optimistic about personal future.	apq40	1	0	a

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ATTAINMENT OF THE GOALS OF LOOKING AFTER CHILDREN: Overall, in working with this particular young person and his/her caregivers, how successful do you think you have been up to now in attaining the following goals of Looking After Children? **(Please answer each item as honestly and frankly as possible.)**

	Very successful	Somewhat successful	Not very successful	
T1: Helping the young person develop his/her potential to a maximum rather than a minimum level.	2	1	0	tmcq49
T2: Focussing on the young person's successes, not just on his/her problems.	2	1	0	tmcq50
T3: Planning according to the young person's individualized needs.	2	1	0	tmcq51
T4: Believing your work with the young person can bring about positive change, even in less than ideal circumstances.	2	1	0	tmcq52
T5: Achieving ambitious but feasible objectives in all major areas of the young person's development.	2	1	0	tmcq53
T6: Helping the young person to develop a positive cultural identity and feeling of cultural safety.	2	1	0	tmcq54

COMPLETION OF THE AAR:

Q1: How many conversations did it take to complete this AAR (including the Background Information Section)?

1 1 session 2 2 sessions 3 3 sessions 4 4 or more sessions aarq5

Q2: Total time to complete the AAR (including the Background Information section)?

6a ___ hours and 6b ___ minutes aarq6

Q3: Total time that the young person participated in completing the AAR?

6c ___ hours and 6d ___ minutes aarq6

Q4: Who took part in the AAR conversation? **(Mark as many as apply.)** aarq1

- b Child welfare worker
- c One foster parent
- d Two foster parents
- m FNMI Band or Community representative
- k Family worker
- e One adult caregiver other than a foster parent
- f Two adult caregivers other than a foster parent
- i One birth parent
- j Two birth parents
- g Other

Q5: The young person for whom the AAR is being completed: aarq9

- 10 Participated in the entire AAR conversation
- 7 Participated in only part of the AAR conversation
- 8 Participated in only part of the AAR conversation because of refusal
- 9 Participated in only part of the AAR conversation because of lack of capacity
- 3 Participated in none of the AAR conversation because of refusal
- 4 Participated in none of the AAR conversation because of lack of capacity

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Q6: **If a FNMI Band or Community representative, Elder, or Cultural Teacher** took part in the AAR conversations, was he/she familiar with the Looking After Children approach? aarq8

[1] Yes [0] No [3] Uncertain [4] Not applicable

Q7: The AAR is intended to be completed in face-to-face conversations, unless for some reason this is impossible. How was this AAR conversation being completed? **(Mark as many as apply.)** aarq2

[a] In a face-to-face conversation conducted by the child welfare worker

[f] In a face-to-face conversation conducted by the child welfare worker in conjunction with a member of ...'s FNMI community

[b] In a telephone conversation conducted by the child welfare worker

[c] Through self-administration by the caregiver

[e] Through self-administration by the young person

[d] Other

Thank you for your participation!

The AAR-C2-2010 is the 2010 version of the second Canadian adaption of the Assessment and Action Record from the Looking After Children international initiative. The authors of this new version are Robert Flynn and Meagan Miller (Centre for Research on Educational and Community Services [CRECS], University of Ottawa), Lynn Desjardins and Hayat Ghazal (Ottawa Children's Aid Society [CAS]), and Louise Legault (Social Research and Demonstration Corporation, Ottawa).

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