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Joan M. MacDonald
AUTEUR DE LA THÈSE / AUTHOR OF THESIS

Ph.D. (Clinical Psychology)
GRADE / DEGREE

School of Psychology
FACULTÉ, ÉCOLE, DÉPARTEMENT / FACULTY, SCHOOL, DEPARTMENT

Needs, Service-costs and Outcomes in Foster Care in Three Ontario Children's Aid Societies

TITRE DE LA THÈSE / TITLE OF THESIS

Robert Flynn
DIRECTEUR (DIRECTRICE) DE LA THÈSE / THESIS SUPERVISOR

CO-DIRECTEUR (CO-DIRECTRICE) DE LA THÈSE / THESIS CO-SUPERVISOR

EXAMINATEURS (EXAMINATRICES) DE LA THÈSE / THESIS EXAMINERS

Douglas Angus

Tim Aubry

Carolyn Dewa

Elizabeth Kristjansson

Gary W. Slater
LE DOYEN DE LA FACULTÉ DES ÉTUDES SUPÉRIEURES ET POSTDOCTORALES /
DEAN OF THE FACULTY OF GRADUATE AND POSTDOCORAL STUDIES

NEEDS, SERVICE-COSTS AND OUTCOMES IN FOSTER CARE IN THREE ONTARIO CHILDREN'S AID SOCIETIES

Joan Matilda MacDonald

Thesis submitted to the

Faculty of Graduate and Postdoctoral Studies

In partial fulfillment of the requirements

For the PhD degree in Clinical Psychology

School of Psychology
Faculty of Social Sciences
University of Ottawa

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Your file Votre référence
ISBN: 978-0-494-15030-6
Our file Notre référence
ISBN: 978-0-494-15030-6

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HUI – Health Utilities Index

LAC – Looking After Children

NLSCY – National Longitudinal Study of Children and Youth

POW – Production of Welfare

Abstract

Costing studies are necessary to ensure that scarce funds are allocated to services that best meet children's needs and lead to positive changes in their functioning. The Production of Welfare (POW) model for costing social services provides a conceptual framework for examining variations in cost in relation to needs and outcomes. The few studies that have looked at costs of services to children and youth suggest that health needs, emotional/behavioural problems, gender and age may influence cost. Our study questions were: (1) What are the average annual per-child costs of foster care? (2) Do higher health needs predict higher costs? (3) Do higher costs during a 12-month period predict better outcomes?

The outcomes included in the study were self-esteem, prosocial behaviour, emotional distress/anxiety, conduct disorder/physical aggression, indirect aggression and ill-health. The total average annual opportunity cost per child was $22,892 (N=119). Greater ill-health at baseline predicted higher costs. Cost did not predict changes on self-esteem, prosocial behaviour and emotional distress/anxiety. Contrary to expectations, higher costs were associated with increases in conduct disorder/physical aggression, indirect aggression and ill-health over the 12 months of the study. Kinship care was less expensive than regular foster care, but the study included only 8 children in kinship care.

Our results suggest that higher expenditures are targeted at children with greater health needs. Costs may not have yet been able to predict positive changes in outcomes because the time period of the study was for the interventions to have the impact on behaviour that would bring about positive changes. This means that further research with a longer follow-up period is required. A prospective cost study could provide a more complete description of the total costs

required to support a child in foster care. Given the small number of participants in kinship care in our study, the relationship between kinship care and cost can only be viewed as exploratory. A larger sample of children in kinship care could provide more information on the costs of kinship care and the relationship between costs and outcomes in kinship care in comparison to regular foster care.

Acknowledgements

I gratefully acknowledge the collaboration and support of the staff of the three CASs included in this study. I acknowledge the financial support the Looking After Children in Ontario (OnLAC) project received from the Social Sciences and Humanities Research Council of Canada (strategic grant 828-1999-1008, awarded to Robert Flynn, principal investigator; and to co-investigators, Tim Aubry, Marie Drolet, and Douglas Angus). I also acknowledge the additional financial support the OnLAC project received from the Ministry of Children and Youth Services of Ontario (grant made to the Ontario Association of Children's Aid Societies [OACAS]), Social Development Canada (grant made to the Child Welfare League of Canada [CWLC]) and Services to Children and Adults of Prescott-Russell (SEAPR). I would like to thank all the organizational partners (OACAS, CWLC, SEAPR, and participating Ontario CASs), as well as the many young people, child welfare workers, supervisors, foster parents, and group home workers who have been participants in the OnLAC project. I extend a special thanks to the staff of the Centre for Research on Community Services at the University of Ottawa, in particularVivian and Ginette, as well as to Mireille, Kim and Jeanne d'Arc at the School of Psychology.

I also extend my thanks to the members of my thesis committee: Tim Aubry, Doug Angus, and Elizabeth Kristjansson and my external examiner, Carolyn Dewa. I particularly thank my thesis supervisor, Dr Bob Flynn for his encouragement, support and assistance.

I also wish to thank Nicholas, Jodie, my brothers and sister, and my friends for their support and encouragement. Special thanks to Marilyn and Dave in Calgary. And to my parents and grandparents for giving me a love of learning.

CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW

1.0 Foster care and costing studies

During the fiscal year 1999-2000, Children's Aid Societies in Ontario provided substitute care to 25,586 children (Ontario Association of Children's Aid Societies [OACAS], 2002). Most children in care live with foster families for several months, often with a brother or sister in the same foster home, until they go home or a permanent plan is made for them. Such a plan may include adoption or long-term care in a foster home where they can grow up securely (Steinhauer, 1991). There are many reasons why children and youth come into the care of a Society: physical, sexual or emotional abuse; neglect; family problems; or parental issues, such as substance abuse, marital problems, or mental health issues. Because of these life experiences, children and youth placed in foster care can present emotional and behavioural challenges to their foster parents (Steinhauer, 1991).

The ultimate goal of intervention by the child welfare system is to increase the likelihood that children in care will overcome their social and emotional difficulties and achieve lasting well-being in adulthood (Parker, Ward, Jackson, Aldgate, & Wedge, 1991). Unless outcomes in child welfare are measured, there is no way of ascertaining whether these objectives are met (Parker et al., 1991). Increasing cuts to social service funding mean that assessing costs should become a necessary part of evaluating social or psychological interventions (Yates, 1994). These assessments of costs need to go beyond simple tabular comparisons of the outcomes and costs of a treatment to a real exploration of the relationships between costs and outcomes (Yates, 1994). After undertaking a review of 24 years of treatment research, Yates (1994) found that as of 1991, less than 5% of the literature on treatment

outcomes included any *mention* of costs, and very few had any data on the relationship between costs and outcomes.

Although methodologies for evaluating costs and the relationship between costs and outcomes have been available since the 1970s, Yates (1994) suggests that these methods are rarely used in the evaluation of social or mental health interventions because program managers fear the results may be used to justify funding cuts. However, an understanding of the relationship between costs and outcomes is essential for ensuring the most effective use of scarce resources (Knapp, 1984; Yates, 1994; Yates, 1996). Furthermore, as a psychologist, Yates (1994) believes that the profession is moving toward a scientist-manager-practitioner model, where an understanding of costs and cost-benefit and cost-effectiveness analysis will be considered an important skill set for the evaluation of clinical services.

The research project described in this thesis examines the relationship between children's health needs, positive changes in their emotional-behavioural functioning and the costs of the services that they receive. This thesis research forms part of a larger study, Looking After Children in Ontario. The larger study is being undertaken by Dr. Robert Flynn and his co-investigators (Flynn, Aubry, Drolet, Angus, 1999) and grew out of a pilot study in the Prescott-Russell Children's Aid Society. Almost all the Children's Aid Societies (CASs) in Ontario are now participating in the larger study. This research uses a non-experimental longitudinal design. The costing study presented in this thesis forms an important component of this larger study. The cost analysis is based on the Production of Welfare model of costing developed by Knapp (1984, 1993a, 1993b) and his colleagues, Netten and Beecham (1993; Beecham, 1995, 2000; Beecham, Knapp & Allen, 1995).

The cost analysis described in this thesis examines the relationships between needs, outcomes, and costs in three of the 30 CASs initially involved in the larger study. Specifically, the cost research includes a description of the component costs of foster care and an examination of the relationship between children's health needs at Time 1 (2002) and the costs of services that they received in the twelve months between Time 1 and Time 2 (2002-2003). In addition, this study includes analyses of the relationship between outcomes (positive changes in the participants' emotional-behavioural functioning at Time 2) and the costs of the services they received during the previous twelve months.

This document begins with an historical overview of foster care. Following this, a review of research on the health status of children in foster care is presented. The literature review concludes with a review of costing studies in child welfare. It then describes Looking After Children (LAC), which is a new approach to the delivery and evaluation of child welfare services that was first initiated in Britain in the early 1990s (Ward, 1995). This description includes an introduction to the conceptual models that underlie the LAC system: 1) the competence model and 2) the Production of Welfare (POW) approach. This section begins with an examination of the competence model and how it is applied in the LAC approach, followed by a description of the Production of Welfare approach to costing, which is used by Knapp (1984, 1993a, 1993b) and his colleagues at the Personal Social Services Research Unit (PSSRU) at the University of Kent in Canterbury, England. This description of the LAC approach and the conceptual models on which it is based is then followed by an overview of costings studies, beginning with a brief description of the different types of economic evaluations. This section then goes on to give a more in-depth description of the POW model. The steps used to estimate

costs in this approach are outlined, as well as the methods for exploring cost variations. In the final sections of this document, I present a description of the research study, including sections on the hypotheses, the methodology, the analysis, the results and the discussion of the findings.

1.1 Historical overview of foster care

Foster family care was first introduced in North America more than a century ago. Foster care arrangements in both western Europe and America began with the practice of placing abandoned children in the country with wet nurses (Aries, 1962; Bigot, 1984). Prior to that, institutions called foundling homes or hospitals had provided temporary care to abandoned children, "but not proper parenting" (Steinhauer, 1991, p. 4). Mortality rates in these foundling hospitals were very high (Steinhauer, 1991). Both Barr and Holt (1994) and Bigot (1984) have described the shift historically from institutional care to placement in family settings. Their descriptions are summarized in the next four paragraphs.

Rousseau's writings on children led to a shift in beliefs about children: they came to be viewed as naturally innocent and worthy of aid. This shift resulted in a move from institutional to family placements for orphaned or abandoned children, because influential individuals intervened on children's behalf. Older children who had been orphaned or abandoned were placed with families in rural communities, with the understanding that they would provide agricultural labour to these families. In Britain, this practice included transporting needy children to Canada and Australia to serve as farm labourers, a practice that continued until just before the Second World War.

At the end of the 19th century, foster families began to receive boarding-out allowances, initially just for infants and toddlers. Increases in boarding-out allowances over the years were

related to shifts in society's definition of childhood. For example, in France, payments were linked to the age of the child, with the amount decreasing from infancy to twelve years of age. Allowances were terminated when children were 12-years-old. It was expected that, as children aged, they would contribute labour to compensate the family for the expenses occasioned by the children's care.

Because mortality rates for infants in foster care were much higher than those of other young children, suspicion grew about the quality of care young children were receiving. As a result, some agencies began to regulate and review their boarding homes. These early evaluations of family foster care were motivated by a desire to protect the life and health of very young children. One method used to ensure high-quality care was to hire professionally trained social workers to manage foster care placements. Consequently, early in the 20th century, child welfare workers with formal social work training began to assume responsibility for placements of children in child welfare agencies. This led to modernization of the foster care system. In addition, new interventions were aimed at keeping children at risk with their biological families or decreasing the length of time they were separated from their biological parents. In particular, many Jewish and Catholic agencies did not subscribe to the practice of permanently separating children from their families.

According to Barr and Holt (1994), professional social workers advocated the collection of statistics on outcomes of children placed in out-of-home care by child welfare agencies. This led to supervised placements in care: social workers monitored placements to ensure the safety and well-being of the children in care. By the 1920s, social workers' push for supervised placements led to the development of a set of standards for foster care. However, these

standards for foster care were more commonly invoked for younger children. Older children placed out as labourers were less likely to have their placements supervised by agency staff and institutionalisation of older children continued to be a common practice. Even today, institutions remain the preferred placement for children in out-of-home care in some countries, such as those in Eastern Europe. However, in North America and Britain, beginning in the 1950s, children were increasingly placed in foster care, and institutions and orphanages were gradually phased out.

In the early 1980s, as the percentage of children in out-of-home care increased in Britain and North America, criticism of the lack of planning involved in these placements became widespread (Packman, Randall, & Jacques, 1984). The proportion of these children who had been removed from their homes by court order had also risen. This increase in the number of children in care was attributed to increases in poverty, unemployment, social isolation, and single-parent families (Packman et al., 1984). Consequently, the magnitude and diversity of many of these children's needs were also greater than those of the previous generation of children in out-of-home care (Steinhauer, 1991). To meet the greater treatment needs of these children, group homes with professionally trained staff were introduced as an alternative to foster care (Steinhauer, 1991).

With the introduction of group homes, a concurrent trend developed that favoured treatment in the "least disruptive setting," that is, preventive and family reunification services rather than long-term foster care (Lyman & Wilson, 1992). Foster parents were viewed as lacking the training needed to work with children experiencing emotional or behavioural difficulties (Steinhauer, 1988). Out-of-home placement was perceived as a traumatising

experience that might lead to permanent emotional scars for children already experiencing difficulty coping (Steinhauer, 1991). Bowlby's (1980) observations of attachment and separation behaviour in young children led to research on the attachment behaviour of abused and neglected children (Main & Solomon, 1986). The attachment style often exhibited by abused/neglected children ('Disorganized/Disoriented') is associated with distancing and provocative behaviours toward parents. These behaviours might lead foster parents to reject children in their care and cause these children further trauma (Steinhauer, 1991). To minimize the trauma of out-of-home placement, Steinhauer (1991) suggested that foster parents' ability to meet the attachment needs of children in out-of-home care be considered when determining their parenting capacity.

Guidelines were developed to inform placement decisions. An example of these guidelines are the four principles developed by Lyman and Wilson (1992) for deciding the appropriate setting for children at risk. First, treatment was to be provided in the least disruptive setting. Second, the setting was to permit the most effective treatment of the child's identified problems and ensure that treatment effects were generalized outside the treatment setting. Third, a comprehensive evaluation of cost-effectiveness was to be used to demonstrate that improvements were maintained post-treatment. Finally, the philosophy, structure and techniques of the treatment program were to match the child's clinical and behavioural needs. In Lyman and Wilson's (1992) view, a program that is poorly matched to the child's needs could cause caregivers to burn out or children to derive little benefit from the interventions. They believed that extensive effectiveness research would be needed to ensure an understanding of the

relationship between child demographics, previous history, needs, program factors, program outcomes, and comprehensive costs (Lyman & Wilson, 1992).

In summary, foster care developed in conjunction with a recognition of the rights of the child and a desire to decrease infant mortality rates of children in institutional care. However, mortality rates of children in early foster care remained high and this led to the earliest evaluations of foster care, the establishment of placement standards and the professionalisation of child welfare services. With the influence of Bowlby's attachment theory, foster care became the preferred placement for children in out-of-home care. Recently, however, the greater needs of many children in the child welfare system has led to increasing placements in group homes. At the same time, a focus on placement in the least disruptive setting has favoured funding of family preservation services. Principles for determining the best placement for children at risk are now well-established and applied to decisions about out-of-home care in North America. These principles include a call for the evaluation of the cost-effectiveness of child welfare services.

In the next section of the literature review, we examine the history of foster care in Ontario. The first three paragraphs will summarize information from a document published by the OACAS (2002).

1.1.1 Foster Care in Ontario. In Ontario, prior to 1874, neglected or abused children had only two avenues of assistance, neither considered appropriate by today's standards: the courts or apprenticeship. While the government funded the court system, other services for the poor or neglected were funded privately and provided by volunteers. In 1874, legislation was passed that permitted charitable institutions to intervene to prevent maltreatment of apprenticed

children, and a cost-sharing relationship was established between these organizations and the provincial government. Further legislation, in 1888, allowed the courts to make children wards of institutions and charitable organizations, with local Government assuming the maintenance costs of wards. In addition, foster home placements began to be preferred over institutional care.

In 1891, J.J. Kelso founded the first CAS in Ontario and advocated legislation to protect children. As a result of legislation passed in 1893, CASs became semi-public agencies with legal powers to remove children from their homes, to supervise the provision of out-of-home care, and to receive municipal funding for the maintenance costs for children in their care. Between 1891 and 1912, 60 CASs were founded in Ontario, which joined together to form the association now known as OACAS.

The goals of the OACAS were to promote the welfare of children, to co-ordinate the work of CASs, and to review child welfare legislation. New Child Welfare Acts passed in 1921, 1954, 1965, as well as the Child and Family Services Act (CFSA) passed in 1984, helped shift CASs from a volunteer to a professional service system. In addition, the provincial governments accepted direct responsibility for the delivery of child welfare services through public financing, agency reporting and provincial supervision, and the focus of services shifted progressively from protection and institutional care to preventive and non-institutional services.

The most recent legislation, the Child and Family Services Amendment Act, was enacted into law on March 31, 2000. In this paragraph and the next, I will summarize information on this new legislation and its implications from an article by Bala (1999). Bala is a lawyer who specializes in legislation related to family law. The amendment to the Child and Family Services Amendment Act was motivated by a desire to better protect children at risk, by

removing the "least restrictive or disruptive course of action" clause from the statement of purposes of the CFSA, and emphasizing the "best interests" clause. In addition, the threshold for finding a child in need of protection was lowered by revising the description of grounds for intervention to read "risk that the child is likely to be harmed," rather than "substantial risk." The grounds for intervening were also expanded to include a "pattern of neglect," in addition to the previous grounds dealing with physical harms, risk of physical harm, emotional harm and risk of emotional harm. The threshold of emotional harm was lowered from "severe" to "serious" anxiety, depression, withdrawal or self-destructive or aggressive behaviour and "delayed development" was added to the list of symptoms that might result from emotional harm by the parent.

Bala (1999) suggests that one of the implications of this legislation is that increased funding of children's services is crucial to protecting and nurturing Ontario's children. The reason for the need for increased funding is the rise in the use of out-of-home care for children and youth in Ontario. After a period of stability during the 1990s in Ontario, a 26% increase in the number of children in care occurred between 1998-1999 and 2000-2001 (OACAS, 2002). Although funding for child welfare has increased in Ontario, the increased number of children in care mean that resource issues remain critically important. Bala (1999) suggests that without additional funding increases legislative reform may result in little improvement to children's services. Economic evaluations and costing studies are, therefore, necessary to ensure that scarce funds are allocated to those services that best meet children's needs or lead to positive changes in their functioning.

In recent years, as a means of better meeting the needs of children in foster care, new types of foster care have been introduced in the child welfare system in North America, including in Ontario, to provide more intensive services to those children with higher needs and to minimize the disruption of placements in out-of-home care. In the next section of this document, we describe the types of foster care currently used in Ontario.

1.2 Types of Foster Care

In recent years, increasing numbers of children in the child welfare system have been placed in kinship care, in specialized foster care, or in treatment foster care (Human Resources Development Canada [HRDC], 1999). The aims of these types of placements are, respectively, to increase the stability of placements (Berrick, 2000), to accommodate children with identified developmental, emotional, or physical needs, and to improve the outcomes of very troubled children whose emotional and behavioural needs require professional community-based treatment (HRDC, 1999). Each of these types of care differ in significant ways from regular family foster care. In regular family foster care, the child is expected to readily adapt to the daily routines of the foster family (HRDC, 1999). This may also be true of kinship care (Beeman & Boisen, 1999), but not of specialized or treatment foster care.

1.2.1 Kinship care

Child welfare authorities define *Kinship care* as the formal placement by child welfare authorities of a child in the home of a relative (Berrick, 2000). In many cultures throughout the world, children's relatives have often provided substitute parenting when the children's parents were unable to care for their children (Berrick, 2000). Although this was previously an informal practice, in the 1980s, in response to a shortage of foster care providers, there was a shift toward kinship care in child placements in the United

States (Berrick, 2000). In the United States, this type of out-of-home care has increased more rapidly than any other type of placement (Gleeson & Craig, 1994; Wulczyn & Goerge, 1992). In some states, kinship care now accounts for almost half of all out-of-home care in child welfare (Berrick, 2000) and, in some urban centres, exceeds the number of placements in traditional foster care (Scannapieco & Hegar, 1999). Research suggests that children in kinship care are more likely to express happiness about their placement than children in other types of care (Berrick, 2000).

Kinship foster care appears to differ from care provided by non-relatives in several ways: 1) caregivers tend to be single, older, less educated, more economically disadvantaged, and more likely to belong to a visible minority; 2) placements tend to be more stable and longer-lasting, and include more frequent contacts with the biological parents but lower rates of reunification (Keller, Wetherbee, LeProhn, Payne, Sim, & Lamont, 2001). In some states in the United States, kinship caregivers receive lower subsidies than other types of caregivers, and this may have an impact on how long the children remain in foster care (Berrick, 2000). Those children whose caregivers received lower payments were less likely to remain in long-term care (Berrick, 2000). The research described in this thesis compares kinship care with the other types of foster care, to determine if kinship care is associated with lower costs than other types of foster care are.

1.2.2 Specialized Foster Care. In *specialized foster care*, the child's exceptional needs require that foster parents provide more intensive services than they would for regular foster family care (HRDC, 1999). As a result, one of the foster parents may need to provide full-time care, so this type of care is also called *intensive foster care* (Redding, Fried, & Britner, 2000).

Although specialized foster care and treatment foster care are separate categories in Ontario, in many places they are just different names for the same services (Nutter, Hudson, Galaway, & Hill, 1995).

1.2.3 Treatment Foster Care. *Treatment foster care* is also called *therapeutic foster care* (Redding et al., 2000). This type of foster care is meant to combine the "features of residential treatment and foster family care" (Redding et al., 2000). It is a means of meeting the needs of emotionally and behaviourally disturbed children that cannot be met in traditional foster care (Redding et al., 2000). Often these placements are time-limited, as the goal is to prepare children for permanent placements by helping them to modify their behaviours (HRDC, 1999). The features of a treatment foster placement usually include professionalizing foster parents by providing them with training and support services and treatment-oriented supervision (Dawson, 1989; Redding et al., 2000). Placement stability is considered critical for ensuring positive outcomes for treatment foster care (Redding et al., 2000). However, placement breakdown has been found to be common in this type of foster care (Redding et al., 2000).

2.0 Health of children/youth in foster care

Health and emotional/behavioural functioning are two of the developmental dimensions included in the LAC approach (Parker et al., 1991). The World Health Organization (WHO, 1948) recommended that social programs use a broad definition of health: "a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity." In keeping with this recommendation, the measure of ill-health used as the needs variable in the research study described in this thesis includes some cognitive and emotional aspects. This measure of ill-health is used to predict costs of foster care. In addition, measures of change in

emotional-behavioural functioning or health are used as the outcome variables predicted by cost, while controlling for children's initial level of ill-health. The next section of this thesis examines the literature on the health needs of children in foster care, on the health services provided to them in care, on their emotional/ behavioural functioning and on their health outcomes after foster care interventions.

2.1 Health Needs

Parker and his colleagues (1991) indicate in their literature review that they found very few studies on the health of children in care, although they do note that Lambert's (1983) report on the National Child Development Study indicated that children in out-of-home care in Britain had numerous health problems. Research in the 1970s and 1980s indicated that the health care needs of children in foster care in the United States were neglected (Schor, 1982; Schor, 1985; Swire & Kavaler, 1977). Children in care often had high rates of chronic medical, mental health and developmental conditions and suffered multiple health problems (Simms & Halfon, 1994). They had certain health problems more often than children in the general population. These health problems included: inadequate or undocumented immunizations, visual abnormalities, hearing problems, a slow growth rate, and chronic health conditions (Schor, 1985). In addition, children in foster care had higher rates of intellectual or academic problems and psychiatric, emotional, or behavioural concerns (Schor, 1985).

These health problems of foster children may be related to their personal histories of neglect or abuse, their parents' histories of neglect or abuse, family mental illness, substance abuse, homelessness, and physical disabilities (Simms & Halfon, 1994). The neglect experienced by these children may have extended to their physical health. Prior to entering

care, these children may not have been provided with basic preventative and primary health care (Simms & Halfon, 1994). Some researchers found that when initially entering care, children in foster care frequently exhibited untreated dental caries, immunization delays, and vision problems for which they had not previously received corrective lens (Blatt, Soletsky, Meguid, Church, O'Hara, Haller-Peck, & Anderson, 1997). In some cases, children may have had pre-existing health problems that overwhelmed their families' capacity to cope, and may have contributed to the children being neglected and placed in care (Simms & Halfon, 1994). Steinhauer (1991) indicates that children who have suffered parental neglect, rejection or victimization are prone to conduct disorders, which may be difficult to remedy, strain the resources of foster parents and often experience placement breakdown.

The literature on health needs of foster children largely originates from the United States. Given that their health care system is very different than Canada's, the health needs of children in care in Canada may differ. Kufeldt and her colleagues (2000) found this to be the case for physical health conditions: in fact, they found the percentage of children in foster care who reported chronic health conditions was lower than the percentage in the comparison group of children who were not clients of child welfare. Furthermore, they found that when questions about chronic health conditions were posed again nine months to one year later, the children in foster care showed improvements: fewer of them reported a chronic condition (Kufeldt et al., 2000). In addition, the vast majority (93 per cent) of the children in foster care were reported to be normally in good health, in comparison to 88 per cent of the national sample from the National Longitudinal Study of Children and Youth(NLSCY; Kufeldt et al., 2000). Kufeldt and

her colleagues (2000) concluded that Canadian children in foster care did not show evidence of the same health disadvantages as children in foster care in the United States.

2.2 Health services

Simms and Halfon (1994) indicate that health care services play an important role in effective child welfare interventions. However, most agencies do not have official policies concerning health care for children in their care or sufficient staff with health-care training (Halfon and Klee, 1991). Some researchers suggest that children in kinship care are less likely to receive mental health services than children in other types of out-of-home care (Berrick, Barth, & Needell, 1994), and that child welfare workers tend to view these children as having fewer problems than children in other placements (Iglehart, 1994). However, workers have also been found to have less contact with these children and their foster families than with children in other types of placements (Berrick et al., 1994).

In response to the research findings on the higher health needs of foster children, some agencies in the United States designed programs to meet these needs (Blatt et al., 1997; Chernoff, Coombs-Orme, Risley-Curtiss, & Heisler, 1994; Flathery & Weiss, 1990; Schor, Neff, & LaAsmar, 1984; Simms, 1989). Some of these programs provided medical passports to the children, which contained important medical information that could be transferred to new service providers when the children changed foster families or physicians (Klee, Soman, & Halfon, 1994; Simms & Kelly, 1991). Others programs ensured that health services to all children in out-of-home care in the community were provided by a single clinic, so that changes in children's placements did not result in changes in health care providers (Blatt et al., 1997). Simms and Halfon (1994) suggest that children with complex, chronic health problems are

likely to benefit from ongoing care from the same health care providers. This continuity of care had the added advantage of decreasing the number of new relationships that the child needed to establish when changing residential placements (Simms & Halfon, 1994).

One of these clinics, which provided comprehensive multidisciplinary health services, was closely monitored and the services evaluated to determine whether children did received the planned health services from this clinic. The findings of the evaluation indicated that more than one-third of the foster children were seen for their first physical exam within one week of placement in care, and the vast majority had a physical within one month of placement. However, less than half the children received a planned comprehensive examination within 60 days, only 20% had a discharge visit, and less than 5% received both a comprehensive examination and a discharge visit. Therefore, whereas initial health assessments were frequent, follow-ups were less often provided even in programs specifically designed to improve health services to children in out-of-home care.

2.3 Emotional/behavioural functioning

Blatt and colleagues (1997) found that slightly more than half the children in foster care exhibited behavioural and emotional problems that warranted referral for further assessment or therapy. Research by Dubowitz and colleagues indicated that children in kinship care are more likely to have clinical level emotional and behavioural problems than children in the general population (Dubowitz, Feigelman, & Zuravin, 1993; Dubowitz & Sawyer, 1994; Dubowitz, Zuravin, Starr, Feigelman, & Harrington, 1993). Other researchers have suggested that in comparison to children whose foster family is not related, children in kinship care have fewer

problems (Berrick et al., 1994; Keller et al., 2001), and some researchers have found no statistical differences between the two groups (Landsverk, Davis, Ganger, & Newton, 1996).

Cantos and his colleagues (1996) assumed that therapy referral should serve as an indicator of behavioural and emotional maladjustment of foster children. To test this assumption and to identify the factors that were associated with poorer functioning while in foster care, they carried out a cross-sectional study in which they compared 49 foster children who had been referred for therapy by a foster parent, caseworker, teacher or judge to 19 who had not been referred. They excluded children who had been in foster care for less than a year. The participants were between 5 and 18 years old, however, the referred group was, on average, significantly older than the non-referred group.

These researchers found that the referred children were rated by foster parents as having more problems than the non-referred children, with regard to both externalizing and internalizing problems and also the range of areas of difficulty. These differences remained significant even when statistical controls were used to remove the effects of differences in age and length of time in care (Cantos et al., 1996). The referred group also had lower scores of academic achievement on the WRAT. Those in the referred group had been older when first placed in foster care, had spent less time in their current foster home, had a higher number of placements, and had spent less total time in out-of-home care overall (Cantos et al., 1996). The non-referred group were more likely to be in kinship care, more satisfied with their current foster home and less likely to have been placed in care as a result of drug abuse by their mother (Cantos et al., 1996).

Clark and his colleagues (1996) indicated that children exhibiting indicators of high risk of emotional/behavioural disturbance, who received individually tailored, intensive intervention services were actually functioning better on average 2 ½ years later than children in standard placements.

Flynn and Biro (1998) compared the needs on four of the LAC developmental dimensions of 43 children in foster care in Ontario with a normative comparison group from the National Longitudinal Study of Children and Youth (NLSCY). The four developmental dimensions were identity, education, family and social relationships, and emotional and behavioural development. They found that the children in care were more disadvantaged than the comparison group with regard to education and emotional and behavioural development, but not with regard to identity or their family relationships (Flynn & Biro, 1998).

2.4 Long-term health outcomes

In general, the research indicates that foster care has a positive impact on children. Most children in both short-term (Fein, Maluccio, Hamilton & Ward, 1983) and long-term care (Fein, Maluccio & Kluger, 1990) were found to be functioning moderately well overall, although some children in short-term placement were viewed by their foster parents as not functioning well in school (Fein et al., 1983). Researchers have found that qualitative data also indicated improvements in the overall well-being of children while in foster care (Wise, 1999).

Although the literature indicates that most children entering out-of-home care in the United States are in poor health, there are also indications that children experience significant improvements in physical and emotional health while in care (Simms & Halfon, 1994). With regard to long-term health outcomes, Dumaret and his colleagues (1997) found that most young

adults who had been in foster care as children rated themselves in good health, although more than one-third reported psychosomatic problems.

2.5 Summary and Critique of the Literature

In summary, most of the research suggests that foster care improves the overall functioning of children in care, although these children on average function below the norm for children in the general population. Their health needs, at least in the United States, are higher than those of other children when they enter care, and this may have an impact on their functioning in general. Early research on the LAC dimensions suggests that children in foster care may be behind their peers on some dimensions, including emotional/behavioural functioning, but not on others. Given that research in the United States indicates higher needs on the health dimension, this would appear to be an important dimension for exploring the needs and outcomes of children in out-of-home care.

However, Kufeldt and her colleagues (2000) conducted the only study found in the literature which included a large sample of foster children (263), comparison groups (45 children not in the child welfare system and population data from the NLSCY) and longitudinal information on psychometric measures that measured changes in functioning. In general, the other studies in the literature supplied only descriptive cross-sectional data, mostly acquired from semi-structured interviews and file reviews. Although, these other researchers suggested that foster children's health needs were higher than those of children in the general population, they did not describe comparisons such as those made by Kufeldt and her colleagues (2000) with normative population data. There were also contradictory findings about which children had higher needs, those in kinship care or those in regular foster home placements. Some studies

suggested those in kinship care had poorer emotional/behavioural functioning, while other indicted these children functioned at an equivalent level or better than children in regular foster homes.

3.0 Costing studies in Child Welfare

Evaluations of social programs are intended to permit organizations to ensure their services meet targeted needs and improve the outcomes of program clients (Rossi, Freeman, & Lipsey, 1999). As mentioned earlier, economic evaluation of social services are necessary because scarcity of resources is a fact of life (Knapp, 1993; Yates, 1994; Yates, 1996). Therefore, choices must be made between alternatives in the funding of social services and, to make the best use of scarce resources, these choices need to be based on both outcomes and costs (Knapp, 1993; Yates, 1994; Yates, 1996).

Drummond and his colleagues (1997) have developed a checklist for assessing economic evaluations that serves here as a guideline for reviewing the literature on costing studies of child welfare services. The criteria used for assessing economic studies include determining whether a well-defined question was asked. To be well-defined the question needed to include an examination of both costs and the effects of the services, as well as a comparison of alternative interventions. The alternatives and the manner in which the effectiveness of the services were established should be comprehensively described. All the important costs and consequences for each alternative should be identified and accurately measured with the sources of all values clearly identified. Costs and consequences that are expected to occur in the future should also be discounted to their present values, and the incremental costs of one alternative over another should be compared to the incremental effects

generated. In addition, allowances should be made for the uncertainty of estimates of costs and consequences. Finally, the presentation of study results should include a discussion of issues of concern to the targeted users of the information, such as generalizability, program implementation issues and comparability to other studies (Drummond et al., 1997).

Knapp (1997) indicates that certain themes in the literature on mental health interventions with children and youth are particularly pertinent to costing studies. These themes are: 1) epidemiological evidence suggests that current interventions do not meet many needs of children and youth; 2) the multiple agencies that provide services to children and youth frequently fail to coordinate their efforts; 3) service providers are unsure whether "managed care" will result in more carefully targeted services to children and youth; and 4) policy makers generally recognize that the economic consequences of child and adolescent mental disorders may be long-term and extensive (Knapp, 1997). Services to at-risk children are very expensive and rarely produce results in the short term, but the resources expended today may well result in enormous savings in the future (Bagley & Pritchard, 1998; Littner, 1974). The greatest savings may be derived from mental health services that are carefully targeted to ensure the greatest impact on the quality of life of children and their families (Knapp, 1997). Littner (1974) points out that placement in out-of-home care cannot substitute for adequate mental health services to vulnerable children. That is, the higher children's needs are, the more they need professional services in addition to regular foster care.

Knapp (1997) proposed that costing studies can help inform difficult choices between competing programs for meeting children's and adolescents' needs for mental health services and programs. In particular, evaluations of cost and outcomes can provide answers to five

generic research questions in the health economics field: "What intervention is most cost-effective? Where is the treatment most cost-effectively provided? When? To whom? How?" (Knapp, 1997, p. 4).

In a literature review, Knapp (1997) found that economic evaluations in child and adolescent mental health services are rare. He discovered only two studies that provided answers to the "What" question. He had expected to find answers to the "What" question included in clinical drug trials with children because cost data for these interventions would be readily available. However, he found that the literature included few controlled drug trials with children and none of these included cost data. As a result, he concluded that cost evaluations are so rare in the literature on child mental health interventions that they are even absent from the areas of research where they would be most expected.

In a study of the costs of assessment services for children, Beecham and Knapp (1995) found that assessment costs were higher for children in residential care than for those in foster care. However, the children in residential care also tended to have more emotional and behavioural problems. In fact, 60 per cent of the variations in cost could be explained by the following characteristics: mixed race parentage, behavioural problems, and self-injury or suicide attempts, and prior contact with the youth justice system. Their findings suggested that the money was well-spent: at a follow-up one year later, higher assessment costs were associated with better child outcomes.

Knapp (1986) also compared the costs of public sector, private sector, and voluntary sector residential care for children. One of the variables he looked at in this research was economies of scale. He discovered that larger scale homes in the voluntary sector were more

expensive than smaller scale ones. Knapp described the small scale voluntary homes were described by Knapp as being very similar to foster family care. He concluded that when the scale of production increased beyond what could be easily handled by a dedicated couple, the costs of care also increased.

Knapp and Smith (1985) undertook a cost-function analysis of residential child care services in Britain to examine variations in cost. They obtained their data for this study from 448 community residential facilities that participated in a survey of a representative sample of 789 children's residential care facilities. They used financial information provided by the facilities to calculate costs. Using accounting information to calculate costs is an expedient and less expensive route for gathering data than comprehensive costing procedures. These researchers used accounting information because resources for the study were too limited to permit comprehensive opportunity costing. In addition, capital costs were excluded from the study. Knapp and Smith (1985) chose to analyse the data at the facility level (the group home level) because there was considerable variation in costs between the group homes and they wanted to explain these variations. Final outcomes were not included in the cost-function analysis because the researchers had no means of measuring these outcomes in the study. To measure client outcomes, data on child functioning would need to have been collected at two points in time, once at the beginning of the year for which cost data were provided and once at the end of the year. This study of residential child care included only one data collection point and was, therefore, cross-sectional. Since the facility was chosen as the unit of analysis, the cost-function could be used to predict variations in the average cost per child for each facility. Cost data was deflated by using input prices as separate predictors in the regression analysis

(Knapp & Smith, 1985). In this study of children in residential care, children under four and in the mid to late teens were found to have higher costs of care than children of other age groups. Also, the cost function equation predicted higher costs for those facilities with a lower ratio of girls to boys (Knapp & Smith, 1985). As would be expected, facilities with a higher ratio of children with physical handicaps also had higher average costs (Knapp & Smith, 1985).

An unpublished pilot study of the costs of foster care was undertaken by Flynn and Lemay (1999), as part of the LAC study in Ontario. Their findings were used to develop the service questions on the AAR, used in the current costing study. The average cost per child in this pilot study was similar to the average cost found in the costing study undertaken for the costing study described in this thesis.

3.1 Summary and critique of the literature

In reviewing the literature economic evaluations of children's services, I was unable to find any published costing studies of foster care, per se. In fact, the only published costing studies of children's services that I found were those described above, which were undertaken by Knapp and his colleagues at the PRSSU. Their research on residential services, was cross-sectional and so did not include analyses of outcome variables. Their costing study of assessment services compared the costs for children in residential services to those in foster care, and included two data collection points, a year apart. This last study, therefore, involved a comparison of two types of treatment and an evaluation of outcomes over time. Therefore, with regard to Drummond's guidelines for evaluating economic studies, all three studies described above asked well-defined questions, but only one included an examination of effects and a comparison of alternatives. In addition, Knapp's study of residential services used accounting

costs provided by the agency, rather than the recommended POW approach of comprehensive opportunity costing. The findings of these costing studies suggest that emotional/behavioural problems, gender and age were all associated with differences in costs of some child welfare services. Therefore, these variables are appropriate for inclusion in the analyses in the current research.

The next section of this document will examine Looking After Children (LAC) approach, which was developed as part of a renewal of child welfare services in Britain and has now been exported to many other countries. We will also describe the conceptual models that underpin the LAC approach.

4.0 The Looking After Children (LAC) approach

Both this costing research and the larger project of which it is a part are based on LAC, and the two conceptual models that underlie the LAC approach to children's services: the Competence model and the Production of Welfare (POW) model. The next five paragraphs will summarize the overview of the LAC approach as described by Parker and her colleagues (1991).

Research in Britain in the late 1980s suggested some needs of children in out-of-home care were not being met. This research, along with the emerging trend toward preventive policies that aimed to keep children with their natural families, convinced policy-makers and program managers to re-evaluate the effectiveness of child welfare programs. In some cases, policies that favoured family reunification over long-term out-of-home care had resulted in children being re-abused after they were returned to their families. Consequently, policy makers and service providers wanted to better understand the factors that contributed to failures in the

child welfare system. They were also concerned about costs and wanted to better assess the effectiveness of services targeted at high-risk children.

In 1987, the British Department of Health set up a working group to review research on outcomes in child welfare. The committee members ascertained that previous research had mainly focused on placement breakdown as the measure of effectiveness, and the outcomes measures in use were unsatisfactory. In fact, the committe members discovered that outcomes were rarely assessed in child welfare. Furthermore, research was unclear about whether children's outcomes were the result of social welfare interventions or of other factors outside the control of child welfare agencies.

After the working group was established, the British parliament enacted new legislation to establish a reliable process for setting goals and evaluating outcomes. This legislation required that the views of children, their families and caregivers be considered in establishing goals and deciding which outcomes to measure. Moreover, child welfare agencies were to take a supportive rather than a punitive role, with biological parents retaining some responsibility for their children. Child welfare agencies were to consult biological parents about their children's care. Consequently, the LAC approach focuses on the outcomes of the individual child, rather than on family, professional, service or public outcomes.

To measure children' individual outcomes, questionnaires called Assessment and Action Records (AARs) were developed. The AARs are used to assess children's progress on developmental objectives derived from research and to plan interventions that aimed at achieving these objectives. These questionnaires are designed to provide research data and to help practitioners set goals for intervention that are specific to the needs of each child. The

progress of each child is to follow a sequence from short-term to intermediate to long-term outcomes. The AARs provide a means to continually re-evaluate each child's progress through this sequence of outcomes. To measure progress, children-at-risk are compared to their peers in the general population, to determine if and where they are falling behind. Therefore, this approach is both dynamic and relative: dynamic because it assesses changes over time, and relative because it uses an external point of reference (population norms).

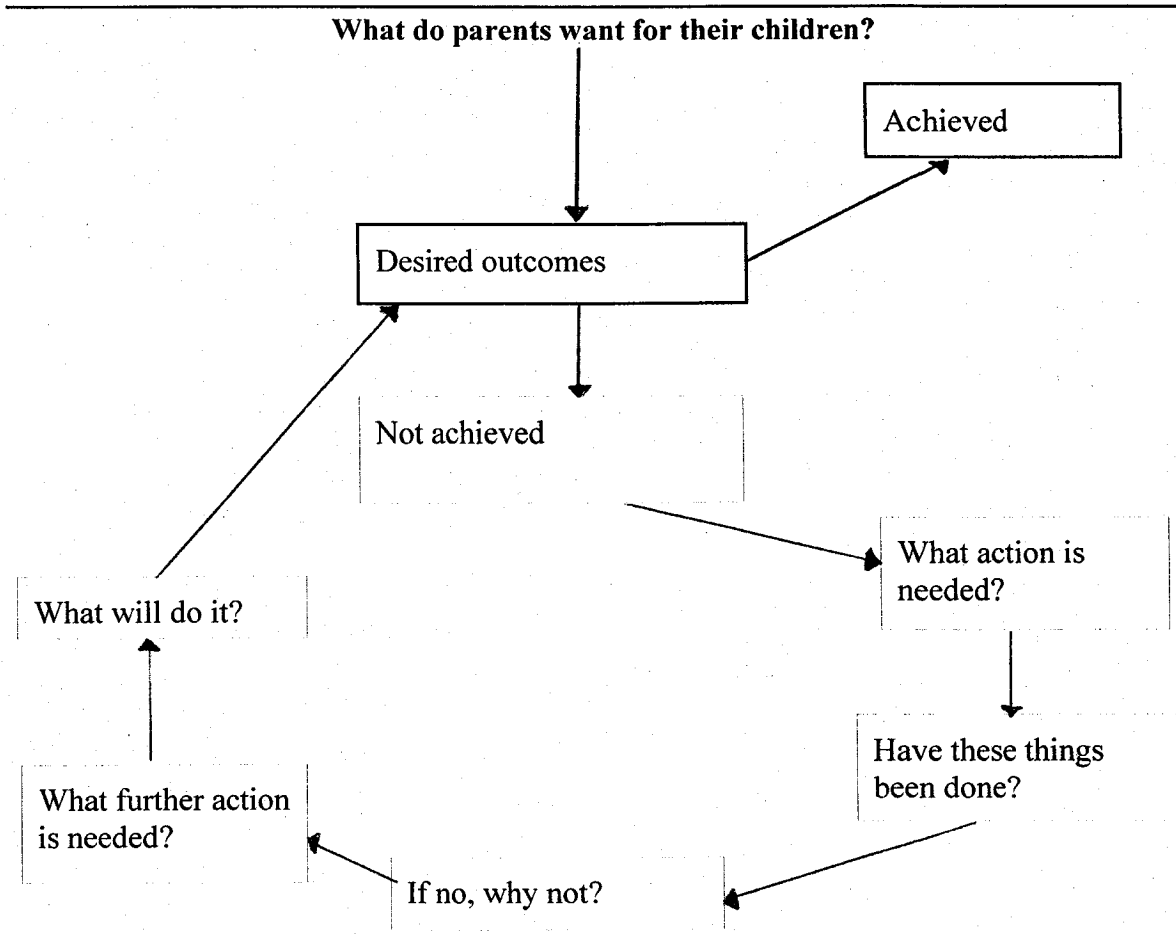
In the LAC approach, two complementary models for assessing outcomes in children's services are combined: the Competence model and the Production of Welfare (POW) model. Both these models use an interactional approach: each draws attention to intermediate outcomes and emphasizes any particular outcome involves a complicated interaction between factors.

4.1 The Competence Model

Parker and colleagues (1991) state that *competence* has been defined by psychologists as the factors that enable individuals to cope with the challenges in their lives. This concept is borrowed from Maluccio (1981), who describes competence as resulting from the combination of an individual's abilities, skills, motivation and certain aspects of the environment, such as social support, that influence an individual's capacity to manage life stresses and events. Because outcomes are the result of the interplay of individual and environmental factors, effective interventions can be aimed at either the individual or the environment (Aldgate, Maluccio & Reeves, 1989). This inclusion of environmental factors prevents blame of the individual for his or her problems. From this perspective, the social worker's job is to assist individuals to apply to new situations coping strategies that they have used in the past in other situations (Parker et al., 1991; Durkin, 1990).

The competence model is incorporated into LAC by assessing children's skills on seven dimensions of development on the AAR. The seven dimensions are: health, education, identity, emotional and behavioural development, family and peer relationships, self-care skills, and social presentation. In the LAC approach, the goal of interventions then is to improve outcomes on these seven dimensions. Figure 1 provides a graphic representation of how this model uses information from the AAR to guide interventions.

Figure1. The Competence model in action: Assessment and Action Record



Adapted from Jackson (1995, p. 329).

4.2 The Production of Welfare (POW) Model

The costing model associated with the LAC approach is the Production of Welfare model developed by Martin Knapp (1984) and his colleagues from the Personal Social Services Research Unit (PSSRU) at the University of Kent in Canterbury, England. This model provides a framework for many costing studies in social services, where the aim of the services is to improve clients' welfare (Beecham, 2000). This costing model is based on four main criteria for service and resource allocation. In the next section of this thesis, Information on these criteria will be summarized from the writings of Knapp and his colleagues (Bebbington & Davies, 1983; Knapp, 1984, 1995; Knapp & Lowin, 1998).

4.2.1. POW Criteria. Initially, the researchers at the PSSRU based their methodology on three criteria for service and resource allocation, the "three Es": Economy, Efficiency, and Effectiveness, which increasingly form the basis of public sector costing studies of health and social services (Knapp, 1995). To ensure a fair and just distribution of resources to service users, Knapp (1984, 1995) argued for the inclusion of a fourth "E": Equity.

In the allocation of resources, *Economy* is concerned with saving resources. To achieve economy then detailed and accurate cost information is required. However, on its own, economy alone is an insufficient criterion, because allocation decisions must also involve an evaluation of the impact of lower spending on the clients who receive services, or on their families or society at large.

Effectiveness is the criterion concerned with outcomes, that is, the achievement of program objectives or the impact of services on clients and their families. In child welfare, effectiveness is "conveniently defined as improvements to child and family welfare, health or

quality of life" (Knapp & Lowin, 1998, p. 172). Effectiveness, strictly speaking, is independent of cost. Therefore, like economy, effectiveness is an insufficient criterion because allocation decisions must include an examination of costs. In child welfare, effectiveness may be methodologically difficult to measure because many of the most important intervention outcomes with children may not occur until years after the service was provided. Consequently, these child welfare outcomes are likely to be complex and difficult to attribute to the intervention itself. In child welfare, therefore, interventions that halt a deteriorating trend or accelerate an improvement are viewed as signs of program effectiveness. This means that a comparison group or *set of norms* is generally required to assess effectiveness. Knapp and Lowin (1998) suggested that comprehensive measure of effectiveness is partly subjective as it would by necessity include service users' perceptions of their quality of life. Because children may be unable to provide reliable information on their outcomes, effectiveness may be difficult to measure in child welare. Furthermore, because interventions in child welfare often have multiple clients, the question of whose outcomes should be assessed and whose perspectives are relevant needs to be determined.

Efficiency links resources and effectiveness. Efficiency can be achieved in two ways: 1) by reducing the cost of a given level of effectiveness; or 2) by improving the volume or quality of outcomes from a fixed budget. In other words, efficiency requires an analysis of costs in relation to outcomes. Knapp and Lowin (1998) caution against equating efficiency with cutbacks: efficiency is sometimes achieved by spending more rather than spending less.

Equity is associated with needs rather than outcomes. This criterion requires that the level of need be considered in determining whether to provide services and how much resources

to allocate. To ensure a fair and equitable distribution of resources, services must be targeted to those most in need. Equity is not the same as equality: the aim of equity "is a fair and acceptable way to distribute resources or services *unequally*" (Knapp, 1995, p. 15). Knapp describes two forms of equity: (1) *Horizontal equity*, defined as "the equal treatment of equals" (Knapp & Lowin, 1998, p. 173), which is achieved when individuals with the same needs receive equal services; (2) *Vertical equity*, "the unequal treatment of unequals" (Knapp & Lowin, 1998, p. 173), which means allocating different levels and types of services to individuals whose needs differ. *Target efficiency* refers to how efficiently equity is pursued; that is, whether the program provides individuals with services tailored to their needs.

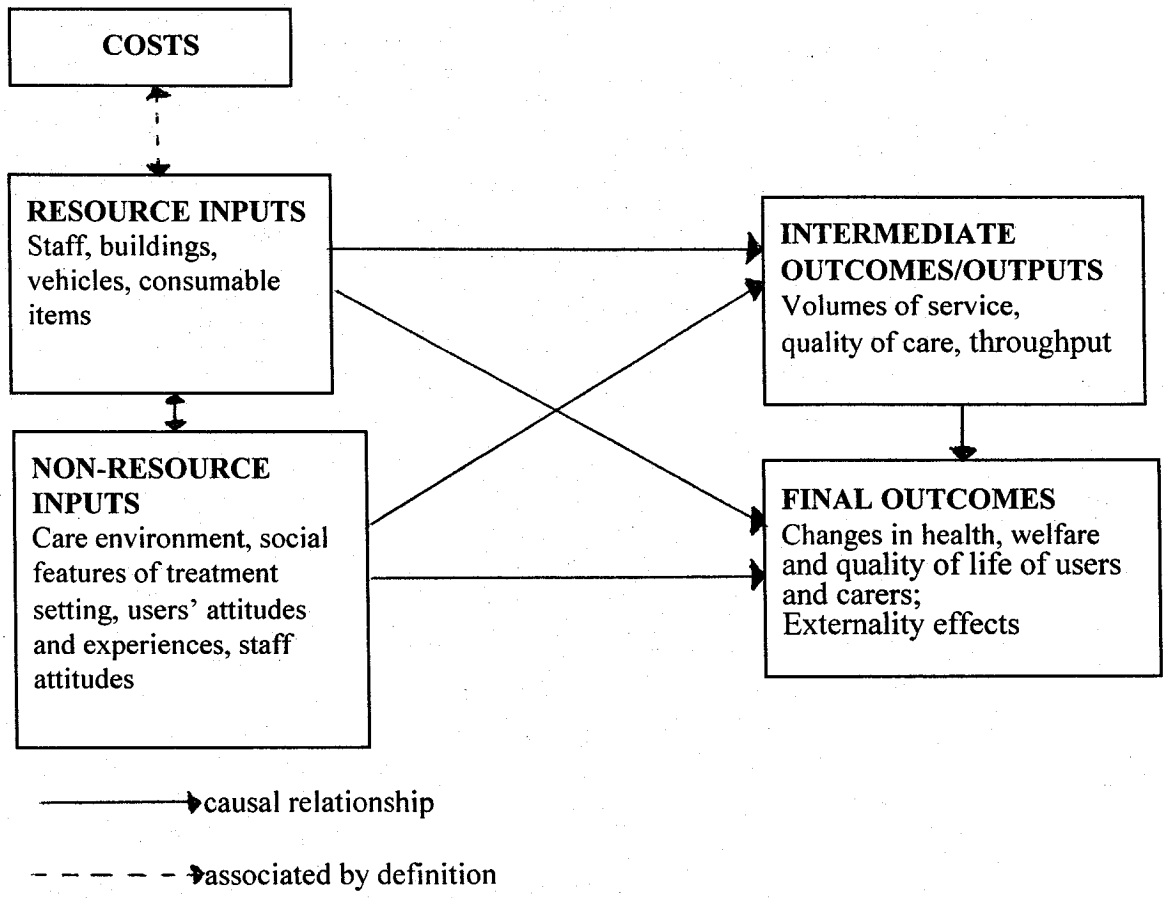
4.2.2 Elements of the POW model. The elements of the POW model are illustrated in Figure 2. The elements of service delivery provide a conceptual framework for defining and measuring the four allocation criteria described above. As stated by Knapp (1995): the model "encapsulated the economist's perspective on the organisation and allocation of services and user-level achievements" (p. 17). As such, the model summarizes the relationships between services and outcomes. The following is a description of the components of the model and their inter-relationships.

According to Knapp (1995), the five elements of the model are costs, resource inputs, non-resource inputs, intermediate outcomes or outputs, and long-term or final outcomes. *Costs* include the costs of all resource inputs and, therefore, is associated by definition with resource inputs. The *resource inputs* include the staff, capital, and consumables used to provide services. Another way of viewing the resource inputs is as the budget for an agency plus any added opportunity costs of resources that are not billed to or reimbursed by the agency. The

non-resource inputs are factors that influence outcomes, but cannot easily be priced nor have their opportunity costs calculated. In child welfare, this would include the care setting, staff attitudes, and the personal characteristics of children and their families, including children's life histories.

The *outputs* or *intermediate outcomes* are the volumes of service components provided, but should include a quality of care aspect and be weighted to include some aspects of user characteristics. The *final outcomes* are changes over time in the health, welfare and quality of life of children and their caregivers in comparison to a standard or a set of norms. These changes are viewed as a direct result of program services, resource allocations and the social environment of care.

Figure 2 The production of welfare



Taken from Knapp (1995, p. 16), The Economic Perspective: Framework and Principles

The production of welfare model, therefore, summarizes the complex inter-relationships between service-costs and resources and user-level outputs and outcomes. Effectiveness, efficiency and equity can all be defined and described in terms of the components of the model (Knapp, 1995). If program managers consider information about only one or two of these components when they allocate program resources, they will achieve an incomplete understanding of how the intervention works and they may allocate scarce resources to less

effective programs and strategies of intervention. Knapp and Lowin (1998) suggest that the POW model can help child welfare researchers and professionals to organise and interpret clinical evidence, to develop and interpret performance criteria, and to understand variations in costs and outcomes.

5. Economic evaluations and costing studies

Now that we have presented the POW model as one of the conceptual models of the LAC approach, we will next look at where the POW fits with regard to the types of economic evaluation and costing studies.

5.1 Types of economic evaluation

In this section, I will give an overview of the types of evaluations that economists commonly use and find most informative are: cost-benefit analysis (CBA) and cost-effectiveness analysis (CEA) (Beecham, 2000; Knapp & Lowin, 1998; Torrance, 1986). Both CBA and CEA include measures of outcomes in the analysis, but in different ways so they answer different policy and practice questions (Knapp & Lowin, 1998).

5.1.1 Cost-benefit analysis (CBA). In *cost benefit analysis*, costs and outcomes are measured in the same units, usually monetary, and a net social benefit is calculated by subtracting the monetary value of the costs from the monetary value of the benefits (Torrance, 1986). Costs and benefits can, thereby, be directly compared so that anytime benefits exceed costs (i.e., the net social benefit exceeds 0), economists may recommend implementing or continuing a program (Knapp & Lowin, 1998; Torrance, 1986). Economists can use this type of analysis to assess a single program or to compare similar or dissimilar programs (Torrance, 1986). However, when comparing programs that serve dissimilar populations, this type of

analysis would be biased in favour of programs that serve individuals in the labour market (Torrance, 1986). Consequently, this approach is of limited usefulness in child welfare because there is no straighforward method of evaluating outcomes in child welfare in monetary terms (Knapp & Lowin, 1998).

Cost-savings analysis (CSA) is a variation of CBA that can used to evaluate programs that serve children. CSA can assess long-term benefits of children's programs that are easily monetized, and these benefits can sometimes outweigh the cost of the program (Karoly, Greenwood, Everingham, Houbé, Kilburn, Rydell, Sanders & Chiesa, 1998). CSA may demonstrate that funds invested early in the lives of at-risk children can create considerable long-term government savings (Karoly et al., 1998). The four types of significant long-term savings or monetary benefits may include: 1) increased tax revenues; 2) decreased welfare expenditures; 3) reduced expenses for education, health and other services; and 4) lower criminal justice costs. CSA program evaluations require an experimental design and a sample size large enough to allow for statistically significant differences between two groups (Karoly et al., 1998). Program outcomes and cost savings must be measured long-term and attrition of paritiepants must be low. However, leading indicators may be used to estimate some longer-term predicted cost-savings. In other words, some measured outcomes may be used to estimate unmeasured outcomes, in situations where previous research has demonstrated a relationship between the measured and unmeasured outcomes (Karoly et al., 1998).

5.1.2 Cost-effectiveness analysis (CEA). In *cost-effectiveness analysis*, costs and outcomes are not measured in the same units, so instead of a net social benefit, the end result of a CEA is a ratio of cost/effects (Torrance, 1986). Generally, this approach is used to choose

between alternate programs with similar objectives that are aimed at the same client groups (Knapp & Lowin, 1998; Torrance, 1986). If two options cost the same, the one with better outcomes is chosen for implementation or continuation (Knapp & Lowin, 1998). If the two alternatives have similar outcomes, the one that costs less is chosen (Knapp & Lowin, 1998). One difficulty with this approach for child welfare research is that it generally calculates the cost effectiveness ratio from a single outcome measure, for example placement breakdown (Knapp & Lowin, 1998).

Torrance (1986) describes CUA, the newest approach to economic evaluation, as a form of CEA (Torrance, 1986). In CUA, outcomes are expressed as quality adjusted life years (QALYs) and are measurements of health improvements. Although the outcome variable in a CUA is a single measure, a health utility score expressed in QALYs, this single measure is multidimensional so it avoids the one-dimensionality of outcomes in traditional CEAs. That is, the outcome measure is single score, but includes information from several dimensions of outcome, for example a health index that includes information on physical, emotional and cognitive health. Because CUA uses a common measure of effectiveness, it can be used like CBA to compare quite distinct programs. If an appropriate method of measuring health utility for social care programs is available, this method would theoretically fits well with the POW model.

Because the outcomes of child welfare interventions are generally much more complex, a variation of CEA called *cost-consequences analysis* (CCA) is preferred over traditional CEA for child welfare research (Knapp & Lowin, 1998). Technically any of these approaches to economic evaluation (CBA, CSA, CEA, CUA, or CCA) can use the POW model, as they all

include costs and outcomes and examine the relationship between them. However, CCA, although considerably more difficult to compute than CEA, is closer to the everyday reality of child welfare programs and, therefore, preferred.

5.2 Costing studies

Sometimes, however, practical, time or monetary constraints do not permit evaluators to carry out a formal economic evaluation of any type. In those situations, other types of costing studies may still provide some useful information with regard to costs and outcomes. For example, Knapp and his colleagues sometimes conduct cross-sectional costing studies, when a longitudinal study is required to determine effectiveness. Sometimes, time and money constraints also prevent the use of a comparison group. In those situations, costing research can still provide a good estimate of the costs of a program and regression analysis can provide some information for predicting outcomes from costs (Knapp, 1984).

The research described in this thesis includes multiple outcome measures and is, therefore, similar to a CCA. However, since no comparison group has been included, it is technically not a CEA of any type. In the research described in this thesis, variations in costs in relation to changes on outcome measures are used to determine whether costs can predict outcomes. This permits the research to determine whether there is a relationship between the amount of money spent and positive outcomes for the children and youth receiving services. While this approach cannot determine whether foster care is cost-effective, it can determine whether the amount of money spent on foster care services is associated with positive changes in the health and functioning of children in care.

5.3 POW costing methodology

5.3.1 Estimating costs. The next few paragraphs will summarize how Beecham (2000) describes the POW methodology for estimating costs. In any costing study that uses the PSSRU Production of Welfare model, the first step consists of a comprehensive description of all services included in the package of care, and calculation of the unit costs of these services. Beecham (2000) states that service costs need to be more widely understood to ensure that high quality services are delivered to children. Furthermore, to permit costs to be compared across agencies, programs, or locations, costs must be consistently measured.

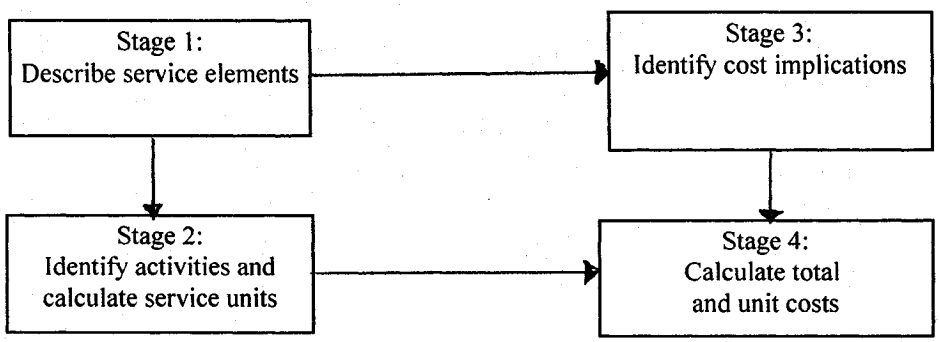
There are two ways of estimating costs: top-down or bottom-up. The *top-down* approach consists of starting with the total costs of a services and then estimating the average costs for each program recipient from the total (see Allen & Beecham, 1993). The *bottom-up* approach, in contrast, consists of calculating the total and average costs from the actual unit costs of the service. The bottom-up approach is usually considered superior because it is likely to include more elements of the service and, therefore, result in a more accurate calculation of total and average costs. However, the need to identify all the elements of the service makes the bottom-up approach more time-consuming and challenging than the top-down approach. On the other hand, because the bottom-up approach is more comprehensive, it permits more confident comparisons of costs across agencies, programs, or locations. As much as possible, the bottom-up approach has been used in the costing study described in this thesis.

Aggregate costs provide summary cost variables for each individual child and a means to link children's needs and outcomes to services-costs (Beecham, 2000). To arrive at aggregate costs, we establish the amount of each service that each child receives, then work out the cost of

each unit of service before adding everything together. The costs of each unit of service should include the salary of the individual providing the services, as well as the cost of administrative support services, of shared office space and of management services. For costs to be comparable, overhead costs must be measured consistently. Comparisons are frequently made between service costs at agencies in different communities (urban vs rural) or sectors (such as, contractor or in-house providers) that deliver services differently.

5.3.2 Fundamental Principles. There are four general principles in estimating unit costs. First, the unit cost for each service needs to be comprehensive, that is include all components of the gross total cost to the agency of providing the service: staffing, building, power, maintenance, management, payroll, administration, as well as any contributions for other agencies or budgets.

Figure 3. Representation of the service costing model



Taken from Allen & Beecham, 1993, p.29

Second, the unit cost should be expressed in a way that reflects how the service is delivered and permits the costs to be aggregated. In other words, unit costs are measured for the units in which service is provided, for example, bed-days for residential care, but contact hours for social work services. The unit costs can then be aggregated for groups of children so that variations in care package costs can be examined in relation to service setting, socio-demographic variables, and children's needs and outcomes. Aggregate costs can be compared, for example, by age, gender, needs category or other characteristics by which service users can be grouped.

Third, unit costs should reflect long-term marginal opportunity costs. A marginal cost is the cost of serving an extra client, and this cost can be calculated for the short term or the long term. However, the short-term perspective is usually inappropriate in health and social services, where the social costs of expanding services are generally not evident in the short term. All opportunity costs need to be included in the package of care, particularly when a choice is being made between alternative programs. Therefore, comprehensive costing should assess costs of foregone opportunities, such as paid employment by voluntary workers.

Finally, unit costs need to be as up-to-date and reflect prices and costs during the period during in which the service was delivered. Costs may vary considerably from year to year, so that using cost information gathered during the previous year may lead to erroneous conclusions about cost-effectiveness and poor allocation decisions in the future.

5.3.3 Stages. Figure 3 provides a graphic illustration of the stages of PSSRU unit costing model: 1) describing the components of the service; 2) identifying the activities and a unit of measurement; 3) estimating the costs of the service elements; and 4) calculating the unit

and total costs for services (Beecham, 2000). Describing the components entails listing every aspect of a service: the building used, office services, food and travel arrangements, and the number, level and working hours of all staff, as well as any hidden costs, such as resources shared with another agency. Identifying the activities means listing all the activities of the service providers and deciding on an appropriate unit of measurement for services (for example, bed-days or contact hours). Service-specific financial information is often difficult to obtain, so this is a time-consuming process. Service providers may hesitate to explain how their budgets are spent but this information will ensure that cost estimates are more accurate (Beecham, 2000). Expenditure accounts, salary scales, superannuation rates, and new purchase information for capital goods can all be used to calculate cost estimates (Beecham, 2000).

To calculate the unit costs, the financial information is adjusted to ensure that all service elements are included and each component is treated appropriately. Long-term investments, such as buildings, are usually represented by calculating capital opportunity costs, so that the capital costs are expressed in a way that matches revenue costs, that is per-annum costs. Unit costs are then aggregated to calculate total costs for the package of care for each individual.

5.4 Exploring Cost Variations

Once a total cost has been computed, Knapp (1984) advocates that cost variations be explored using statistical cost analysis to arrive at a cost-function equation. The cost-function is essentially a means of examining and attempting to explain cost variations through a series of exploratory multiple regression equations to find the equation that best fits the data.

5.4.1 Cost-function. The aim of cost-function analysis is to explore the relationship between the cost of providing a service and other variables that may explain variations in cost.

The statistical method used to achieve this 'explanation' of variations is multiple regression (Knapp, 1984). Theoretical considerations and the findings of previous research studies are used to determine the form of the cost-function *a priori*.

The information from these cost function analyses can be used to lower program costs while maintaining quality of service (Knapp, 1984). Understanding variations in costs can also improve program equity by targetting resources where they are most needed. Using equity as a criteria for resource allocation implies the assumption that the more extensive clients' needs are, the more extensive the services required to meet those needs (Beecham, Knapp & Fenyo, 1993). To test this assumption, measures of needs are included in the cost function regressions. The cost function also provides a means of distinguishing between avoidable and unavoidable influences on cost. For example, the amount of money that an agency must pay for its resources may be unavoidably higher in urban than in rural areas (Knapp, 1984).

The first stage of calculating the cost-function is to select the production unit to be analysed. Knapp (1984) indicates that production takes place at three levels: the individual client level, the facility level, and the agency or organizational level. In residential care, production is difficult to monitor at the individual level since most resources are shared with other clients. Therefore, Knapp (1984) recommends the organizational level, unless there are great differences in costs between facilities.

The second step involves deciding on a measure of output: in social care research, multiple final outputs, that is the attainment of client-level objectives of the services, are usually preferred. However, the researchers may also include 'intermediate outputs,' which are measures of the "extent, range, and variety of care services offered to clients" (Knapp & Smith,

1985, p. 128). These intermediate outputs generally include the volume of output, the throughput or rate of production, and some indicators of the quality of care (Knapp, 1995; Knapp & Smith, 1985). The volume of output is also referred to as the scale of production, such as the number of places available in a home. Economies can be realized from these volumes of output, for example if from the capacity of a facility is increased because more extensive use is made of the building, which is a fixed resource. On the other hand, diseconomies of scale may result if prices for scarce resources, such as qualified social workers, rise or when employees in a larger facility become demotivated (Knapp & Smith, 1985).

Throughput or the rate of production is a measure of the extent to which the available capacity of the facility is used (Knapp & Smith, 1985). This can be measured by occupancy rate (the average number of residents in the facility divided by the average number of places) or by the admission or turnover rate and the average length of stay.

Characteristics of service users may also predict differences in average costs. For example, food costs are likely to be higher for older children, and children with emotional or behavioural problems are likely to require greater staff time and attention (Knapp & Smith, 1985). Knapp and Smith (1985) state that many child characteristics may have cost raising implications, but may be time-consuming and complicated to measure reliably. They suggest that age, gender and disability are important characteristics to measure and explore in cost function analyses.

Knapp and Smith (1985) also suggest including indicators of the quality of care, which may be useful substitutes for final outcomes, when they have proven relationships with the client outcomes targeted by the service providers. Quality of care indicators include aspects of

the social and physical environment of the facility. This might include such factors as bedroom size and distribution or access to private space.

Knapp (1984; Knapp & Smith, 1985) emphasize that staffing ratios should not be included in the cost-function analysis, because they measure the same thing as costs: that is, resource inputs. Furthermore, staffing ratios may be higher in one facility than in another because the residents of that facility have higher needs and, if so, need is the true predictor of the cost variations. Variations in staffing ratio do need to be explored, therefore, to ascertain the reason for these variations that may have unavoidable influences on cost. However, some staff characteristics, such as attitudes, experiences, and qualifications, can be legitimate predictors of cost variations and may be included in the cost function analysis (Knapp & Smith, 1985). Knapp and Smith (1985) state that variations in the average cost of care between agencies should not be interpreted as differences in efficiency.

The third step in calculating the cost-function is determining the time unit to be studied, ideally a complete production cycle (Knapp, 1984). However, most studies are restricted to annual, or quarterly data, since the cost of collecting more frequent data is often prohibitive. For the fourth step, the researcher needs to decide on a time-series or a cross-sectional design, or ideally a combination between the two. Originally, most evaluations were cross-sectional, but combining cross-sectional with longitudinal research permits estimation of both a short-run cost-function a long-run cost-function (Knapp, 1984).

The fifth step is deciding on the measure of cost: opportunity costs or accounting costs (Knapp, 1984). Opportunity costs are preferred but they are less readily available and more difficult and more expensive to measure than accounting costs. Knapp recommends that all

operating costs be measured, including overhead costs and salaries, as well as other opportunity costs and all costs to service-users and their families (Knapp, 1984). In keeping with the theory of long-run costs, he recommends including capital costs, although current accounting practices for social care may mean that depreciation costing is distorted.

The next step is to select the cost concept to be explained by the cost-function: either average or total cost. Knapp (1984) suggests that errors of measurement in the basic output variable can lead to bias and spurious correlation when average costs are used. Total costs, on the other hand, are more susceptible to multicollinearity and heteroscedasticity. In general, average costs are more frequently used, perhaps because they have more intuitive appeal.

The seventh step in estimating the cost-function is deflating the cost data, using input prices to deflate the observed costs before estimating the cost-function, or including the input prices as separate predictors in the regression analysis, as suggested by cost-function theory (Knapp, 1984). The following step is to match cost with output and other determinants. That means that all costs for services provided and for outcomes achieved during the period of the evaluation must be included, even if there was a delay in payment or recording of the expenditures (Knapp, 1984).

The final step in the estimation of the cost-function is to select the form of the cost-function itself, for example, additive, multiplicative, or log-linear. Knapp suggests that this be selected *a priori* if possible, although post-estimation comparisons of alternative forms may be necessary. The criteria for selecting the final form of the cost-function should be: the statistical significance of goodness-of-fit, agreement of the cost-function with prior restrictions or notions, and parsimony (Knapp, 1984).

There are two stages to the estimation of the cost-function: in the first, as many cost-influencing factors as possible are included in the analysis, then those not considered sufficiently reliable are omitted (Knapp & Smith, 1985). At the second stage, they report a single cost-function equation that on the grounds of statistical significance has the best fit (Knapp & Smith, 1985).

Statistical cost-function analyses are still relatively rare in children's services. This is unfortunate, as cost-function analyses can provide basic information for planning and providing optimal care (Knapp, 1984). Criticisms of cost-function studies have generally been related to inadequate research methodologies in particular studies and not of cost-functions themselves (Knapp, 1984). For example, some studies were criticized because opportunity costs were not used, time references were not explicitly stated, capital costs were excluded or inappropriately measured, or overhead costs were omitted (Knapp, 1984).

An additional criticism is related to the theoretical assumption of cost minimization as an objective of production (Knapp, 1984). Cost minimization is not the goal of a cost function analysis, which can only represent the mean relationship between cost and output (Knapp, 1984). However, cost-functions remain useful, since non-minimization does not invalidate cost or production functions, but simply means both the cost function and the production function can be interpreted as expressing a behavioural rather than a technical relationship (Knapp, 1984). Knapp (1984) concludes that cost-function analysis is the most appropriate, valid and useful technique for comparing cost variations in social care.

5.3.1 Production function. The production function uses cost to predict final outcomes in the POW model. Because the aim of child welfare interventions is improve services to

children and their families, costs have to be linked to outcome data and analysed and interpreted in conjunction with the outcomes (Beecham, 2000). The production function equation predicts positive changes in functioning on outcomes that are measured longitudinally. Cost is one of the variables used in the multiple regression equations to predict these positive changes. Needs at the baseline and other factors associated with variations in cost also need to be controlled for in the production-function equation. A separate function is estimated for each outcome, or an output index is calculated (Knapp, 1984).

6.0 Objectives and research questions

The costing research described in this thesis has five objectives. The first three are: 1) determining the costs of services received by children and youths in the study; 2) computing the total costs to society of the package of care provided to each child; and 3) exploring variations in cost related to characteristics of the foster care environment and of the child. The information on total costs and cost variations can then be used to analyse costs in relation to needs. The fourth objective of this study is to predict the average total annual cost for the package-of-care for children in foster care from an index of ill-health, which includes physical, cognitive and emotional items. The fifth objective of this study is to establish the relationship between costs of foster care and positive changes in children's emotional/behavioural functioning. More succinctly stated, this study aims to answer the following question: Do the costs of services for the twelve months between Time 1 and Time 2 predict the changes from Time 1 to Time 2 in the level of children's functioning on emotional/behavioural factors?

The total annual cost of foster care is the predicted or dependent variable in the regression analysis examining variations in cost. To examine differences in cost, we will use

the following demographic variables to predict variation: gender and age in years of the child or youth in care. In addition, we will determine whether type of care (kinship vs foster care) predicts variation in costs.

This study aims to answer the following questions:

1. What are the total costs of foster care to society as a whole, that is the total costs to the CAS, other government ministries, the foster parents and volunteers? What are the component costs, that is the portion of costs covered by each of the following: the foster parents, the CAS, government ministries and volunteers? And what percentage of the total costs per child do the component costs represent? For example, what percentage of total costs are covered by CAS, by foster parents, etc.?
2. Do average costs for the package of care vary by the type of out-of-home care (foster vs kinship)? By the age of the child? By the gender of the child?
3. After controlling for children's age and gender and placement type, is there a relationship between children level of ill-health and the costs of the services they receive? In other words, do higher health needs predict higher costs?
4. After controlling for age, gender, placement type and ill-health at the end of Year 1, do costs of the services that children received during the 12 months between the end of Year 1 (T1) and the end of Year 2 (T2) predict improvements in children's psychosocial functioning and health from the end of Year 1 (T1) to the end of Year 2 (T2)?

7.0 Hypotheses

This study aims to verify the following hypotheses:

1. After controlling for gender and age of the children/youths in care, and type of placement, higher health needs of children at Time 1 will predict higher costs during the twelve months between Time 1 and Time 2 of the study. This hypothesis is consistent with Rosenberg and Robinson's (2004) findings that children with greater health needs had higher foster care costs than other children in foster care.
2. After controlling for the effects of gender, age, and type of care, and the children's health needs at Time 1, higher costs during the twelve months between Time 1 and Time 2 will predict greater improvements in children's functioning on a measure of self-esteem at Time 2. This hypothesis is derived from theoretical expectations that children's positive experiences in foster care, in which the children's needs are recognized and met, will allow them to internalize a view of themselves as more valued and worthwhile (Steinhauer, 1991).
3. After controlling for the effects of gender, age, and type of care, and the children's health needs at Time 1, higher costs during the twelve months between Time 1 and Time 2 will predict greater improvements in children's functioning on a measure of prosocial behaviour at Time 2. Foster children whose emotional and physical needs are better met in foster care would be expected to develop more positive internal working models of others and a greater capacity to empathize (Pearce & Pezzot-Pearce, 2001). Children who have more positive views of others and a greater capacity to empathize would be expected to show a greater tendency to behave in a prosocial manner.

4. After controlling for the effects of gender, age, and type of care, and the children's health needs at Time 1, higher costs during the twelve months between Time 1 and Time 2 will predict greater improvements in children's functioning on a measure of emotional disorder/anxiety at Time 2. This hypothesis is in keeping with Beecham and Knapp's (1995) findings with regard to assessment services: they found that higher costs predicted better outcomes for children. Furthermore, the research base, though small, suggests that foster care that provides nurturing and therapeutic support to children leads these children to experience better psychological functioning that is sustained even after they leave care (Pottick, Warner & Yoder, 2005).

5. After controlling for the effects of gender, age, and type of care, and the children's health needs at Time 1, higher costs during the twelve months between Time 1 and Time 2 will predict greater improvements in children's functioning on a measure of conduct disorder/aggression at Time 2.

6. After controlling for the effects of gender, age, and type of care, and the children's health needs at Time1, higher costs during the twelve months between Time 1 and Time 2 will predict greater improvements in children's functioning on a measure of indirect aggression at Time 2.

7. After controlling for the effects of gender, age, and type of care, and ill-health at Time 1, higher costs during the twelve months between Time 1 and Time 2 will predict improvements in health (lower scores on the Ill-health Index) at Time 2.

CHAPTER II: METHODOLOGY

1. Context of the study

As mentioned at the beginning of this thesis document, this study forms part of a larger multi-year study on LAC in Ontario (Flynn et al., 1999). This larger study grew out of a pilot study at the Prescott-Russell CAS and now includes almost all the CASs in Ontario. This costing study uses a non-experimental, longitudinal, repeated measures design. The cost analyses are based on the POW model and has the objective of examining variations in costs and outcomes.

2. Description of the programs studied

This study looks at costs for children or youth in foster care in three Ontario CASs, including children in kinship care. The program components costed include staff salaries, costs of professional services, volunteer services, out-of-pocket expenditures by foster parents, spending, gift and clothing allowances, as well as costs of medication and medical supplies reimbursed by the agency. The study uses both accounting data and estimates of costs calculated from service information, using unit cost estimates. Comprehensive opportunity costing was not possible because of time limitations, and although an attempt was made to include capital costs in the study, this information was not provided by the agencies, and so had to be omitted from the calculation of total CAS costs and global costs.

3. Participants

The sample included children and adolescents aged 10 to 20 years of age (n=119) who were receiving foster care services from the three Ontario CASs in the study).

The following criteria were used to select the sample:

1) long-term foster care (6 months or longer) had been planned for these children in Year 1 of the study;

2) the children were Crown wards or Society wards, or were awaiting a court ruling on permanent wardship;

3) the children and their foster parents had consented to participate in the study.

The sample included 56 females (47.1 %) and 63 males (52.9%), who ranged in age from 10 to 20 years of age (M=13.18; SD=2.18). In terms of age groups, 83 (69.7 %) of the participants were between ten and fourteen years of age, and 36 (30.3 %) were 15 years of age or older. Of the 119 participants, 99 (83.2 %) were Crown Wards, 17 were Society Wards, one was a non-ward, while the data on this variable was missing on two participants.

At the time that they were first placed in care, they ranged in age from less than one year to 15 years old (M=7.69; SD=3.75). Of the total, 36 children or youth (30.3 %) were placed in care because of caregiver capacity, 27 (22.7 %) because of physical or sexual harm by commission, 21 (17.6 %) because of harm by omission, and 20 (16.8 %) because of abandonment or separation. At the beginning of the study, the breakdown for the type of placement that participants were in was: 99 in society-operated foster homes, 10 in purchased outside foster care, 2 in Care Homes and 8 in kinship care. With regard to the type of foster care at the beginning of the study, 76 (63.9 %) of participants were in regular foster care, 17 were in specialized foster care, 13 were in special treatment and 13 were in provisional foster care.

At the beginning of the study, most of the participants (86; 72.3 %) had their own bedrooms in their foster home. Twelve (10.1 %) lived in households with one adult member, 73 (61.3 %) in households with two adults, 22 (18.5 %) in households with three adults. Sixteen (13.5 %) were the only child or youth 17 or under living in the dwelling, 23 (19.3 %) lived with only one other child or youth, 30 (25.2 %) with two other children/youths, 27 (22.7 %) with three, and 17 (14.2 %) with four or more. Of the participants, 30 (25.2 %) were the only foster child in the home, 24 (20.2 %) lived with one other foster child, 21 (17.6 %) with two other foster children, and 23 (19.3 %) with three others.

With regard to the CAS providing services, the number of participants from the three CASs were: 44, 43 and 32. Most participants were in foster homes in rural areas: 75 (63 %) of the participants. Of the remaining children and youth, 19 (16 %) were in communities with a populations less than 30,000, 4 (3.4 %) in communities with populations between 30,000 and 99,999, and 14 (11.8 %) in communities with populations of 100,000 to 499,999, and 5 (4.2 %) in communities of 500,000 and over. Foster parents reported that 11 of the children or youth in care participated in weekly volunteer work during the year between Time 1 and the follow-up. In addition, 19 of the youth in the study were reported on the AAR at Time 2 as involved in weekly paid employment.

4. Description of the measurement instruments

One principal questionnaire was used to collect the data for this study: the Assessment and Action Record (AAR). Two versions were used: the one for those 15-years-old and up is included as Appendix A and the one for 10 to 14 year-olds is Appendix B. In addition, information was collected directly from the financial records of the CASs on payments to foster

parents and other caregivers, as well as to private service providers who were reimbursed by the CASs. A supplementary questionnaire, attached as Appendix C, was sent to foster parents after follow-up to gather information on their estimates of out-of-pocket expenditures on their foster children during the twelve months of the costing study, as well as expenditures by the child, biological parents, or by other adults in the child's or youth's life. This questionnaire also asked about reductions in foster parents' incomes and their volunteer hours as a result of their foster care activities.

The AAR is adapted from the questionnaire developed in Britain by Ward and her colleagues (1995), which is a key component of the Looking After Children system, as described earlier in this document. There are six versions of the AAR, one version for each of the following age groups: less than one year old, 1 to 2 years, 3 to 4 years, 5 to 9 years, 10 to 14 years, and 15 years old and up. The current Canadian version developed for those 15 years and over is attached as Appendix A, and the Canadianized version for 10 to 14-year-olds is Appendix B. The six versions of the AAR developed in Britain were adapted by the research team involved in the Looking After Children study in Ontario to fit the legislative and linguistic context in Canada, and also translated into French (Flynn, Ghazal, Moshenko, & Westlake, 2001).

This Canadianized version of the AAR is based on scales used in the National Longitudinal Survey of Children and Youth (NLSCY), and also includes a health utilities measure, the McMaster Health Utilities Index – Mark III (HUI-3), that had been used in other large-scale population studies. The NLSCY was developed by Statistics Canada and Human Resources Development Canada to gather critical information on developmental factors in

Canadian children and youth. It includes questions on child adjustment related to the seven dimensions of development in the LAC approach, as well as social demographic information that will provide data on moderating variables that impact on cost. The inclusion of these variables on both the AAR and the NLSCY data from this study of children in the child welfare system to be compared to population norms provided by the NLSCY data. This is in keeping with both the LAC and POW approaches to costing services in child welfare: both underscore the usefulness of a set of population norms to which research outcomes can be compared (Parker et al., 1991; Knapp & Lowin, 1998).

The following variables from the AAR have been used to assess needs and outcomes:

(1) ill-health;

(2) self-esteem;

(3) prosocial behaviour;

(4) emotional distress/anxiety;

(5) conduct disorder/physical aggression; and

(6) indirect aggression.

4.1 Demographic variables

The AAR questionnaires gathered information on the gender, age, and educational levels of foster parents and child welfare workers, as well as the chidren and youth in care. It also included information on the type of placement, type of foster care and the reason the child or youth was initially placed in care. To test the hypotheses of the current study, the main demographic variables of interest are: (1) the gender and (2) age of the child or youth in care, and (3) the type of placement, that is whether the child is in foster or kinship care.

4.2 Need variable

The variable used to measure need is a Ill-Health Index developed by combining several of the items from the AAR administered at baseline. The need variable, a measure of health needs at Time 1 in the study will be described first. It is composed of items from the HUI-3 and other health questions from the AAR.

4.2.1 Index of ill-health.

The participants' health needs were measured by an index of ill-health calculated by combining scores on several health-related items from the AAR. Initially, we had planned to use the HUI-3 as the measure of health needs. The HUI was developed by researchers in the Health Utilities Group at the Centre for Health Economics and Policy Analysis at McMaster University as a means of measuring health outcomes using multi-attribute utility functions (Boyle, Furlong, Feeney, Torrance, & Hatcher, 1995). Because the HUI is based on the economic theory of rational choices, it is consistent with the theoretical foundation of cost-effectiveness and cost-benefit analyses and, therefore, particularly appropriate for measuring health outcomes in economic evaluations (LeGalès, Buron, Costet, & Rosman, 2002).

The HUI is actually a series of three measures, designated as Mark I (HUI-1), Mark II (HUI-2), and the HUI-3, each developed with a separate purpose in mind. The HUI-1 was designed to evaluate health outcomes of high-risk neonates, whereas the HUI-2 was developed to analyse the cost-utility of childhood cancer treatments (Feeney, Furlong, Barr, Torrance, Rosenbaum, & Weitzman, 1992). The HUI-3, on the other hand, was designed to measure aspects of health in the general population. It has been extensively used for this purpose since 1994 (Richardson & Zumbo, 2000) in surveys that include the National Population Health

Survey (NPHS), the Ontario Health Survey (OHS), and cycle 6 of the Canada-wide General Social Survey (GSS). Because the HUI-3 was developed for measuring health in the general population, it was the most appropriate of the three versions of the HUI for our purpose.

All three measures in the series are comprised of two main components: 1) a classification system that describes functioning on a number of dimensions, and 2) an overall index score that integrates the dimensional scores "with predetermined societal preference ratings of said states" (Richardson & Zumbo, 2000, p. 174). However, because a multi-attribute utility specific to the HUI-3 was not developed, the HUI-3 attribute scores have to be mapped onto HUI-2 attributes to generate a best-estimate utility score for the HUI-3 (Richardson & Zumbo, 2000). The HUI-3 has eight dimensions: vision, hearing, speech, ambulation, dexterity, emotion, cognition, and pain. However, the participants in our study appeared to have difficulty understanding the skip directions on the HUI-3 questions on the AAR. The skip directions are such that this questionnaire is probably best administered by a trained researcher. Because the skip directions were not properly followed, the quality of our participants' responses to the HUI-3 items that follow a skip direction were poor. Consequently, we would have been unable to attain a valid health utility score from our participants's responses.

However, the main questions on the questionnaire, those that preceded skip directions did appear to be answered appropriately, so we felt that we could use those items to create an Ill-Health Index by combining them with other items on the AAR that were also related to health or disability. The Ill-Health Index is comprised of three indices that were calculated from health-related items from the AAR. Two of these indices included items from the HUI-3. The items that were used to develop the Ill-Health Index are listed in Appendix D.

The first of these indices is a disability index, that we formed by counting the number of "No" answers to HUI-Q10 and HUI-Q28 and the number of "Yes" answers to H-11 and E-6 on the AAR. A "No" answer to HUI-Q10 indicates a speech impairment, and a "No" answer to HUI-Q28 indicates a presence of a pain disability. A "Yes" answer to H-11 indicates the presence of a health problem that limits participation in normal daily activities. A "Yes" answer to E-6 indicates that the child or youth was receiving special resource help because of a physical, emotional, behavioural or other problem that limits the kind or amount of school work that he or she can do.

The second index is a long-term conditions index, a count variable derived from counting the number of items marked in response to question H-10, with the exception of the final item(that is items A to O were counted, but the final item P was not). The third index provides a cognitive/emotional dimension to the Ill-Health Index: it is comprised of the three items on the HUI-3 related to memory, thinking and feeling. These are questions HUI-Q25, HUI-Q26 and HUI-Q27. The scores on these three items were summed to get a score for cognitive/emotional health needs. Consequently, our index of ill-health includes HUI items measuring four of the eight dimensions from the HUI-3: speech, pain, cognition and emotion.

Standardized variables were then calculated for each of the three ill-health indices (the disability index, the long-term conditions index and the HUI index of cognitive/emotional health needs). The standardized values of the three indices were then summed, and a standardized score was calculated for the summary index of ill-health. The standardized score was then converted to a T-score, and this T-score is the variable used to measure health needs in the analyses used to test the hypotheses in this study. A factor analysis of the three dimensions

(the disability index, the long-term conditions index and the HUI index of cognitive/emotional health needs) used to calculate the index of ill-health revealed that all three indices loaded on only one principle component, with factor loadings varying from 0.77 to 0.81. However, for the Ill-health index in Year 2, $\alpha = .48$.

4.3 Outcome Variables

The outcome variables are scores on the emotional and behavioural functioning scales from the AAR for Time 1, after controlling for the participants' scores on those same scales at Time 2. These scales include measures of self-esteem, prosocial behaviour, emotional disorder/anxiety, conduct disorder/aggression and indirect aggression. All scales are derived from the NLSCY questionnaire.

With the exception of the self-esteem scale, these measures all come from scales on the 43-item Self-Questionnaire developed by Statistics Canada and Human Resources and Development Canada for the NLSCY (Statistics Canada, 2002b). Of these 43 items, 37 were included in the factor structure of the Feelings and Behaviour scales described in the documentation from Statistics Canada -- the remaining five items on the Self-Questionnaire are about property offenses (Statistics Canada, 2001). Statistics Canada (2002) reports that the source of most of the items on this measure was the Ontario Child Health Survey, although some items on all subscales, except indirect aggression, were taken from the Montreal Longitudinal Survey.

The objective of the Feelings and Behaviour Scales is to determine the child's perception of his or her general behaviour. Each item on the scale is measured by a three-point Likert scale, on which the choice of reply is "Never or not true," "Sometimes or somewhat

true," or "Often or very true." Respondents are asked to report the response that most accurately describes themselves, and scores on the items range from 1 to 3, with a score of "1" corresponding with "Never or not true." Of the five subscales of the Feelings and Behaviour Scale, four are used in this study: Prosocial Behaviour, Emotional Distress/Anxiety, Conduct Disorder/Physical Aggression, and Indirect Aggression.

4.3.1 Self-esteem. On the Canadian AAR, self-esteem is measured by eight items (ID-14, ID-15, ID-16, ID-17, P-7, P-8, P-9, P-10) that were used in the About Me Scale of the NLSCY for which they had been borrowed from the General-Self Esteem Scale of the Marsh Self Description Questionnaire. For these items, $\alpha = 0.797$ for a sample of 503 children in the care of CASs in Ontario (including the participants in this costing study, as measured at Time 1, the baseline measurement for the study). Four these items (ID-14 to ID-17) are from Developmental Dimension 3: Identity. The remaining four are from Developmental Dimension 5: Social Presentation.

4.3.2 Prosocial behaviour. The Prosocial Behaviour subscale is comprised of ten items (B1, B4, B8, B13, B20, B26, B30, B37, B41 and B43 on the AAR) and a coefficient α of .741 was reported by Statistics Canada for the NLSCY sample (Statistics Canada, 2002a). For the sample of 503 children in the care of Ontario CASs , $\alpha = 0.835$ for this scale.

4.3.3 Emotional distress/anxiety. The Emotional Distress and Anxiety subscale includes eight items (B6, B11, B16, B21, B27, B32, B35, and B40 on the AAR). Alphas were .72 in the NLSCY and 0.814 in the CAS sample. This subscale forms part of Developmental Dimension 6: Emotional and Behavioural Development.

4.3.4 Conduct disorder/aggression. The Conduct Disorder subscale includes six items (B7, B23, B25, B29, B33, and B36 on the AAR). Alpha was 0.678 in the NLSCY and 0.80 in the CAS sample.

4.3.5 Indirect aggression. The Indirect Aggression subscale is comprised of five items (B-10, B-17, B-24, B-34 and B-42 on the AAR). Alpha was 0.784 in the CAS sample for Year 1. These items are from Developmental Dimension 6: Emotional and Behavioural Development.

4.3.6 Ill-health index, Year 2. The same Ill-health index which was measured to use as a need variable in the regressions predicting of costs and improvements in outcomes on psychosocial functioning was also calculated from the data for Year2 of the study. Changes in this measure from Year 1 to Year 2 were then included as an outcome variable. As in Year 1, a z-score and a T-Score of the Index was calculated and the T-score was used in the analyses. The Cronbach's Alpha was only .48 for this measure in Year 2.

4.4 Cost Variables

4.4.1 Service Costs. The data on services that foster children received were recorded by social workers on the AAR at follow-up (T2). We obtained information from pages 10 to13 of the AAR on the direct services and the residential services received by each child during the previous twelve months. These service variables include information on the type of service, on whether the service was received by the child or youth in care during the previous twelve months, on the service category and on the frequency and the duration of the services received. The service category is based on who pays for the service: Category 1 is for those services that are provided directly by a CAS staff member; Category 2 is comprised of services provided by

any public agency, other than the CAS and health-related services reimbursed by OHIP or the Ministry of Health; Category 3 includes those health services reimbursed by OHIP or the Ontario Ministry of Health; Category 4 services provided by private service providers and reimbursed by the CAS; and Category 5 is for services provided by volunteers.

We developed a repertory of unit costs (fixed amounts per unit of service) to facilitate the calculation of costs from the service data. We used provincial or regional norms (market costs) to develop this repertory of unit costs. We obtained the information required for this repertory of unit costs from a variety of sources: OHIP guidelines, the guidelines of professional organizations, the Ministry of Health, other provincial government departments and Statistics Canada data. We used the minimum hourly salary in effect at the time of the study, that is $6.85/hour, to cost the services of volunteers. The repertory of units costs in included as Appendix E in this document. In addition, a cost variables dictionary is included as Appendix F. This dictionary shows all the services that would make up the package of care for children in foster-care. The costing questionnaire that we used to gather costing information from both the AAR and the accounting data of the CASs is also attached as Appendix G. All of these appendices provide information on the costing of the package-of-care. We also had access to accounting information from each CAS to help calculate costs of services, as well as service data from the AARs that we could multiply by the unit cost from our repertory to arrive at an annual amount for that service.

4.4.2 Expenditure Accounts. We gathered as much costing information as we could from the expenditure accounts of each agency. These expenditure accounts included actual dollar costs for residential services and for services reimbursed by the agency. For example,

these costs included actual per-diem costs for foster care and for medications and recreational costs that were paid directly by the agency to foster-parents or to service providers. If we had already estimated the cost of a service from the service data on the AAR, but direct information on the costs of that service from the CAS accounting information, we used the accounting expense as the variable in our study, rather than the estimate from the service data and the unit cost repertory.

4.4.3 Foster Parent Expenditures. Cost data was also gathered using an additional questionnaire, a copy of which is included in Appendix C. This questionnaire gathered data from foster parents on out-of-pocket expenditures by foster parents and others, as well as opportunity costs related to paid work and volunteer work forgone by the foster parents in order to fulfill their responsibilities as foster parents.

4.5 Co-variables

Gender of the children or youth in care, their age in years at baseline and the type of placement they were in at baseline (foster vs. kinship care) were identified from exploratory analyses as the demographic and placement variables that needed to be controlled for in analyses predicting both cost or outcomes. Therefore, these variables were entered as control variables in the regressions. The data providing information on these variables was included on the AAR.

5. Procedures

A repeated measures research design was used for this study. The two periods of interviews that served to collect the data for this study took place twelve months apart, that is at Time 1 (Baseline) and 12 months later at Time 2 (Follow-up). The larger study is still

continuing and will include additional follow-ups each year for those children and youth still in care. However, for the present costing study, we are interested in only the first two data collection points.

5.1 Time 1 (Baseline)

The study sample was drawn from a larger group of young people who were in the care of 23 local CASs in the province of Ontario, during 2001-2002. These CASs were taking part in the larger longitudinal study (Flynn et al., 1999) of the implemenation and outcomes of Looking After Children: Good Parenting, Good Outcomes. Each CAS had agreed to use the second Canadian adaptation of the Assessment and Action Record (see Appendices A and B) from Looking After Children to assess the needs and monitor the progress of children or adolescents in its care. Because of the longitudinal nature of the study, each CAS had also agreed to select as much as possible, young people who were likely to remain in care for the duration of the study. The choice of which young people and which social workers would participate in the study was left up to the CAS.

After receiving training in the Looking After Children approach, the young person's child welfare worker used the AAR-C2 in a conversational interview that typically included the child and his or her foster parent and covered one to four sessions. Having both the child and the foster parent respond to questions on the AAR may have improved the reliability of responses by having each respondent naturally validate the other's responses to the questionnaire. The child welfare worker completed the AAR for each child or youth who met the criteria for the study and who was receiving services from one of the three selected CASs. These data included responses on the items that comprise the health needs variables and the

services received by each young person in the study. In addition, socio-demographic information on each child was gathered on the AAR, as well as the baseline responses to the measures that would be used to test for positive changes in the follow-up data from Year 2.

5.2 Time 2 (Follow-up)

An almost identical questionnaire was used to gather the same information in the second year, 2002-2003. It included the outcomes scales, with the same items as in the baseline measures from Time 1. This questionnaire was also used to collect information on the units of service that each participating child received during the twelve months between Time 1 and Time 2, that is during 2002-2003. Cost variables for these services were calculated by using the appropriate unit costs for each unit of service, in keeping with the procedures outlined by Beecham (2000). Foster care services were represented in daily units on the AAR, while social work services were expressed in terms of hourly units. From information gathered from the AAR, the relevant unit costs for each service were used to calculate the total annual cost for that service for each participating child based on the frequency and duration of the services reported on the AAR.

Other data on costs were gathered by the researcher directly from financial information provided by the agencies' accounting departments. Annual costs for those services and goods paid or reimbursed to providers by the CAS were calculated using this financial information. When costs for the same service were available from both the AAR and from the agency accounting department, we used the amount from the CAS account rather than the estimate based on service data from the AAR multiplied by unit costs from our repertory. Data on out-

of-pocket expenditures and forgone wages and volunteer work were collected directly from foster parents using a short questionnaire sent to the foster parents by mail.

CHAPTER III: RESULTS

This chapter will present the results of the research. In the first two sections, the preparation of the data and the properties of the instruments used to measure the scales will be reported. In the next section, we will present the results of the descriptive and correlational analyses. In the last section, the results of the regressions used to verify the hypotheses and research questions, as well as the post-hoc analyses, will be reported.

1.0 Data preparation

Before starting the analyses, we examined the variables that we included in the analyses for accuracy and to identify the presence of missing data. The data from the AAR were initially in two separate data bases, one for the baseline (Time 1) data (n=495) and one for the follow-up (Time 2) data (n=616). These data bases included data on the participants from all the CASs in the larger study, not just those involved in the costing study. We began our examination of the outcome variables in these initial databases. When we analyzed the outcomes we used the scores on the Time 2 outcome scales, and statistically controlled for the scores on these same scales at Time 1. Consequently, we began by examining the items on each of the outcome scales in the Year 1 database (n=495). We examined the 10 items that comprise the Prosocial Behaviour Scale, the 8 items of the Self-Esteem Scale, the 8 items of the Emotional Distress Scale and the 6 items of the Conduct Disorder Scale. We found that the percentage of missing cases for these items ranged from 1.0 per cent to 3.4 per cent. The SPSS Missing Value Analysis program was used to estimate and fill in missing values. We conducted a separate MVA analysis and estimation of missing values for each scale. Similarly, we ran a missing values analysis on the same scale items in the Year 2 data (n=616). The percentage of

missing cases in these data in the Year 2 database ranged from 2.6 per cent to 6.7 per cent. We used the SPSS MVA program to estimate and plug the missing items in the Year 2 database.

We then combined the two databases (Year 1 and Year 2) to create a longitudinal database that included all the baseline data from the Year 1 database, and all the follow-up data from the Year 2 database, for those cases for which data had been collected at both time points (n=294). Next, we created a smaller longitudinal database, that included only the cases reported by the three CASs involved in the costing study and in which the child/youth was in some type of foster care at the time of Year 1 data collection (n=119). The financial data were then entered into this longitudinal database. Once the financial data was entered, we determined that these data included three univariate outliers on total costs. We removed theses three cases from our sample (n=116). At this point, we decided to include the Indirect Aggression Scale in the regression analyses, so we conducted a missing value analysis for that scale on both the Time 1 and Time 2 variables in the longitudinal database (n=116).

1.1 Imputation of missing values procedure

The rate of missing data for the cost and outcome variables was typically low, usually in the 0 to 7% range, with some exceptions. In imputing missing values, we used the maximum likelihood (ML) approach recommended by Schafer and Graham (2002). This approach uses an EM (Expectation-Maximization) algorithm, an option available in the SPSS missing values program. When data was missing for any of the items on a particular scale, we used the values on all the other items on that scale to impute the missing values. Basically, what this procedure does in SPSS is to provide a ML estimation of a covariance matrix for all the data in each scale based on the observed and filled-in data. That is, the values on the completed data in each scale

were used to estimate the missing data on each scale. The same missing values analysis was conducted for the cost variables, with these variables grouped by costing category. Missing data on all the costs variables, except foster parents' out-of-pocket expenditures, ranged from 0.8 per cent to 6.7 per cent of cases.

Because neither the AAR nor the agency accounting data provided information on foster parents out-of-pocket expenditures, we prepared a supplementary questionnaire which we mailed out to foster parents. In this questionnaire, we requested information from foster parents on their non-reimbursed expenditures for foster care, as well as information on non-reimbursed expenditures by the foster child, the biological parents and other adults. This questionnaire also included questions on the implementation of LAC in Ontario, which are not relevant to this costing study. The section of the questionnaire that includes the questions related to costs is included in Appendix B of this thesis. The consent form that we sent with the questionnaire is also included with the questionnaire in Appendix B. This questionnaire was mailed out in the early fall, likely a busy time for foster parents, so the response rate was low. Also, we sent this supplemental questionnaire to foster parents whose foster children were in the first year of the study. Of the completed questionnaires mailed back to use, three of the foster children were not in the second year of the study and, therefore, could not be used in our study. Only 46 questinnaires included information that we could use in the study.

Consequently, the missing values ranged from a rate of 57 % to 63 % for these questions on out-of-pocket expenditures. We still conducted an SPSS MVA on these variables, in spite of the large percentage of missing values and we plugged the missing data. However, we decided to use only one of these variables in our calculation of the total costs of foster care, and this

variable was the out-of-pocket expenditures of foster parents. We included the out-of-pocket expenditures by foster parents in the calculation of total costs because it did on average add about $2373 to the total costs and we thought this seemed a reasonable estimate of these foster parent expenses. In addition, this amount was similar to estimates of these expenditures obtained from other sources. For example, this amount was very similar to the amount of out-of-pocket expenditures reported in the earlier pilot study. In the pilot study, the researcher interviewed foster parents directly by phone to gather detailed information on foster parents' non-reimbursed expenditures. In addition, our estimate of these expenses using the MV analysis also matched the findings in a CAS report on out-of-pocket expenditures, from data gathered prospectively in three CASs, one of which participated in the costing pilot study, as well as in our current costing study. As a result, we decided that the total costs would be more accurate if we included our estimate of the foster parents' out-of-pocket expenditures than if we omitted them.

Summary cost variables were then calculated by adding the values for the variables in each costing category. Summary cost variables were created from the components of each of the service categories from the AAR and the data on foster parent out-of-pocket expenditures. The summary cost variables were: 1) total costs to the CAS; 2) total costs to other public agencies; 3) out-of-pocket expenditures by foster parents; and 4) costs of volunteer services. These summary cost variables were then combined to form the total cost variable.

An examination of the standardized scores for the cost variables, using a value of ±3.29 as suggested by Tabachnich and Fidell (1996, p. 89), revealed three univariate outliers for total costs. The elevated costs for these three cases were the result of extended stays in hospital or a

Young Offender facility. As a result, these three cases were removed from the database, leaving a sample of N=116.

Log10 transformations were then calculated for all the summary cost variables, so that either raw cost variables or transformed (log10) cost variables could be used in the hypotheses testing, depending on whether the results differed if the log10 transformation was used instead of the raw variable. Table 1 shows values for skewness and kurtosis on the raw and transformed variables. In addition, the self-esteem scale was negatively skewed. Therefore, it was transformed by being first reflected and then reflected variable was transformed again using log10. We used the log of the reflected value as the self-esteem variable in the regression that examined whether changes in self-esteem could be predicted from cost.

Table 1

Pre and post values for the raw and transformed (lg10) cost variables (N=116)

	Skewness		Kurtosis	
Variable	Raw	lg10	Raw	lg10
Total CAS costs	1.85	0.07	6.46	1.38
Total costs for other public agencies	5.82	-8.7	38.22	89.27
Total volunteer costs	6.64	1	46.94	-0.29
Total caregiver out-of-pocket costs	2.42	-2.74	8.88	6.51
Total costs	2.12	0.72	6.46	1.54

2.0 Scale Properties

Descriptive information on the measurement scales used in our analyses, including the means, the standard deviations and the coefficients of internal consistency (Cronbach alpha) are presented in Table 2. The Cronbach alpha coefficients vary from 0.81 to 0.91, which indicates a good internal consistency for the measures used. The potential ranges for these scales are also shown in Table 2, as well as the actual ranges obtained in the current research project.

Table 2

Descriptive information on the measurement scales used in the analyses

Scale	N	Number of items	Potential range of scores	Range obtained	M	SD	Cronbach's Alpha
Self-esteem, Year 1	116	8	0 - 32	6 - 32	25.2	5.93	0.88
Self-esteem, Year 2	116	8	0 - 32	2 - 32	24.9	5.87	0.91
Prosocial Behaviour, Year 1	116	10	0 - 20	2 - 20	12.5	4.47	0.87
Prosocial Behaviour, Year 2	116	10	0 - 20	0 - 20	12.5	4.3	0.86
Emotional Disorder/Anxiety, Year 1	116	8	0 - 16	0 - 14	4.79	3.47	0.84
Emotional Disorder/Anxiety, Year 2	116	8	0 - 16	0 - 15	4.76	3.33	0.83
Conduct Disorder/Aggression, Year 1	116	6	0 - 12	0 - 11	2.09	2.32	0.82
Conduct Disorder/Aggression, Year 2	116	6	0 - 12	0 - 12	1.61	2.24	0.85
Indirect Aggression, Year 1	116	5	0 - 10	0 - 10	2.34	2.37	0.83
Indirect Aggression, Year 2	116	5	0 - 10	0 - 10	1.9	2.28	0.85

3.0 Statistical Analyses

The data analyses were completed in three stages. First, preliminary exploratory analyses were undertaken to answer the first research question: What are the annual costs for services from Time 1 to Time 2 for a child or youth who was in foster care at Time 1 (that is at the beginning of the twelve months on which service and costing data have been gathered)? To answer this question, the descriptive statistics were run on the cost variables. The raw data on these continuous cost variables were used for these descriptive analyses, as was the original sample (n=119) before the three univariate outliers were removed from the database.

The second step involved preliminary exploratory analyses, that included running bivariate correlations between costs and other variables, to explore possible relationships between demographic, agency and placement variables that might possibly predict variations in cost. For these analyses, when variables had been transformed to meet the assumption of normal distribution, the transformed variable was used for the correlations, unless there was no difference between the results for the raw variables and the transformed variables. This was sometimes the case with the cost variables. Therefore, correlations were run with both the transformed and non-transformed cost variables. The third step in the analyses involved the multiple regressions for testing the hypotheses.

4. Descriptive and correlational analyses

4.1 Descriptive analyses

Table 3 presents the means, standard deviations, and the percentage of total costs of each cost component, and the ranges and the medians for the cost variables. In this table, the costs are grouped to represent the components of each of the four primary cost domains: (1) the

costs to the CAS (CASCOST); (2) costs to other public agencies (PUBCOST); (3) out-of-pocket costs to foster parents or other caregivers (FPCOST); and (4) costs to volunteers (VOLCOST). To obtain the total annual cost of services, the costs for all domains were summed: CASCOST + PUBCOST + FPCOST + VOLCOST = TOTCOST.

The results of this descriptive analysis of cost variables show considerable variability in the costs of services provided to children/youth in foster care. The distribution of the costs are positively skewed because clients with elevated costs in the different domains are in the minority. The coefficients of variation (CV = SD / M) for the different cost domains are shown in Table 4. The cost variables related to health services and volunteer services show the greatest variability: (1) costs for medications and medical supplies reimbursed by the CAS; (2) costs for health care services covered by OHIP or the Ministry of Health; and (3) costs for volunteers.

For the 12 months examined in this research, the average total annual per child costs ranged from $15,272.00 to $156,149.00. The youth at the lowest end of the range moved from foster care to independent living during the twelve months from baseline to follow-up. Those youths at the high end of the range for total costs were in intensive treatment foster care for much of the 12 month period and/or in a young offender youth detention centre for an extended period during the 12 months. The three cases with the highest costs were univariate outliers that were removed from the sample in further analyses.

Of the total annual per child costs, the CAS paid an average of 65 per cent of the total. The total annual per child costs paid by the CAS varied from $5,197.00 to $124,021.00. Residential services paid by the CAS amounted to almost 45% of the total annual per child

costs. The CAS paid costs for residential services, which ranged from $1,211.00 to $114,564.00 for the 12 month period. Social work costs for CAS staff amounted to about 10% of the total annual per child costs, ranging from $2,079.00 to $9,375.00 during the 12-month period of the research. The CAS also reimbursed other professionals for their services (including lawyers, psychologists, dentists) and these costs for professional services paid for by the CAS accounted for 7 per cent of the total annual costs. In further analyses (N=116), the total costs paid by the CAS, ranged from an average of $21, 482.00 for CAS A, to an average of $18, 565 for CAS C.

Other public agencies, including the Ontario Health Insurance Plan (OHIP) and the Ontario Ministry of Health (MOH), paid total annual per child costs that ranged from $0 to $62,019. The participants whose costs to other public agencies were at the high end spent time during the year of the study either in a youth detention centre or in a hospital. The average total annual per child cost for other public agency expenditures was $9,854.47 and this represented 27.93 per cent of the total costs. The costs paid by OHIP/MOH represented approximately 13.5 per cent of costs for public agencies other than the CAS, or 3.72 per cent of the total package of care. However, there was considerable variability in the costs of these medical services: the total annual per child costs for OHIP/MOH expenditures varied from $0 to $47,570.

The cost data collected from the CAS account information did not include costs to other public agencies; therefore, these costs could only be estimated from the retrospective information on services collected from social workers on the AAR. Consequently, these medical costs are likely underestimated, as are education costs. For example, many of these

children receive special education services at school, which we were unable to cost retrospectively. Also, although costs for hospital stays vary considerably by hospital, the retrospective data did not specify the hospital, so costs for hospital stays were estimated using the average cost per day for hospital care in Ontario, which was provided by the Ministry of Health. Consequently, the data likely underestimates the cost to other public agencies for many children and youths, particularly with regard to health and education services.

We sent a supplementary questionnaire to foster parents to gather data on the out-of-pocket expenditures of caregivers. The questionnaire included questions on expenditures by foster parents, biological parents, other adults, and by foster children and youths themselves. Because of the extremely high percentage of missing data (60 per cent to 63 per cent) and the small percentage of total expenditures (less than 1 per cent) reported for biological parents, other adults and by foster children/youths, we did not include these data in the total costs. However, because the data on foster parents' out-of-pocket expenditures were estimated at 7% of the total costs, we did include these data in the total. The percentage of missing data for this variable was high (61 per cent). However, when we estimated missing values using the SPSS MVA, the the resulting estimates of foster parent expenditures were consistent with two sources of preliminary information on foster parent out-of-pocket expenditures in Ontario CASs: an unpublished pilot study in one Ontario CAS (Flynn & LeMay, 1999), and unpublished preliminary data collected on foster parents out-of-pocket expenditures in two Ontario CASs by a committee looking at costs to foster parents of providing care. Because the estimated out-of-pocket expenditures of foster parents constituted 7 per cent of the total costs

of foster care, we decided to include the estimated amounts of these costs in the calculation of the total costs of foster care.

Table 3

Means, standard deviations and percentages for the cost variables (costs for the CAS, other public agencies, foster parents and volunteers) during a period of 12 months. (N=119)

	M	SD	%	Range	Median
Costs for the CAS	22,892.73	15,993.05	64.88%	5,197-124,921	19,517.12
-Social work costs	3,532.77	1,608.03	10.02%	2,079-9,375	2,969.31
-Residential services	15,277.44	15,162.69	43.33%	1,211-114,564	12,051.15
- Professional services	2,500.55	2,365.19	7.09%	0-17,201	2,057.49
- Medications & Med supplies	476.96	974.11	1.35%	0-6,734	91.69
- Allowances	1,105.12	439.84	3.13%	0-2,008	1,218.29
Total Costs paid by other public agencies	9,854.48	7,810.86	27.93%	0-62,019	8,041.55
- OHIP/Ministry of Health	1,314.22	5,342.08	3.72%	0-47,570	181.40
- Other agencies	8,540.25	5,631.23	24.20%	0-59,556	7,807.00
Out-of-pocket expenditures of caregivers	2,468.72	1,894.69	7.00%	0-12,000	2468.73
Costs for volunteers	70.86	288.40	0.02%	0-2374	.00
Global Total costs	35,286.91	20,191.68	100.00%	15,272-156,149	30,227.08

The costs for volunteers were based on the service data from the AAR, for services provided by volunteers. They were calculated used the number of hours of service multiplied by the minimum wage for Ontario. The total was less than 1% of total annual per child costs. Please see the unit costs in Appendix D.

Table 4

Coefficients of variability for the different cost domains (N=119)

Variable	Coefficient of Variability
Costs for the CAS	0.69
-Social work costs	0.45
-Residential services	0.99
- Professional services	0.94
- Medications & Med supplies	2.04
- Allowances	0.39
Total Costs paid by other public agencies	0.79
- OHIP/Ministry of Health	4.06
- Other agencies	0.65
Out-of-pocket expenditures of caregivers	0.76
Costs for volunteers	4.06
Global Total costs	0.57

Table 5

Comparison of the cost variables (costs for the CAS, other public agencies, foster parents and volunteers) by agency during a period of 12 months. (N=116)

	CAS A	CAS B	CAS C	Overall
Costs for the CAS	21,482.00	21,731.00	18,565.00	20,822.00
-Social work costs	2,876.00	4,738.00	2,740.00	3,547.00
-Residential services	14,997.00	12,233.00	12,445.00	13,289.00
- Professional services	1,943.00	3,384.00	1,697.00	2,426.00
- Medications & Med supplies	347.00	346.00	718.00	443.00
- Allowances	1,318.00	1,031.00	965.00	1,118.00
Total Costs paid by other public agencies	9,856.00	8,953.00	8,868.00	9,258.00
- OHIP/Ministry of Health	1,472.00	919.00	1,040.00	1,151.00
- Other agencies	8,384.00	8,037.00	7,828.00	8,107.00
Out-of-pocket expenditures of caregivers	2,438.00	2,572.00	2,183.00	2,423.00
Costs for volunteers	155.00	34.00	14.00	72.00
Global Total costs*	33,930.00	33,289.00	29,630.00	32,575.00

*All costs have been rounded off to nearest dollar amount

4.2 Correlational analyses

A correlation matrix of demographic variables, cost variables, need and outcome variables is shown in Table 5. Among the variables that did not correlate significantly with costs were: gender, age, reason for admission to care, type of community (rural or urban) in which the child or youth resided, the agency, or the income of the foster parent. No significant variations were found in cost between the three agencies. The only variables that did show significant correlations with costs were the five HUI variables used in the Ill-Health Index, the disability question (H11) from the health section of the AAR, the disability from the education section (E-6), the number of long-term conditions, and whether the child/youth rated him or herself as not having been in good health. Most of these health questions were combined to form the Ill-Health Index.

In addition, two emotional/behavioural variables were found to be significantly correlated with costs: Conduct disorder/aggression and indirect (relational) aggression. After conducting these exploratory correlational analyses, multiple regressions were run to test the research hypotheses and answer the remaining research questions: What variables predicted variations in cost? And were higher costs associated with positive changes in levels of functioning?

Table 5 shows the intercorrelations between age and gender and between the costing variables. Total costs and the log of total costs were particularly highly correlated with each other, which meant that there was generally little difference in the results of the aggression analyses, when total costs were used rather than the log value. Consequently, most of the regressions will use the raw value rather than the transformed value for total costs.

5. Verification of the hypotheses and research questions

Our first research question on what the costs of foster care were was answered using the descriptive analyses discussed above. Our other research questions were related to whether we could predict costs from needs identified at the beginning of the study, as well as whether we could use costs to predict positive changes in youth in care between Time 1 and the follow-up.

Table 6
Intercorrelations between age, gender and cost variables. (N=116)

Variable	1	2	3	4	5	6	7	8	9	10	11	12
1. Gender		-.09	-.02	-.02	.03	-.02	.01	-.02	-.07	.04	-.10	.00
2. Age		--	-.20*	.04	.12	-.12	-.12	-.20*	-.05	.11	-.19*	-.13
3. $ CAS		--	--	.05	-.06	.10	.81**	.94**	.11	-.16	.10	.83**
4. $ Other agencies		--	--	--	-.14	.04	.61**	.03	.46**	.07	.08	.51**
5. $ Foster parents		--	--	--	--	-.10	.19*	-.05	-.01	.59**	-.17	.17
6. $ Volunteer		--	--	--	--	--	.11	.13	.04	-.03	.57**	.13
7. Total Costs		--	--	--	--	--	--	.75**	.34**	.01	.11	.97**
8. Log of $ CAS		--	--	--	--	--	--	--	.11	-.18	-.14	.84**
9. Log of $ Other agencies		--	--	--	--	--	--	--	--	-.02	.08	.38**
10. Log of $ Foster parents		--	--	--	--	--	--	--	--	--	-.17	-.02
11. Log of $ Volunteer		--	--	--	--	--	--	--	--	--	--	.13
12. Log of Total Costs		--	--	--	--	--	--	--	--	--	--	--

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

Gender (1=male, 0=female)

Table 7
Intercorrelations between total cost, Ill-health index and outcome variables. (N=116)

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Total Cost		.51**	.51**	.22*	.15	-.12	-.10	.36**	.21*	.33**	-.34**	.13	.25**
2. Ill-health, Year 1		--	.77**	.22*	.08	-.21*	-.05	.44**	.22*	.28**	.30**	.13	.12
3. Ill-health, Year 2		--	--	.17	.07	-.23*	-.17	.34**	.30**	.39**	.43**	.21*	.22*
4. Log of reflected Self-esteem, Year 1		--	--	--	.57**	-.32**	-.29**	.42**	.31**	.34**	.32**	.23*	.14
5. Log of reflected Self-esteem, Year 2		--	--	--	--	-.15	-.25**	.34**	.48**	.18	.42**	.23*	.18
6. Prosocial behaviour, Year 1		--	--	--	--	--	.51**	-.10	-.13	-.46**	-.26**	-.24**	-.16
7. Prosocial behaviour, Year 2		--	--	--	--	--	--	.04	-.05	-.29**	-.36**	-.13	-.12
8. Emotional disorder/anxiety, Year 1		--	--	--	--	--	--	--	.56**	.32**	.20*	.42**	.26**
9. Emotional disorder/anxiety, Year 2		--	--	--	--	--	--	--	--	.23*	.44**	.27**	.39**
10. Conduct disorder/physical aggression, Year 1		--	--	--	--	--	--	--	--	--	.40**	.54**	.33**
11. Conduct disorder/physical aggression, Year 2		--	--	--	--	--	--	--	--	--	--	.36**	.56**
12. Indirect aggression, Year 1		--	--	--	--	--	--	--	--	--	--	--	.53**
13. Indirect aggression, Year 2		--	--	--	--	--	--	--	--	--	--	--	--

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

5.1 Prediction of costs from needs

More precisely, our goal was to determine, after controlling for relationship of age and gender to costs, whether health at Time 1 and type of placement had any relationship with costs. It was expected that children and youth in kinship care would have lower costs and that those participants who had higher scores on a measure of ill-health would also have higher costs.

5.1.1 Hypothesis 1. This first hypothesis predicted that after controlling for gender, age, and type of placement, greater health needs would predict higher global costs for services. A hieracrchical step-wise multiple regression was used to test this hypothesis. Using Mahalanobis distance in the SPSS regression, one multivariate outliers were detected and removed from the analysis, leaving an N of 113. Table 6 shows the correlations between the variables in the regression. Table 7 displays the steps in the regression and the results: the unstandardized coefficients, the standardized regression coefficients, the R^2 at step 1 and the change in the R^2 at each subsequent step. After step 3, with all four IVs in the equation, R^2 = .21, F=1.12, p<.01.

After step 1, with gender and age in the equation, R^2 =.02, and the model at this step is not significant. However, at step 2, when the Ill-Health Index is entered in the equation, ΔR^2 = .15, F=7.64, p < .0001, indicating the addition of this variable to the equation results in a significant increment to the R^2. Therefore, the child/youth's health needs significantly predicted variations in cost (p < .01), as at step 3 the recoded current placement (foster vs. kinship), significantly predicted variation in cost, with costs lower for kinship care, p < .03.

Table 8
Intercorrelations between Variables of Hierarchical Regression Analysis Predicting Total Cost for the year between Time 1 and Time 2 (N=113)

Variable	1	2	3	4	5
1. Total cost	--	.07	.12	.41**	.21*
2. Gender	--	--	.11	.15	-.01
3. Age	--	--	--	-.07	.01
4. T-score of Ill-Health Index, Year 1	--	--	--	--	.07
5. Placement (Foster or Kinship)	--	--	--	--	--
Mean	31,365.98	.53	13.2	44.44	.92
SD	8097.06	.50	2.19	9.45	.25

*p<.05 **p<.01

Gender (1 = male, 0 = female)

Placement (1 = foster care, 0 = kinship care)

Table 9

Summary of Hierarchical Regression Analysis for Variables Predicting Total Cost for the year between Time 1 and Time 2 (N=113)

Variable	B	SE B	β
Step 1			
Gender of child/youth	1294.67	1534.46	0.08
Age of child/youth	-463.92	351.50	-0.13
Step 2			
Gender of child/youth	280.60	1433.04	0.02
Age of child/youth	-329.37	325.56	-0.09
T-score of Ill-Health Index, Year 1	341.10	75.69	0.40**
Step 3			
Gender of child/youth	527.37	1411.02	0.03
Age of child/youth	-416.17	321.90	-0.11
T-score of Ill-Health Index, Year 1	326.65	74.58	0.38**
Placement (Foster or Kinship)	6138.29	2716.72	0.20*

Note. R^2 = .02 for Step 1; ΔR^2 = .15 for Step 2; ΔR^2 = .04 for Step 3

*p<.05 **p<.01

Gender (1 = male, 0 = female)

Placement (1 = foster care, 0 = kinship care)

5.2 Prediction of positive changes from total service costs

After controlling for age, gender, health needs at Time 1, and type of placement at Time 1, we also examined the capacity of costs to predict positive changes with regard to self-esteem, and the functioning of participants in four components of the emotional/behavioural dimension of development: prosocial behaviour, emotional disorder/anxiety, conduct disorder/aggression, and indirect aggression. This entailed five separate multiple regressions.

As noted in guidelines for measuring change, published by the American Psychological Association (Hummel-Rossi & Weinberg, 1975, p. 47), the appropriate method to measure change in a correlational, one-group, repeated measures design like this one is with a step-wise, hierarchical multiple regression, in which the predicted variable is the posttest score on the outcome variable. The pretest score on the same variable at Time 1 is controlled for, by entering it as Step 1 in the regression. This allows for changes to be analyzed in relation to the child's baseline level of functioning and to permit determination of the variables that predict the most benefit from interventions given a certain pretest level of functioning.

5.2.1. Hypothesis 2. This hypothesis predicted that higher costs would be associated with greater positive changes in self-esteem during the year of the study. To verify this hypothesis, a hierarchical regression was used, in which the log of the reflected score on the self-esteem scale at Time 1 was entered in Step 1 of the regression. The predicted variable is the log of the reflected score on the self-esteem scale at Time 2. Correlations of the variables in this regressions are shown in Table 8. Table 9 displays the steps in the regression and the results: the unstandardized coefficients, the standardized regression coefficients, the R^2 at step 1 and the change in the R^2 at each subsequent step. After step 5, with all six IVs in the equation, $R^2 = .34$, $F=9.44$, $p<.01$.

After step 1, with the log of reflected self-esteem during year 1 in the equation, R^2 =.32, and the model at this step is already significant: f=54.037, p<.0001. However, at step 2, when gender and age are entered in the equation, ΔR^2 = .02 and the change is not significant, indicating the addition of these variables adds nothing to the model statistically. The same is true at steps 3 and 4, when the Ill-Health Index and the placement (kinship vs foster care) respectively are added to the model. Similarly, at step 5, with the addition of total cost to the model, there is no significant change to the model. Therefore, the child/youth's health needs, placement type and cost of services did not predict changes in self-esteem.

The only variable in this regression that significantly predicts scores on the log of the reflected self-esteem variable at Time 2 is the log of the reflected self-esteem variable at Time 1. A follow-up paired samples t-test indicated a significant interaction between gender and time with regard to scores on this log of reflected self-esteem. Girls scores on self-esteem appear to have decreased between Time 1 and Time 2, while boys scored about the same at Time 2 as they did at Time 1.

Table 10

Intercorrelations between Variables of Hierarchical Regression Analysis Predicting Changes in Self-Esteem between Time 1 and Time 2 (N=115)

Variable	1	2	3	4	5	6	7
1. Log of reflected Self-Esteem, Year 2	--	.57**	-.06	.15	.01	.05	.15
2. Log of reflected Self-esteem, Year 1	--	--	0.1	.23**	.22**	0.1	.22**
3. Gender	--	--	-.11	.22**	.22**	.12	.22**
4. Age	--	--	--	-.07	.10	-.05	.01
5. T-score of Ill-Health Index, Year 1	--	--	--	--	--	.01	.51**
6. Placement (Foster or Kinship)	--	--	--	--	--	--	.18*
7. Total cost	--	--	--	--	--	--	--
Mean	.75	.73	.52	13.20	50.0	.93	32,547.97
SD	.42	.42	.50	2.19	10.0	.25	10,963.39

*p<.05 **p<.01

Gender (1 = male, 0 = female)

Placement (1 = foster care, 0 = kinship care)

Table 11

Summary of Hierarchical Regression Analysis for Variables Predicting Log of Reflected Self-Esteem, Year 2 (N=115)

Variable	B	SE B	β
Step 1			
Log of reflected Self-Esteem, Year 1	0.56	0.08	0.57**
Step 2			
Log of reflected Self-Esteem, Year 1	0.56	0.08	0.57**
Gender of child/youth in Care	-0.10	0.07	-0.13
Age of child/youth in Care	0.01	0.02	0.03
Step 3			
Log of reflected Self-Esteem, Year 1	0.57	0.08	0.58**
Gender of child/youth in Care	-0.10	0.07	-0.12
Age of child/youth in Care	0.01	0.02	0.03
T-score of Ill-Health Index, Year 1	-0.00	0.00	-0.04
Step 4			
Log of reflected Self-Esteem, Year 1	0.57	0.08	0.58**
Gender of child/youth in Care	-0.10	0.07	-0.12
Age of child/youth in Care	0.01	0.02	0.03
T-score of Ill-Health Index, Year 1	-0.00	0.00	-0.03
Placement (Foster or Kinship)	-0.04	0.13	-0.03
Step 5			
Log of reflected Self-Esteem, Year 1	0.57	0.08	0.58**
Gender of child/youth in Care	-0.10	0.07	-0.12
Age of child/youth in Care	0.01	0.02	0.04
T-score of Ill-Health Index, Year 1	-0.00	0.00	-0.06
Placement (Foster or Kinship)	-0.06	0.13	-0.04
Total Cost	0.00	0.00	0.06

Note. $R^2 = .32$ for Step 1; $\Delta R^2 = .02$ for Step 2; $\Delta R^2 = .00$ for Step 3; $\Delta R^2 = .00$ for Step 4; $\Delta R^2 = .00$ for Step 5
*p<.05 **p<.01

Gender (1 = male, 0 = female)

Placement (1 = foster care, 0 = kinship care)

5.2.2. Hypothesis 3. This hypothesis predicted that higher costs would be associated with greater positive changes in prosocial behaviour at the follow-up (Time 2). To verify this hypothesis, another hierarchical regression was used, in which the score on the prosocial behaviour scale at Time 1 was entered at Step 1 of the regression. The predicted variable is the score on the prosocial behaviour scale at Time 2. Correlations of the variables in this regressions are shown in Table 10. Table 11 displays the steps in the regression and the results: the unstandardized coefficients, the standardized regression coefficients, the R^2 at step 1 and the change in the R^2 at each subsequent step. After step 5, with all six IVs in the equation, $R^2 = .31$, $F=8.19$, $p<.001$.

After step 1, with prosocial behaviour during year 1 in the equation, $R^2 =.26$, and the model at this step is already significant: $f=39.61$, $p<.001$. At step 2, when gender and age are entered in the equation, $\Delta R^2 = .04$, and the change is not significant, although it is approaching significance ($p=.05$). Gender is a significant variable at this step: the standardized coefficient for gender -.16, $t=-1.94$, $p<.001$. At steps 3, 4, and 5, when the Ill-Health Index, the placement (kinship vs foster care), and total cost are added to the model, there are no significant increments to the R^2 . Therefore, the child/youth's health needs, placement type and cost of services did not predict changes in prosocial behaviour.

Aside from the pretest score on the prosocial behaviour scale, the only variable that predicts posttest scores on the prosocial behaviour scale is gender. A follow-up paired samples t-test that examined the interaction between time and gender, showed no significant interaction. At both Time 1 and Time 2, females consistently scored higher on this measure than males did.

Table 12

Intercorrelations between Variables of Hierarchical Regression Analysis Predicting Changes in Prosocial Behaviour between Time 1 and Time 2 (N=116)

Variable	1	2	3	4	5	6	7
1. Prosocial Behaviour, Year 2	--	.51**	-.25**	.07	-.05	-.07	-.10
2. Prosocial Behaviour, Year 1	--	--	-.21*	-.10	-.21*	-.05	-.11
3. Gender	--	--	--	.09	.10	-.05	.01
4. Age	--	--	--	--	-.07	.10	-.12
5. T-score of Ill-Health Index, Year 1	--	--	--	--	--	.08	.51**
6. Placement (Foster or Kinship)	--	--	--	--	--	--	.18*
7. Total cost	--	--	--	--	--	--	--
Mean	12.46	12.45	.53	13.20	50.0	.93	32574.98
SD	4.29	4.47	.50	2.19	10.0	.25	10963.39

*p<.05 **p<.01

Gender (1 = male, 0 = female)

Placement (1 = foster care, 0 = kinship care)

Table 13

Summary of Hierarchical Regression Analysis for Variables Predicting Prosocial Behaviour, Year 2 (N=116)

Variable	B	SE B	β
Step 1			
Prosocial Behaviour, Year 1	0.49	0.08	0.51**
Step 2			
Prosocial Behaviour, Year 1	0.47	0.08	0.49**
Gender of child/youth in Care	-1.35	0.70	-0.16
Age of child/youth in Care	0.26	0.16	0.13
Step 3			
Prosocial Behaviour, Year 1	0.49	0.08	0.50**
Gender of child/youth in Care	-1.40	0.70	-0.16*
Age of child/youth in Care	0.28	0.16	0.14
T-score of Ill-Health Index, Year 1	0.03	0.04	0.08
Step 4			
Prosocial Behaviour, Year 1	0.48	0.08	0.50**
Gender of child/youth in Care	-1.44	0.70	-0.17*
Age of child/youth in Care	0.29	0.16	0.15
T-score of Ill-Health Index, Year 1	0.04	0.04	0.09
Placement (Foster or Kinship)	-1.17	1.36	-0.07
Step 5			
Prosocial Behaviour, Year 1	0.48	0.08	0.50**
Gender of child/youth in Care	-1.46	0.70	-0.17*
Age of child/youth in Care	0.28	0.16	0.14
T-score of Ill-Health Index, Year 1	0.05	0.04	0.12
Placement (Foster or Kinship)	-0.99	1.38	-0.06
Total Cost	0.00	0.00	-0.07

Note. $R^2 = .26$ for Step 1; $\Delta R^2 = .04$ for Step 2; $\Delta R^2 = .01$ for Step 3; $\Delta R^2 = .00$ for Step 4; $\Delta R^2 = .00$ for Step 5
*p<.05 **p<.01

Gender (1 = male, 0 = female)
Placement (1 = foster care, 0 = kinship care)

5.2.3. Hypothesis 4. This hypothesis predicted that higher costs would be associated with greater positive changes on the emotional disorder/anxiety scale at the follow-up (Time 2), that is that higher costs would predict a decrease in behaviour that indicated emotional disorder/anxiety at the follow-up. To verify this hypothesis, we ran another hierarchical regression, in which the score on the emotional disorder/anxiety scale at baseline (Time 1) was entered at step 1 of the regression. Correlations of the variables in this regressions are shown in Table 12. Table 13 displays the steps in the regression and the results: the unstandardized coefficients, the standardized regression coefficients, the R^2 at step 1 and the change in the R^2 at each subsequent step. After step 5, with all six IVs in the equation, $R^2 = .32$, $F=8.62$, $p<.001$.

At step 1, with emotional disorder/anxiety during year 1 in the equation, $R^2 = .31$, and the model at this step is already significant: $f=52.27$, $p<.001$. At step 2, when gender and age are entered in the equation, $\Delta R^2 = .01$, and the change is not significant. At steps 3, 4, and 5, when the Ill-Health Index, the placement (kinship vs foster care), and total cost are added to the model, there are no significant increments to the R^2. Therefore, the child/youth's health needs, placement type and cost of services did not predict changes in emotional disorder/anxiety. Aside from the pretest score on the emotional disorder/anxiety scale, no variable predicts scores on the emotional disorder/anxiety scale at follow-up 12 months later. This was true whether the raw data were used for total costs, or the transformed log10 total cost variable.

Table 14

Intercorrelations between Variables of Hierarchical Regression Analysis Predicting Changes in Emotional Disorder/Anxiety between Time 1 and Time (N=116)

Variable	1	2	3	4	5	6	7
1. Emotional Disorder/Anxiety, Year 2	--	.56**	-.20*	-.01	.22**	.11	.21*
2. Emotional Disorder/Anxiety, Year 1	--	--	-.22**	.04	.44**	.18*	.36**
3. Gender	--	--	--	.09	.10	-.05	.01
4. Age	--	--	--	--	-.07	.10	-.12
5. T-score of Ill-Health Index, Year 1	--	--	--	--	--	.07	.51**
6. Placement (Foster or Kinship)	--	--	--	--	--	--	.18*
7. Total cost	--	--	--	--	--	--	--
Mean	4.76	4.79	.52	13.20	50.0	.93	32574.97
SD	3.33	3.47	.50	2.19	10.0	.25	10963.39

*p<.05 **p<.01

Gender (1 = male, 0 = female)

Placement (1 = foster care, 0 = kinship care)

Table 15

Summary of Hierarchical Regression Analysis for Variables Predicting Emotion Disorder/Anxiety, Year 2 (N=116)

Variable	B	SE B	β
Step 1			
Emotional Disorder/Anxiety, Year 1	0.54	0.08	0.56**
Step 2			
Emotional Disorder/Anxiety, Year 1	0.52	0.08	0.55**
Gender of child/youth in Care	-0.51	0.53	-0.08
Age of child/youth in Care	-0.04	0.12	-0.03
Step 3			
Emotional Disorder/Anxiety, Year 1	0.53	0.09	0.55**
Gender of child/youth in Care	-0.47	0.55	-0.07
Age of child/youth in Care	-0.04	0.12	-0.03
T-score of Ill-Health Index, Year 1	-0.01	0.03	-0.02
Step 4			
Emotional Disorder/Anxiety, Year 1	0.53	0.09	0.55**
Gender of child/youth in Care	-0.48	0.55	-0.07
Age of child/youth in Care	-0.04	0.12	-0.03
T-score of Ill-Health Index, Year 1	-0.01	0.03	-0.02
Current Placement (Foster or Kinship)	0.19	1.05	0.01
Step 5			
Emotional Disorder/Anxiety, Year 1	0.53	0.09	0.55**
Gender of child/youth in Care	-0.48	0.55	-0.07
Age of child/youth in Care	-0.04	0.12	-0.02
T-score of Ill-Health Index, Year 1	-0.01	0.03	-0.03
Current Placement (Foster or Kinship)	0.19	1.05	0.01
Total Cost	0.00	0.00	0.03

Note. $R^2 = .31$ for Step 1; $\Delta R^2 = .01$ for Step 2; $\Delta R^2 = .00$ for Step 3; $\Delta R^2 = .00$ for Step 4; $\Delta R^2 = .00$ for Step 5
*p<.05 **p<.01

Gender (1 = male, 0 = female)

Placement (1 = foster care, 0 = kinship care)

5.2.4. Hypothesis 5. This hypothesis predicted that higher costs would be associated with a decrease in conduct disorder/aggression at the follow-up (Time 2). To verify this hypothesis, another hierarchical regression was used, in which the score on the conduct disorder/aggression scale at Time 1 was entered at Step 1 of the regression. The predicted variable is the score on the conduct disorder/aggression scale at Time 2. Two multivariate outliers were removed from the sample before running this analysis. Table 14 displays the correlations for the variables in this analysis. The results of this analysis are shown in Table 15: the unstandardized coefficients, the standardized regression coefficients, the R^2 at step 1 and the change in the R^2 at each subsequent step. After step 5, with all six IVs in the equation, $R^2 = .29$, $F=7.35$, $p<.001$.

As expected, scores on the pretest predicted scores on the posttest, conduct disorder/aggression at Time 1 predicted conduct disorder/aggression at Time2. At step 1, the $R^2 = .20$, $F=28.49$, $p<.001$. There is no incremental change in the significance of the model at step, but there is at step 3 when the Ill-Health Index is entered into the model, the $R^2=.25$, and the there is a significant incremental change in the predictive power of the model: $\Delta F=6.17$, $p<.05$.

Health needs significantly predicted changes in functioning on the conduct disorder/aggression scale, but only at Steps 3 and 4 in the regression. The positive relationship between the two variables indicates that more health problems predicted more aggressive/conduct disordered behaviour. Once total cost is entered in the analysis, the Ill-Health Index is no longer a significant predictor of outcome in this analysis. The total cost variable significantly predicts changes in conduct disorder/aggression, but not in the direction expected. Higher costs predicted increases in aggressive/conduct disordered behaviour.

Table 15

Table 16

Intercorrelations between Variables of Hierarchical Regression Analysis Predicting Changes in Conduct Disorder/Aggression between Time 1 and Time 2 (N=114)

Variable	1	2	3	4	5	6	7
1.Conduct Disorder/Aggression, Year 2	--	.45**	.09	.02	.31**	.07	.40**
2. Conduct Disorder/Aggression, Year 1	--	--	.15	-.00	.26**	.13	.31**
3. Gender	--	--	--	.08	.14	-.05	.06
4. Age	--	--	--	--	-.05	.10	-.10
5. T-score of Ill-Health Index, Year 1	--	--	--	--	--	.07	.45**
6. Placement (Foster or Kinship)	--	--	--	--	--	--	.19*
7. Log of Total cost	--	--	--	--	--	--	--
Mean	1.53	2.06	.53	13.22	49.67	.93	4.49
SD	2.03	2.32	.50	2.20	9.70	.25	.12

*p<.05 **p<.01

Gender (1 = male, 0 = female)

Placement (1 = foster care, 0 = kinship care)

Table 17

Summary of Hierarchical Regression Analysis for Variables Predicting Conduct Disorder/Aggression, Year 2 (N=114)

Variable	B	SE B	β
Step 1			
Conduct Disorder/Aggression, Year 1	0.39	0.07	0.45**
Step 2			
Conduct Disorder/Aggression, Year 1	0.39	0.07	0.45**
Gender of child/youth in Care	0.07	0.35	0.02
Age of child/youth in Care	0.02	0.08	0.03
Step 3			
Conduct Disorder/Aggression, Year 1	0.34	0.08	0.39**
Gender of child/youth in Care	-0.02	0.34	0.01
Age of child/youth in Care	0.04	0.08	0.04
T-score of Ill-Health Index, Year 1	0.04	0.02	0.21*
Step 4			
Conduct Disorder/Aggression, Year 1	0.34	0.08	0.39**
Gender of child/youth in Care	-0.02	0.35	-0.00
Age of child/youth in Care	0.03	0.08	0.04
T-score of Ill-Health Index, Year 1	0.04	0.02	0.21*
Current Placement (Foster or Kinship)	0.02	0.67	0.00
Step 5			
Conduct Disorder/Aggression, Year 1	0.30	0.08	0.35**
Gender of child/youth in Care	-0.01	0.34	-0.00
Age of child/youth in Care	0.06	0.08	0.06
T-score of Ill-Health Index, Year 1	0.03	0.02	0.12
Current Placement (Foster or Kinship)	-0.27	0.66	-0.03
Log of total cost	0.00	1.63	0.25*

Note. R^2 = .20 for Step 1; ΔR^2 = .00 for Step 2; ΔR^2 = .04 for Step 3; ΔR^2 = .00 for Step 4; ΔR^2 = .04 for Step 5
*p<.05 **p<.01
Gender (1 = male, 0 = female)
Placement (1 = foster care, 0 = kinship care)

5.2.5. Hypothesis 6. This hypothesis predicted that higher costs would be associated with a decrease in indirect aggression at the follow-up (Time 2). In the hierarchical regression used to test this hypothesis, the score on the indirect aggression scale at Time 1 was entered at Step 1 of the regression. Table 16 displays the correlations for the variables in this analysis. The predicted variable is the score on the indirect aggression at Time 2. The results of this hierarchical regression analysis are shown in Table 17: the unstandardized coefficients, the standardized regression coefficients, the R^2 at step 1 and the change in the R^2 at each subsequent step. After step 5, with all six IVs in the equation, $R^2 = .33$, $p<.001$.

As expected, scores on indirect aggression in year 1 predicted scores on indirect aggression in year 2. At step 1, the $R^2 = .28$, $F=44.12$, $p<.001$. At step 2, when gender and age are entered in the equation, $\Delta R^2 = .02$ and the change is not significant, indicating the addition of these variables adds nothing to the model statistically. The same is true at steps 3 and 4, when the Ill-Health Index and the placement (kinship vs foster care) respectively are added to the model. However, at step 5, with the addition of total cost to the model, there is a change to the model, $\Delta R^2 = .025$, $p<.05$.

Table 18

Intercorrelations between Variables of Hierarchical Regression Analysis Predicting Changes in Indirect Aggression between Time 1 and Time 2 (N=116)

Variable	1	2	3	4	5	6	7
1. Indirect Aggression, Year 2	--	.53**	-.18*	-.13	.11	.18*	.25**
1. Indirect Aggression, Year 1	--	--	-.11	-.09	.13	.17*	.13
2. Gender	--	--	--	.09	.10	-.05	.01
3. Age	--	--	--	--	-.07	.10	-.12
4. T-score of Ill-Health Index, Year 1	--	--	--	--	--	.08	.51**
5. Placement (Foster or Kinship)	--	--	--	--	--	--	.18**
6. Total cost	--	--	--	--	--	--	--
Mean	1.89	2.34	.52	13.20	50.0	.93	32574.97
SD	2.28	2.37	.50	2.19	10.0	.25	10963.39

*p<.05 **p<.01

Gender (1 = male, 0 = female)

Placement (1 = foster care, 0 = kinship care)

Table 19
Summary of Hierarchical Regression Analysis for Variables Predicting Indirect Aggression, Year 2 (N=116)

Variable	B	SE B	β
Step 1			
Indirect Aggression, Year 1	0.51	0.08	0.53**
Step 2			
Indirect Aggression, Year 1	0.49	0.08	0.51**
Gender of child/youth in Care	-0.52	0.36	-0.11
Age of child/youth in Care	-0.08	0.08	-0.08
Step 3			
Indirect Aggression, Year 1	0.48	0.08	0.50**
Gender of child/youth in Care	-0.55	0.37	-0.12
Age of child/youth in Care	-0.07	0.08	-0.07
T-score of Ill-Health Index, Year 1	0.01	0.02	0.06
Step 4			
Indirect Aggression, Year 1	0.47	0.08	0.48**
Gender of child/youth in Care	-0.53	0.37	-0.12
Age of child/youth in Care	-0.09	0.08	-0.08
T-score of Ill-Health Index, Year 1	0.01	0.02	0.06
Current Placement (Foster or Kinship)	0.88	0.73	0.10
Step 5			
Indirect Aggression, Year 1	0.46	0.08	0.48**
Gender of child/youth in Care	-0.51	0.36	-0.11
Age of child/youth in Care	-0.07	0.08	-0.07
T-score of Ill-Health Index, Year 1	-0.01	0.02	-0.04
Current Placement (Foster or Kinship)	0.64	0.73	0.07
Total Cost	0.00	0.00	0.19*

Note. $R^2 = .28$ for Step 1; $\Delta R^2 = .02$ for Step 2; $\Delta R^2 = .00$ for Step 3; $\Delta R^2 = .01$ for Step 4; $\Delta R^2 = .02$ for Step 5
*p<.05 **p<.01

Gender (1 = male, 0 = female)

Placement (1 = foster care, 0 = kinship care)

5.2.6. Hypothesis 7. This hypothesis predicted that higher costs would be associated with a decrease in ill-health at the follow-up (Time 2). In the hierarchical regression used to test this hypothesis, the score on the ill-health index at Time 1 was entered at Step 1 of the regression. Table 19 displays the correlations for the variables in this analysis. The predicted variable is the score on the indirect aggression at Time 2. The results of this hierarchical regression analysis are shown in Table 20: the unstandardized coefficients, the standardized regression coefficients, the R^2 at step 1 and the change in the R^2 at each subsequent step. After step 5, with all 5 IVs in the equation, $R^2 = .62$, $p<.001$. As expected, scores on ill-health in year 1 predicted scores on ill-health in year 2. However, as with conduct disorder/physical aggression and indirect aggression, the direction of the relationship was not as expected. Higher costs significantly predicted increases in the Ill-health index from Year 1 to Year 2.

Table 20

Intercorrelations between Variables of Hierarchical Regression Analysis Predicting Changes in Ill Health Index between Time 1 and Time 2 (N=116)

Variable	1	2	3	4	5	6
1. T-Score of Ill Health Index, Year 2	--	.77**	.16*	-.11	.12	.51**
2. T-Score of Ill Health Index, Year 1	--	--	.10	-.07	.08	.51**
3. Gender	--	--	--	.09	-.05	.01
4. Age	--	--	--	--	.10	-.12
5. Placement (Foster or Kinship)	--	--	--	--	--	.18*
6. Total cost	--	--	--	--	--	--
Mean	50.0	50.0	.53	13.20	.93	32574.97
SD	10.0	10.0	.50	2.19	25	10963.39

*p<.05 **p<.01

Gender (1 = male, 0 = female)

Placement (1 = foster care, 0 = kinship care)

Table 21

Summary of Hierarchical Regression Analysis for Variables Predicting T-Score of Ill Health Index, Year 2 (N=116)

Variable	B	SE B	β
Step 1			
T-Score of Ill Health Index, Year 1	.77	.06	.77**
Step 2			
T-Score of Ill Health Index, Year 1	.75	.06	.75**
Gender of child/youth in Care	1.92	1.20	.10
Age of child/youth in Care	-.31	.27	-.07
Step 4			
T-Score of Ill Health Index, Year 1	.75	.06	.75**
Gender of child/youth in Care	2.03	1.20	.10
Age of child/youth in Care	-.36	.27	-.08
Current Placement (Foster or Kinship)	2.95	2.36	.07
Step 5			
T-Score of Ill Health Index, Year 1	.68	.07	.68**
Gender of child/youth in Care	2.11	1.18	.11
Age of child/youth in Care	-.30	.27	-.06
Current Placement (Foster or Kinship)	2.10	2.36	.05
Total Cost	.00	.00	.14*

Note. $R^2 = .59$ for Step 1; $\Delta R^2 = .01$ for Step 2; $\Delta R^2 = .01$ for Step 3; $\Delta R^2 = .01$ for Step 4

*p<.05 **p<.01

Gender (1 = male, 0 = female)

Placement (1 = foster care, 0 = kinship care)

CHAPTER IV: DISCUSSION

Children and youth in foster care, particularly in recent years, have increased needs for mental health and other services. In Ontario in recent years, the number of children entering care and their level of emotional distress and behavioural difficulties have increased in Ontario (Bala, 1999; OACAS, 2002; Steinhauer, 1991), as they have in other parts of Canada, in Britain (Parker et al., 1991) and in Australia (Barber & Delfabbro, 2004). As a result, children and youth in foster care today often need not just basic care and surrogate parenting, but also special medical, educational and mental health services. We know intuitively that these special services require extensive resources and can be very costly to child welfare agencies and to society at large. However, we also know intuitively that spending this money now on intensive remedial services will likely result in considerable savings to society in the future. Effectively targeted children's services may lower criminal justice, welfare and health and mental health costs in the future (Karoly et al., 1998). In addition, if these services assist foster children to make a successful transition to adulthood, society could reap monetary benefits from increased tax revenues and productivity.

In our study, we wanted to identify the costs of services for children and youth in foster care in Ontario over a twelve month period. We were particularly interested in establishing whether services were equitably targeted, that is, whether a relationship would be found between the level of need for services and costs. In Knapp's (1984) POW approach, equity is one of the criteria for cost allocation: the theory being that more money should to be spent on children with higher needs. The variable that the literature suggests would be most appropriate for measuring need is a multi-dimensional health variable, one that includes both physical health needs and

emotional-cognitive health needs. We used an ill-health index that included items on physical needs and some on emotional-cognitive needs. An additional objective of the study was to determine whether a relationship would be found between costs and positive changes in children's and youths' psycho-social functioning during a twelve month period in foster care.

This research project does not meet the formal requirements for a cost-effectiveness study, because we did not compare two or more different programs, to which participants were randomly assigned, as would have been the case for a CEA. In contrast, in this costing study, our main goal was to get a good estimate of the average total per-child costs of foster care, and of the average costs for the various cost categories. In addition, we wanted to examine variations in cost in relation to need, as determined by the measure of ill-health, and to outcomes, which were defined as changes in emotional and behavioural functioning over a twelve month period. We wanted to know whether a multi-dimensional measure of ill-health could predict the costs of services required to meet these health needs. We also wanted to know whether expenditures for services would be associated with improvements in psychosocial functioning over a twelve month period. To our knowledge, this is one of the first studies in Canada to use the POW model for a costing study of children's services. It follows up on a small unpublished pilot project on costs of services for children and youth in foster care in one Ontario CAS (Flynn & LeMay, 1999).

Since we cannot compare this costing study to previous research, in the first part of the discussion, we will examine the method of costing services in this thesis in relation to the criteria of the POW model and of Drummond and his colleagues' (1997) checklist for assessing costing studies. In the second and third part of our discussion, we will discuss the findings on the relationship between needs and costs, and between costs and changes in functioning, with

reference to previous research in child welfare. In the fourth and fifth parts, we will discuss the contributions and limitations of this study, respectively.

1. Costing of foster care

With regard to costing, we cannot compare the cost data to previous research, because with the exception of one small unpublished pilot study (Flynn & Lemay, 1999), to our knowledge this is the first comprehensive costing study of foster care. The sample for the pilot project was very small (20 participants), but the comprehensive costs for services were similar to those found in the current thesis research study.

While this thesis is based on Knapp's (1984) POW model, we were unable to completely follow the principles of the POW because of time and financial constraints. We used more constants in the study than we would have liked to do. In particular, we used a constant for education costs, as we did not have the time or financial means to collect detailed information on the actual costs for education services. We do know from our service data that many of the children in this study received some type of special education services in their schools. However, the extent and costs of these special education services can vary considerably. We were unable to retrospectively gather the information we needed to arrive at a realistic estimate of the actual per child costs of these special education services. Special education services have many levels of funding, and a prospective study that includes detailed service and costing information on these services would provide a much clearer picture of the costs to society of services to children in foster care.

A more detailed prospective study could give more accurate estimates of the costs of the package of care for children and youth in foster care in other areas as well. The current study

underestimates costs in several areas: 1) we did not include capital costs in the calculation of total per child costs; 2) we were unable to calculate as detailed and thorough an estimate of the per child costs of services provided by CAS social work staff (including supervision and administrative support utilized by social workers in the provision of services to foster children); and 3) we also had limited information on which to base our estimates of costs for medical and other services provided by public agencies other than the CASs. The only information that we had on the use of medical services was obtained retrospectively from social workers responding to the questions on service use on the AAR. The unit of service use was the number of times that the child or youth saw a family doctor or medical specialist. The estimate of the cost was then based on OHIP reimbursements for that type of physician. A prospective costing study might be able to gather more specific data on the type of medical service and enable more accurate estimates of real costs to society.

In the following paragraphs, we will examine how well our study met each of the ten criteria set out by Drummond and his colleagues (1987). The first criteron is whether a well-defined question was posed that involved a comparison of alternatives and looked at both costs and outcomes. We believe that our study met this criteria: we examined both costs and outcomes and included information on two types of care: foster care and kinship care. However, rather than examining outcomes as a comparison of differences in functioning between two groups after the groups received different treatments, we examined changes in functioning over time of the full group of participants, and used type of care as one of the predictive variables. We also included an additional element: the examination of need, which was not mentioned on their checklist of criteria for a good economic evaluation.

The second criterion listed by Drummond and his colleagues was: whether a comprehensive description of the competing alternatives was given. We did not clearly describe the alternatives, because kinship care and foster care were not alternatives to which children and youth are randomly assigned. Therefore, these different types of out-of-home care cannot strictly speaking be considered alternatives. The difference between the two types of care may be more related to the caregiver than the actual services received by the children in care. Given the variability in costs shown in this study, there is likely more variation in the costs of services received by children within each type of care, than there is between the two groups. However, this criterion does underline the need for a more detailed examination in further research to find if there are differences in the services received by each of the two groups, and if so, what those differences are. For example, in post-hoc explorations of our data, the children in kinship care appeared to have lower costs for residential services, but higher costs for social work services from the CAS. Further research with a larger sample of children in kinship care could provide useful data for examining possible differences between the groups.

Third, Drummond and his colleagues (1987) ask if the effectiveness of the program was established. A formal cost-effectiveness study with a randomized controlled design may not be realistically possible in foster care, given the clinical and practical reasons for assigning children to different types of treatment. Given that our study was not a randomized, controlled clinical trial, it did not strictly speaking permit any conclusions about effectiveness. However, our study did suggest that costs were equitably allocated according to need, at least on the need variable that we used in our costing study. If after controlling for need, greater expenditures had predicted better outcomes, this could have been interpreted as support for the effectiveness of the services, or at

least a suggestion of good value for money spent. That is, a relationship between expenditures and improvements in functioning would have suggested that the expenditures were well-targeted on services that were associated with improvements in children's psychosocial functioning.

Their fourth criterion was that the evaluation should identify the important and relevant costs and consequences for each alternative. As mentioned above in discussing the POW model, financial and time constraints meant that we were unable to identify the costs as completely as would have been ideal. However, our costing of the services entailed in foster care was as comprehensive as possible, given our time and financial constraints. We were able to include costs to other social agencies, out-of-pocket expenditures by caregivers and volunteer services, as well as the direct and reimbursed costs paid by the CASs. In response to the fifth criteria we did measure costs of services in appropriate units: for example, number of physician visits, days of foster care. The sixth criterion is related to whether the costs and consequences were credibly valued. We used market values as much as possible for the services: to cost services we used information on market rates acquired from the agency accounts, from OHIP rates and from professional organisations and from relevant federal and provincial government departments. We did not attach a monetary value to the outcomes, as the outcomes were self-reported emotional/behavioural variables that could not easily be valued in monetary units.

With regard to the seventh criterion, our study also, for practical reasons (time and money constraints), does not include discounting of costs and consequences that are expected to occur in the future. As suggested in the checklist of criteria (Drummond et al., 1987), we have been clear about the uncertainty of some of our estimates of service-costs. In our further discussion, we will

try to address issues of generalizability of our findings, program implementation issues and comparability to previous research.

However, it is important to note that an economic study can provide valuable information and still not meet all or even most of the criteria of an ideal study. Because of money and time constraints, even very experienced economic researchers, such as Knapp, frequently have to forego their criteria for an ideal study because of practical concerns related to time and money. For example, while the POW model favours a longitudinal approach with at least one follow-up to assess outcomes, Knapp has carried out and published cross-sectional studies because monetary and time constraints did not permit a follow-up. We were able to include a follow-up in this study, but had some limitations with regard to access to complete and accurate costs of services in the package of care, especially those provided by public agencies other than the CAS.

2. Relationship of needs to costs

Our first hypothesis predicted that the higher the health needs (on a multi-dimensional measure of ill-health) of participants, the higher the costs would be for their package of care. The findings support our hypothesis and suggest a link between health needs (related to both disability and cognitive/emotional functioning) and costs, with higher health needs predicting higher costs. This suggests that equity is functioning as a principle for making decisions about the allocation of costs in foster care. As mentioned in the section on the POW model, equity is one of the four principles that should guide the allocation of funds. Our results confirm that equity is guiding allocation decisions, which means that resources are being allocated in a rational manner, with children and youth with higher needs receiving more resources to meet those needs.

However, we used only one measure of need, although it is a composite index that includes both physical health and cognitive/emotional health items. The items measuring cognitive-emotional need in this ill-health index are from the HUI-III and could be considered rudimentary measures of this dimension of health need (see Appendix D to examine the items). Some American researchers suggest that children in foster care in the United States are often assessed for mental health needs only (Rubin, Alessandrini, Feudtner, Mandell, Localio, & Hadley, 2004). These reserachers believe their own research underlines the importance of assessing children in foster care for global health needs, not just mental health needs, and that initiatives be aimed at improving all domains of health of this vulnerable population. Our use of an index that includes both physical and mental health items fits with their view. However, in the future, an expanded measure of mental and physical health needs may provide even richer information on the relationship between children's needs and the costs of services in foster care. This could help further to refine the allocation of resources and might eventually lead to a better understanding of outcomes for these children.

In our study, we also found that after controlling for the level of children's need, kinship care was less expensive than regular foster care. One of the reasons for this may be that caregivers providing kinship care are often paid less than those providing regular foster care. Another reason may be that placement stability is associated with lower costs (Rubin et al., 2004) and kinship care is generally associated with better placement stability (Timmer, Sedlar & Urquiza, 2004).

Also, in previous research, kinship foster parents appeared less likely to perceive externalizing problems in their foster children than regular foster carers did, but just as likely to perceive internalizing problems (Shore, Sim, Le Prohn, & Keller, 2002). Timmer and her

colleagues (2004) suggest that this may be because regular foster carers have less tolerance of their foster children's problem behaviours than kinship carers do. Prior research also suggests that kinship carers are less likely to seek mental health services than regular foster parents (Leslie, Landsverk, Ezzet-Lofstrom, Tschann, Slymen & Garland, 2000). Because we found in our study that kinship care is associated with lower costs independently of children's level of need, our findings also appear to indicate that fewer resources are allocated to kinship care than to regular foster care, irregardless of the level of need of the children in kinship care. Because only eight of the children in the current study were in kinship care, the findings with regard to costs for kinship care in this study are best viewed as exploratory. Further research that includes a larger sample of children in kinship care could give us more information on the relationship between needs and costs, and costs and outcomes, in this type of out-of-home care.

3. Relationship of costs to outcomes

The findings did not support our predictions with regard to the relationship between costs and positive changes in functioning. We expected that, after controlling for the level of health needs at the beginning of the study, that higher costs would predict greater improvements in functioning with regard to self-esteem, prosocial behaviour, emotional distress/anxiety, conduct disorder/aggression and indirect aggression. There were no significant findings with regard to the first three outcome variables. There were significant findings in this costing study with regard to the relationship between costs and changes in functioning for both direct and indirect aggression, but not in the direction expected. Increases in both direct and indirect aggression over time were associated with higher costs. This means that, after controlling for health needs at the beginning

of the study, higher costs predicted negative changes in functioning with regard to both direct and indirect aggression.

This may be because the time period (12 months) was too short to begin to see positive changes in conduct disorder/aggression or indirect aggression. Perhaps, children who exhibit aggressive behaviours, both direct and indirect, need longer-term interventions before they begin to show improvements in their behaviours. On the other hand, the expenditures targeted for these children may require further evaluation to assess whether the services used are the best ones for bringing about positive change in these behaviours.

Steinhauer (1991) suggests that children who have suffered parental neglect, rejection or victimization are more prone to conduct disorder and aggressive behaviour. He believes these behaviours may prove challenging for foster parents to remedy. They may also prove costly to foster parents until the child or youth begins to show positive improvements. For example, on the questionnaire on out-of-pocket expenditures, some foster parents reported high costs for home repairs and damages to property that resulted from aggressive behaviours by foster children. Steinhauer (1991) believes that, as a result of the demands placed on foster parents, these challenging behaviours are often associated with placement breakdown. Placement breakdown would intuitively be expected to be associated with higher costs, as transfer to a new setting is likely to require increased social worker involvement, moving costs, and perhaps assessment and monitoring costs to evaluate the new placement. In addition, placement breakdown may create a vicious circle, by exacerbating pre-existing conduct and aggression behaviours which could then lead to further placement breakdowns. An American study found that placement breakdown did result in higher costs for mental health and physical health services (Rubin et al., 2004).

Placement breakdown may also result in the child or youth being transferred to a more intensive intervention, for example from regular foster care to treatment foster care. The aggressive behaviours may also result in stays in hospital or a youth detention facility, both of which would increase overall service costs, as these services are generally more expensive than regular or kinship foster care. Even short stays in a hospital or youth justice facility might result in considerable elevations in overall costs for the package-of-care.

In a pilot study of the costs of children's antisocial behaviour for ten children in London, England, Knapp, Scott and Davies (1999) found that the highest costs were to the families themselves and to the education system. If this holds true for our sample, the costs of aggressive behaviour are likely underestimated in our study, because we were unable to cost special education services. Knapp and his colleagues (1999) also reported significant health care and social services use for these children (Knapp, 1999). It should be noted that the participants in this pilot study were children living at home and not in foster care, although one of the mothers had put her son in foster care temporarily. In this pilot study, the aggregate direct service costs per child per year averaged $8258.00, and 30 per cent of these costs were for medical services provided by the National Health Services.

Knapp and his colleagues (1999) did not include costs for those activities and services used by all children and families, only for costs directly related to the conduct disorder. The largest portion of the total costs was the 58 per cent that covered special education services associated with educating a child with conduct disorder. As we were unable to get data on the additional special education costs that many children in foster care receive at school, our study almost certainly under-estimates the real costs associated with conduct disorder and aggressive

behaviours. Knapp and his colleagues (1999) suggest that the cost of providing foster family placements to these children would be high and they are sometimes placed in care because their parents find them too difficult to manage.

Hence, it may be unrealistic to expect to see significant positive changes over a period of only twelve months. A longer follow-up is likely needed to notice positive changes. Also, the increased costs over the twelve month period may be the result of the deterioration in these behaviours for reasons unrelated to the services that the children are receiving, reasons that may predate the provision of services. These might include attachment behaviours that result from traumatic experiences in their biological families and interfere with the children benefiting initially from the interventions they receive for their aggressive behaviours. These children's distrust of adults may cause them difficulty in establishing positive relationships with both foster parents and professional service providers.

A longer follow-up may also be needed to see improvements in those psycho-social behaviours that did not show any significant changes, either positive or negative, related to costs over the twelve months of the study. More time may also be needed to affect positive changes in the self-esteem, prosocial behaviour and the emotional distress/anxiety of children who have experienced the difficult life experiences that many children in foster care have.

4. Contributions of this study

The current research is, to my knowledge, one of the first in Canada to collect detailed data on services and costs in foster care, and then to link those costs to needs and outcomes of children and youth in care. As far as I am aware, other than the pilot study completed on 20 wards of the

Prescott Russell CAS by Flynn and Lemay in 1999, it is the first study of foster care in Canada to use the Production of Welfare model.

Furthermore, this is one of the first studies to provide information on global health needs and health service use of children in foster care in Canada, and of the package of care these children receive. This study has gathered descriptive data on a number of health factors, including disability, and chronic health conditions, as well as mental health factors, such as emotions and behavioural difficulties of foster children. In addition, this study provides data on the unit and component costs of health care services for the foster children in the study.

Given that no large-scale studies of services and costs in child welfare have yet been published, the description of foster care services and unit costs provides a foundation for future research. The data from this study should provide a basis for future research that will permit more accurate estimates of the costs of foster care to be established and to inform decisions about placements in child welfare. Our research suggests that the information on the AAR on children's health and mental health needs can validly be used to guide allocation decisions. Another contribution of the research is that the information on costs and services has been calculated on an individual basis, thus providing the foundation for a sound analysis of the relationship between costs and outcomes. Although this study is not a true economic evaluation because it does not include a comparison group in the costing analysis, this study did analyse the relationship between foster children's changes with regard to developmental functioning on a number of factors and the cost of the services they received in foster care.

In addition, our research suggests that kinship care is less expensive than regular foster care, and that this association of kinship care with lower costs is independent of the level of

children's health needs. Although our sample of children in kinship care is small, I believe this is the first study to examine the costs of kinship care in Canada.

Given the current concerns about the effectiveness of foster care placements, the findings of this research could provide managers of child welfare agencies with valuable data to guide policy and program development. Because research on outcomes and costs in child welfare is scarce and those studies that have been published to date have been small scale, the study provided information that is not yet available elsewhere. To our knowledge, this is the first study to examine the relationship between needs, costs and outcomes in foster care. Our costing study can give policy makers some idea of how expensive it is to support a child for a year in foster care. Furthermore, it suggests that longer term interventions may be needed to see positive changes in children's functioning in foster care. In addition, the particular interventions being used, especially for aggressive behaviours, both direct and indirect, may need to be examined in more detail. Also, our study suggests that kinship care may be cheaper, regardless of level of need, and that this type of care warrants further investigation.

Further research on the cost of kinship care may help to refine an understanding of the relationship between costs, needs and outcomes in this alternative to foster care. This type of care may be less expensive because kinship carers receive lower payments and access fewer professional services. Unless lower expenditures are associated with equivalent or better outcomes than those of children in regular foster care, savings to society from this type of care may be short term. Further research with a larger sample of children in kinship care, could examine whether children in this type of care in Canada are receiving less services than children in other types of care. Further costing evaluations of kinship care could help establish the benefits and limitations

of kinship care, and could lead to more informed decisions about allocations for children in this type of out-of-home care. Previous research in the United States, for example, suggests that children in kinship care and their caregivers may access mental health services less often than children in regular foster care and their caregivers (Leslie et al., 2000). Thus, kinship care may be less expensive because kinship caregivers and their wards receive fewer services. Some research suggests this may be because kinship caregivers underestimate the needs of children in their care (Timmer, Sedlar,& Urquiza, 2004) . On the other hand, the lower costs may be a the result of the greater placement stability of kinship care: research consistently shows that kinship care is more stable than other types of out-of-home care (Berrick et al., 1994). Placement stability would intuitively be expected to be associated with lower costs.

5. Limitations of this study

This study has a number of limitations. First, the follow-up period (12 months) is too short to allow for confident conclusions to be drawn about the therapeutic effects of the services received by children and youths in foster care. Another limitation of the study was that two different versions of the AAR were used to collect the data on service use, health needs and outcome measures: one version for the 10-to-14 year olds, and another for those foster children who were 15 years of age and older. However, there were no differences between the two questionnaires with regard to the particular measures used in this thesis research.

The data on services and costs were also gathered retrospectively. As a result, these data are likely not as accurate nor as detailed as they would be if they had been collected as they were incurred. If the cost data could be collected using a log in which data is entered at the time that the services are accessed and the costs are incurred, the data on service use and costs would be

more complete and detailed. In addition, cost data collected at the time of service use would be more accurate, as the actual costs could be ascertained for most services and fewer estimates of service costs would be needed.

In addition, the data on the AAR on the needs and outcomes of the children and youth in foster care was generally collected by the social workers in the presence of foster parents. The presence of the social workers and foster parents may have influenced how the children and youth responded to the questions on these measures. However, there is a possibility that this actually improved the reliability of the data by including multiple respondents.

The children and youths in the study had already been in foster care for varying lengths of time. The length of time these foster children had been in care may have influenced the extend to which improvement could be seen on the outcome measures. Children who had been in care for a number of years may have attained considerable benefits from foster care before the period of this research study, but made few gains between the initial data collection point and follow-up of our study.

Finally, the small sample of children in kinship care in this study means that the findings concerning the lower costs of kinship care can only be considered exploratory. Further research on the costs of kinships care may help to refine an understanding of costs, needs and outcomes in this alternative to foster care. This type of care may be less expensive because kinship carers receive lower payments and access fewer professional services. Unless lower expenditures are associated with equivalent or better outcomes than those of children in regular foster care, savings to society from this type of care may be short term. Further research with a larger sample of children in kinship care, could examine whether children in this type of care in Canada are

receiving less services than children in other types of care. Further costing evaluations of kinship care could help establish the benefits and limitations of kinship care, and could lead to more informed decisions about allocations for children in this type of out-of-home care.

A larger prospective study that included larger number of children in specialized and treatment foster care could also compare children in these types of care with children in regular and kinship foster care. Our study did not include large enough numbers of children in either specialized or treatment foster care to notice any significant difference in costs between these two groups and regular foster care. Although more money was spent on children in these types of care than those in regular foster care, the difference in cost was not statistically significant in our study.

References

Aldgate, J., Maluccio, A.N., & Reeves, C. (1989). *Adolescents in foster families*. London, GB: Batsford.

Allen, C., & Beecham, J. (1993). Costing services: Ideals and reality. In A. Netten & J. Beecham (Eds.), *Costing community care: Theory and practice* (pp. 25-42). Canterbury, England, GB: Personal Social Services Research Unit (PSSRU), University of Kent.

Almeida, M.C., Hawkins, R.P., Meadowcraft, P., & Luster, W.C. (1989). Evaluation of foster-family-based treatment in comparison with other programs: A preliminary analysis. In J. Hudson & B. Galaway (Eds.), *The State as Parent* (pp. 299-313). Dordrecht, Netherlands: Kluwer.

Aries, P. (1962). *Centuries of childhood: A social history of family life*. New York: Vintage Books.

Bagley, C., & Pritchard, C. (1998). The billion dollar costs of troubled youth: Prospects for cost-effective prevention and treatment. *International Journal of Adolescence and Youth, 7*, 211-225.

Bala, N. (1999, June). *Reforming the Child and Family Services Act: Is the pendulum swinging back too far?* Paper presented at the Education Programs of the Ontario Office of the Children's Lawyer, in Toronto and Sault Ste. Marie, ON.

Barber, J.G., & Delfabbro, P.H. (2004). Children in foster care. London and New York: Routledge, Taylor & Francis Group.

Barr, B., & Holt, M. (1994). Who will claim them? Tracing the antecedents of foster care in the United States, 1850-1930. In B. McKenzie (Ed.), *Current perspectives on foster family care for children and youth* (pp. 18-36). Toronto, ON: Wall & Emerson.

Beecham, J. (1995). Collecting and estimating costs. In M. Knapp (Ed.), *The economic evaluation of mental health care* (pp. 61-82). Vermont: Ashgate.

Beecham, J. (2000). *Unit costs - Not exactly child's play: A guide to estimating unit costs for children's social services.* Canterbury, England, GB: Personal Social Services Research Unit (PSSRU), University of Kent.

Beecham, J., & Knapp, M. (1995). Mental health economic evaluations: Unfinished business. In M. Knapp (Ed.), *Economic evaluations of mental health care* (pp. 229-241). Cornwall, England, GB: Hartnolls.

Beecham, J., Knapp, M., Allen, C. (1995). Comparative efficiency and equity in community-based care. In M. Knapp (Ed.), *Economic evaluations of mental health care* (pp. 175-194). Cornwall, England: Hartnolls.

Beecham, J., Knapp, M., & Fenyo, A. (1993). Costs, needs and outcomes in community mental health care. In A. Netten & J. Beecham (Eds.), *Costing Community Care: Theory and Practice* (pp. 162-176). Canterbury, England, GB: Personal Social Services Research Unit (PSSRU), University of Kent.

Beeman, S., & Boisen, L. (1999). Child welfare professionals' attitudes toward kinship foster care. *Child Welfare, 78*, 315-337.

Berrick, J.D. (2000). What works in kinship care. In M.P. Kluger, G. Alexander, & P.A. Curtis (Eds.), *What works in child welfare* (pp. 127-137). Washington, D.C.: Child Welfare League of America.

Berrick, J.D., Barth, R.P., & Needell, B. (1994). A comparison of kinship foster homes and foster family homes: Implications for kinship foster care as family preservation.

Bigot, F. (1984). Pensions nourricieres et définition sociale de l'enfance. *Perspectives psychiatriques, 99*, 401-407.

Blatt, S.D., Saletsky, R.D., Meguid, V., Church, C.C., O'Hara, M.T., Haller-Peck, S.M., Anderson, J.M. (1997). A comprehensive multidisciplinary approach to providing health care for children in out-of-home care. *Child Welfare, 76*, 331-347.

Bowlby, J. (1980). *Attachment and Loss, Volume 3, Loss: sadness and depression.* London, UK: Penguin.

Boyle, M.H., Furlong, W., Feeny, D., Torrance, G.W., Hatcher, J. (1995). Reliability of the Health Utilities Index-Mark III used in the 1991 cycle 6 Canadian General Social Survey Health Questionnaire. *Quality of Life Research, 4*, 249-257.

Cantos, A.L., Gries, L.T., & Slis, V. (1996). Correlates of therapy referral in foster children. *Child Abuse and Neglect, 20*, 921-931.

Chernoff, R., Coombs-Orme, T., Risley-Curtiss, C., & Heisler, A. (1994). Assessing the health status of children entering foster care, *Pediatrics, 93*, 594-601.

Clark, H.B., Lee, B., Prange, M.E., & McDonald, M.A. (1996). Children lost within the foster care system: Can wraparound service strategies improve placement outcomes? *Journal of Child and Family Studies, 5*, 39-54.

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*, 155-159.

Dawson, R. (1989). Improving the quality and status of treatment foster care: The concept of certification for providers. *Community Alternatives: International Journal of Family Care, 1*, 11-21.

Drummond, M.F., O'Brien, B., Stoddart, G.L., Torrance, G.W. (1997). *Methods for the economic evaluation of health care programmes (2nd Ed.)*. Oxford, GB: Oxford University Press.

Dubowitz, H., Feigelman, S., & Zuravin, S. (1993). A profile of kinship care. *Child Welfare, 72*, 153-169.

Dubowitz, H., & Sawyer, R.J. (1994). School behavior of children in kinship care. *Child Abuse and Neglect, 18*, 899-911.

Dubowitz, H., Zuravin, S., Starr, R.H., Feigelman, S., & Harrington, D. (1993). Behavior problems of children in kinship care. *Journal of Developmental & Behavioral Pediatrics, 14*, 386-393.

Dumaret, A.-C., Coppel-Batsch, M., & Couraud, S. (1997). Adult outcome of children reared for long-term periods in foster families. *Child Abuse and Neglect, 21*, 911-927.

Durkin, R. (1990). Competency, relevance, and empowerment: A case for restructuring children's programs. *Child and Youth Services, 13*, 105-117.

Feeney, D., Furlong, W., Boyle, M., & Torrance, G.W. (1995). Multi-attribute health status classification systems: Health Utilities Index. *PharmacoEconomics, 7*, 490-502.

Fein, E., Maluccio, A.N., Hamilton, V.J., & Ward, D.E. (1983). After foster care: Outcomes of permanency planning for children. *Child Welfare, 62*, 485-562.

Fein, E., Maluccio, A.N., & Kluger, M. (1990). *No more partings – an examination of long-term foster-care*. Washington, D.C.: Child Welfare League.

Flaherty, E.G., & Weiss, H. (1990). Medical evaluation of abused and neglected children, *American Journal of Disease in Children, 144*, 330-334.

Flynn, R.J., Aubry, T., Drolet, M., & Angus, D. (1999). *Improving child protection practice through the introduction of Looking After Children into the 52 local Children's Aid Societies in Ontario: An implementation and outcome evaluation.* Research proposal funded by SSHRC, SSHRC Strategic Theme: Society, Culture, and Health of Canadians, Grant # 828-1999-1008.

Flynn, R.J., & Biro, C. (1998). Comparing developmental outcomes for children in care with those of other children in Canada. *Children & Society, 12*, 228-233.

Flynn, R., Ghazal, H., Moshenko, S., & Westlake, L. (2001). Main features and advantages of a new "Canadianized" version of the Assessment and Action Record from Looking After Children.

Flynn, R.J., & Lemay, R. (1999). *A pilot study of the cost of foster care at the Prescott-Russell Children's Aid Society.* Invited paper presented at the Fourth International Conference from the Looking After Children Initiative, Oxford University, U.K., September.

Gleeson, J.P., & Craig, L.C. (1994). *Kinship care in child welfare: An analysis of states' policies. Children and Youth Services Review, 16*, 7-32.

Halfon, N., & Klee, L. (1987). Health services for California's foster children: Current practices and policy recommendations, *Pediatrics, 80*, 183-191.

Human Resources Development Canada (1999). *Foster Care*. Federal-provincial working group on child and family services information.

Hummel-Rossi, B., & Weinberg, S. L. (1975). *Practical guidelines in applying current theories to the measurement of change: Part I: Problems in measuring change and recommended procedures. Part II: Numerical illustrations of research designs concerned with measuring change*. American Psychological Association.

Iglehart, A.P. (1994). Kinship foster care: Placement, service, and outcome issues. *Child and Youth Services Review, 16*, 107-122.

Jackson, S. (1995). Looking after children better: An interaction model for research and practice. In J. Hudson & B. Galaway (Eds.), *Child welfare in Canada: Research and policy implications*. Toronto, ON: Thompson Educational Publishing.

Jackson, S. (1998). Looking after children: A new approach or just an exercise in formfilling? A response to Knight and Caveney. *British Journal of Social Work, 28*, 45-56.

Karoly, L.A., Greenwood, P.W., Everingham, S.S., Houbé, J., Kilburn, M.R., Rydell, C.P., Sanders, M., & Chiesa, J. (1998). *Investing in our children: What we khnow and don't know about the costs and benefits of early childhood interventions*. Santa Monica, CA: Rand.

Keller, T.E., Wetherbee, K., LeProhn, N.S., Payne, V., Sim, K., & Lamont, E.R. (2001). Competencies and problem behaviors of children in family foster care: Variations by kinship placement status and race. *Children and Youth Services Review, 23*, 915-940.

Klee, L., Soman, L.A., & Halfon, N. (1992). Implementing critical health services for children in foster care. *Child Welfare, 71*, 99-111.

Knapp, M. (1984). *The Economics of social care*. London, England: McMillan.

Knapp, M. (1986). The relative cost-effectiveness of public, voluntary and private providers of residential child care. In A. Culyer & B. Jönsson (Eds.), *Public and private health services* (pp. 171-199). Oxford, UK: Basil Blackwell.

Knapp, M. (1993a). Background theory. In A. Netten & J. Beecham (Eds.), *Costing Community Care: Theory and Practice* (pp. 9-24). Canterbury, England, GB: Personal Social Services Research Unit (PSSRU), University of Kent.

Knapp, M. (1993b). Principles of applied cost research. In A. Netten & J. Beecham (Eds.), *Costing Community Care: Theory and Practice* (pp. 61-72). Canterbury, England, GB: Personal Social Services Research Unit (PSSRU), University of Kent.

Knapp, M. (1995). The economic perspective: Framework and principles. In M. Knapp (Ed.), *The economic evaluation of mental health care* (pp. 1-26). Vermont: Ashgate.

Knapp, M.R.J. (1997). Economic evaluations and interventions for children and adolescents with mental health problems. *Journal of Clinical Psychology and Psychiatry, 38*, 3-15.

Knapp, M., & Lowin, A. (1998). Child care outcomes: Economic perspectives and issues. *Children and Society, 12*, 169-179.

Knapp, M.R.J., Netten, A., & Beecham, J. (1993). Costing community care: The role of this book. In A. Netten & J. Beecham (Eds.), *Costing Community Care: Theory and Practice* (pp. 1-6). Canterbury, England, GB: Personal Social Services Research Unit (PSSRU), University of Kent.

Knapp, M.R.J., Scott, S., & Davies, J. (1999). The cost of antisocial behaviour in younger children. *Clinical Child Psychology and Psychiatry, 4*, 457-473.

Knapp, M., & Smith, J. (1985). The costs of residential child care: Explaining variations in the public sector. *Policy and Politics, 13*, 127-154.

Kufeldt, K., Vachon, J., Simard, M., Baker, J., & Andrews, T-L. (2000). *Looking After Children in Canada: Final Report.* Submitted to Social Development Partnerships of Human Resources Development Canada, June 2000.

Lambert, L. (1983). *A Study of the Health of Children in Care using Information Derived from the National Child Development Study*, National Children's Bureau report to the Social Science Research Council.

Landsverk, J., Davis, I., Ganger, W., Newton, R. (1996). Impact of child psychosocial functioning on reunification from out-of-home placement. *Children and Youth Services Review, 18*, 447-462.

Le Galès, C., Buron, C., Costet, N., Rosman, S. (2002). Development of a Preference-Weighted Health Status Classification System in France: The Health Utilities Index 3. *Health Care Management Science, 5*, 41-51.

Leslie, L., Landsverk, J., Ezzet_Lofstrom, R., Tschann, J., Slymen, D., & Garland, A. (2000). Children in fostercare: Factors influencing outpatient mental health service use. *Child Abuse and Neglect, 24*, 463-476.

Littner, N. (1974). The challenge to make fuller use of our knowledge about children. *Child Welfare, 53*, 287-294.

Lyman, R.D., & Wilson, D.R. (1992). Residential and inpatient treatment of emotionally disturbed children and adolescents. In C.E. Walker & M.C. Roberts (Eds.), *Handbook of clinical child psychology, 2nd ed.* (pp. 829-843). Oxford, ENG: John Wiley & Sons.

Main, M., & Solomon, J. (1986). Discovery of new, insecure-disorganized/disoriented attachment pattern. In M. Yogman & T.B. Brazelton (Eds.), *Affective development in infancy.* Norwood, NJ: Ablex.

Maluccio, A.N. (Ed.) (1981). *Promoting competence in clients – A new/old approach to social work practice.* New York: Free Press.

Maluccio, A.N., & Fein, E. (1989). An examination of long-term foster family care for children and youth. In J. Hudson & B. Galaway (Eds.), *The State as Parent*, pp. 387-400. Dordrecht, Netherlands: Kluwer.

Netten, A., & Beecham, J. (Eds.) (1993). *Costing community care: Theory and practice.* Personal Social Services Research Unit (PSSRU), University of Kent at Canterbury, England.

Nutter, R.W., Hudson, J., Galaway, B., & Hill, M. (1995). Specialist foster care program standards in relation to costs, client characteristics, and outcomes. In J. Hudson & B. Galaway (Eds.), *Child welfare in Canada: Research and policy issues*, (pp. 201-218).

Ontario Assocation of Children's Aid Societies (OACAS). (2002). Retrieved May 15, 2002, from http://www.casoc.com/English/index.htm

Packman, J., Randall, J., & Jacques, N. (1984). *Who needs care? Social work decisions about children.* Oxford, GB: Basil Blackwell.

Parker, R.A., Ward, H., Jackson, S., Aldgate, J., & Wedge, P. (Eds.) (1991). *Looking after children: Assessing outcomes in child care.* London, UK: HMSO.

Pearce, J.W., & Pezzot-Pearce, T.D. (2001). Psychotherapeutic approaches to children in foster care: Guidance from attachment theory. *Child Psychiatry and Human Development*, 32, 19-44.

Pottick, K. J., Warner, L. A, & Yoder, K. A. (2005). Youths Living Away From Families in the US Mental Health System: Opportunities for Targeted Intervention. *Journal of Behavioral Health Services & Research*, 32(3), 264-281.

Redding, R.E., Fried, C., & Britner, P.A. (2000). Predictors of placement outcomes in treatment foster care: Implications for foster parent selection and service delivery. *Journal of Child and Family Studies, 9*, 425-447.

Richardson, C.G., & Zumbo, B.D. (2000). A statistical examination of the Health Utility Index Mark III as a summary measure of health status for a general population health survey. *Social Indicators Research, 51*, 171-191.

Rosenberg, S.A., & Robinson, C.C. (2004). Out-of-home placement for young children with developmental and medical conditions. *Children and Youth Services Review, 26*, 711-723.

Rossi, P.H., Freeman, H.E., & Lipsey, M.W. (1999). *Evaluation: A systematic approach, 6th ed.* Thousand Oaks, CA: Sage.

Rubin, D.M., Allessandrini, E.A., Feudtner, C., Mandell, D.S., Localio, A.R., Hadley, T. (2004). Placement stability and mental health costs for children in foster care. *Pediatrics, 113*, 1336-1341.

Scannapieco, M., & Hegar, R.L. (1999). Kinship foster care in context. In R.L. Hegar & M. Scannapieco (Eds.), *Kinship foster care: Policy, practice, and research* (pp. 141-154). New York: Oxford University Press.

Schafer, J.L., & Graham, J.W. (2002). Missing data: Our view of the state of the art. *Psychological Methods, 7*, 147-177.

Schneiderman, M., Connors, M.M., Fribourg, A., Gries, L., & Gonzales, M. (1998). Mental health services for children in out-of-home care. *Child Welfare, 77*, 29-40.

Schor, D.P. & Abel, C.M. (1985). Back to basics in health care for foster children. *Children Today, 14(3)*, 13-16.

Schor, E.L. (1982). The foster care system and health status of foster children, *Pediatrics, 69*, 521-528.

Schor, E.L. (1985). Back to Basics in Health Care for Foster Children, Children Today, 14(3), 13-16.

Schor, E.L., Neff, J.M., & LaAsmar, J.L. (1984). The Chesapeake health plan: An HMO model for foster children, *Child Welfare, 63*, 431-439.

Shore, N., Sim, K., Le Prohn, N., & Keller, T. (2002). Foster parent and teacher assessments in youth in kinship and non-kinship foster care placements: Are behaviors perceived differently across setting? *Children and Youth Services Review, 24*, 109-134.

Simms, M.D. (1989). The foster care clinic: A community program to identify treatment needs of children in foster care, *Developmental and Behavioral Pediatrics, 10*, 121-28.

Simms, M.D., & Halfon, N. (1994). The health care needs of children in foster care: A research agenda. *Child Welfare, 73*, 505-524.

Simms, M.D., & Horwitz, S.M. (1996). Foster home environments: A preliminary report. *Developmental and Behavioural Pediatrics, 17*, 170-175.

Simms, M.D., & Kelly, R.W. (1991). Pediatricians and foster children, *Child Welfare, 70*, 451-461.

Smith, M.C. (1995). A preliminary description of nonschool-based friendship in young high-risk children. *Child Abuse and Neglect, 19*, 1497-1511.

Statistics Canada (2001). *National Longitudinal Study of Children and Youth: Data Dictionary, Cycle 3*. Ottawa, ON: Statistics Canada.

Statistics Canada (2002). *National Longitudinal Study of Children and Youth: Data Users Guide*. Ottawa, ON: Statistics Canada.

Steinhauer, P.D. (1988). The preventive utilization of foster care. *Canadian Journal of Psychiatry, 33*, 459-467.

Steinhauer, P.D. (1991). *The least detrimental alternative: A systemic guide to case planning and decision making for children in care*. Toronto: University of Toronto Press.

Swire, M.R., & Kavaler, F. (1977). The Health Status of children in foster care. *Child Welfare*.

Tabachnick, B.G., & Fidell, L.S. (1996). Using multivariate statistics, 3rd Edition. New York, NY: HarperCollins College Publishers.

Timmer, S.G., Sedlar, G., & Urquiza, A.J. (2004). Challenging children in kin versus nonkin foster care: Perceived costs and benefits to caregivers. *Child Maltreatment, 9*, 251-262.

Torrance, G.W. (1986). Measurement of health state utilities for economic appraisal: A review. *Journal of Health Economics, 5*, 1-30.

Ward, H. (1994). Assessing outcomes in child care: The Looking After Children project. In B.D. McKenzie (Ed.), *Current perspectives on foster family care for children and youth*, pp. 183-197. Toronto, ON: Wall and Emmerson.

Ward, H. (Ed.) (1995). *Looking after children: Research into practice, The second report to the Department of Health on assessing outcomes in child care*. London, UK: HMSO.

Wedeven, T., Pecora, P.J., Hurwitz, M., Howell, R., & Newell, D. (1997). Examining the perceptions of alumni of long-term family foster care: A follow-up study. *Community Alternatives: International Journal of Family Care, 9*, 88-105.

Wise, S. (1999). *The UK Looking after Children approach in Australia.* Melbourne: Australian Institute of Family Studies.

World Health Organization (1948). Constitution of the World Health Organization. Geneva: World Health Organization.

Wulczyn, F.H., & Goerge, R.M. (1992). Foster care in New York and Illinois: The challenge of rapid change. *Social Service Review, 66*, 278-294.

Yates, B.T. (1994). Toward the incorporation of costs, cost-effectiveness analysis and cost-benefit analysis into clinical research. *Journal of Consulting and Clinical Psychology, 62*, 729-736.

Yates, B.T. (1996). *Analyzing costs, procedures, processes, and outcomes in human services.* Thousand Oaks, CA: Sage.

APPENDIX A

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LOOKING AFTER CHILDREN IN ONTARIO

Background Information & Assessment and Action Record Ages 15 Years and Over

Youth's name:

(**Note:** After photocopying this document please white out only the child/youth's name before sending the photocopy to Ms. Hayat Ghazal at the Centre for Research on Community Services, University of Ottawa, 34 Stewart St., Ottawa, Ontario, K1N 6N5. For more information, please contact us at ghazha@hotmail.com.)

Youth's initials: (initials of first name and last name)

Youth's official agency file number:

Youth's gender: ☐ Male ☐ Female

Youth's date of birth: Month / Day / Year / /

Current placement: name, address, & phone number of foster parent or other adult caregiver:

Name

Address: apartment number, unit number, street

Town - City - Province

Postal Code

Current placement: Telephone number of ( ) -

This assessment was coordinated by:

Name of CAS protection worker:

Position:

Agency:

Approved by:

Supervisor:

Date / / Month / Day / Year

Date begun: / / Month / Day / Year

Date completed: / / Month / Day / Year

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INTRODUCTION

This document is in a format that allows it to be read by a computer scanner, for rapid processing. The purpose of the **Assessment and Action Record (AAR)** is to assess a youth'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 **self-care skills.**

It is to be completed by the CAS protection worker in an interview in which the youth in care and the foster parent (or other adult caregiver) who knows him/her best both participate. Some questions are addressed to the youth in care, others to the foster parent (or other adult caregiver), and yet others to the CAS protection worker.

BACKGROUND INFORMATION

The purpose of this background information section is to gather basic socio-demographic information on three key persons in the Looking After Children approach: the youth in care, the CAS protection worker responsible for the youth in care, and the foster parent (or other adult caregiver, such as a group-home staff member) who knows the youth best.

Notes to the CAS protection worker:

> *In many cases, much of this background information section can probably be completed by you before the interview with the youth in care and his/her foster parent (or other adult caregiver).*
> *For each item, please put only an **X** (or, as required, **a number**) in the appropriate box or boxes, so that the computer will be able to scan the questionnaire properly. Please do not put a check mark or any mark other than an **X** (or a number) in the boxes.*
> *The symbol of three dots in a row [...] always refers to the youth on whom the AAR is being completed.*
> *At the beginning of the interview, please give an AAR binder to the youth and another one to his/her foster parent (or other adult caregiver). This will allow them to follow along easily and permit the interview to proceed smoothly and quickly. Only your copy of the AAR is to be filled out.*

The present section is to be answered by the **CAS PROTECTION WORKER**, with assistance, as needed, from the youth in care and his/her foster parent (or other adult caregiver).

1. BACKGROUND INFORMATION ON THE YOUTH IN CARE ON WHOM THE AAR IS TO BE COMPLETED

BG1: What is ...'s official CAS case file number?

BG2: What is ...'s gender?

☐ Male ☐ Female

BG3: What is ...'s date of birth?

		/			/					

Month / Day/ Year

BG4: What is ...'s current age?

		Years			Months

BG5: What is ...'s current status as a client of the local CAS?

☐ Agreement ☐ Non-ward ☐ Society ward ☐ Crown ward ☐ Other Society ward

BG6: How old was ... when he/she was first placed in out-of-home care for the very first time (at this or another CAS)?

		Years			Months

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BG7: PRIMARY REASON FOR CURRENT ADMISSION TO SERVICE: Which of the following categories describes the primary reason why ... came into care on the most recent occasion? (**Mark one only. The categories and accompanying definitions are taken from the Ontario Child Welfare Eligibility Spectrum.**)

- ☐ **Physical/sexual harm by commission** (i.e., the child/youth has been or is at risk of being physically or sexually harmed as a result of an act or action by a caregiver)
- ☐ **Harm by omission** (i.e., the child or youth has been or is at risk of being harmed as a result of the caregiver's failure to provide adequate care for him/her)
- ☐ **Emotional harm** (i.e., the child/youth has been or is at risk of being emotionally harmed as a result of specific behaviours of the caregiver towards him/her)
- ☐ **Abandonment/separation** (i.e., the child has been abandoned or is at risk of being separated from the family as a result of intentional or unintentional actions of the caregiver)
- ☐ **Caregiver capacity** (i.e., although no harm has yet come to the child, the caregiver's characteristics indicate that without intervention, the child would be at risk in one of the previous categories)
- ☐ **Extended care & maintenance** (i.e., requested by and granted to a former Crown Ward)
- ☐ **Other (Specify:)** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

BG8: CURRENT PLACEMENT: Which of the following best describes ...'s current placement? **(Mark one only.)**

- ☐ Society operated foster home
- ☐ Kinship care
- ☐ Society operated group home
- ☐ Foster home - purchased outside care
- ☐ Group home - purchased outside care
- ☐ CMHC residential facility
- ☐ Regular hospital (short-term)
- ☐ Psychiatric facility
- ☐ Young offenders facility
- ☐ With birth parent(s)
- ☐ Adoption probation
- ☐ With relatives (not in foster care)
- ☐ Independent living
- ☐ Extended care & maintenance
- ☐ Other

☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Specify**

BG9: If ... is in a foster home (with or without relatives): What is the designation of this foster care placement?

☐ Provisional ☐ Regular ☐ Specialized ☐ Special treatment ☐ Other

☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Specify**

BG10: For how many years in total have the foster parents been providing foster care to the youth (i.e., including but not limited to ...)?

☐☐ **Years**

BG11: How long has ... been in his/her current placement?

☐☐ **Years** ☐☐ **Months**

BG12: What is the type of dwelling that best describes ...'s current placement? **(Mark one only.)**

- ☐ Single detached house
- ☐ Semi-detached or double (side-by-side)
- ☐ Mobile home
- ☐ Garden house, town house or row house
- ☐ Duplex (one above the other)
- ☐ Institution
- ☐ Low-rise apartment (less than 5 stories)
- ☐ High-rise apartment (5 or more stories)
- ☐ Other

BG13: What is the size of the area of residence in which this dwelling is situated?

- ☐ Urban, population 500,000 or over
- ☐ Urban, population 100,000 to 499,000
- ☐ Urban, population 30,000 to 99,999
- ☐ Urban, population < 30,000
- ☐ Rural area

BG14: How would you rate the general condition of most of the buildings on the block or within 100 yards of the foster parent's (or other adult caregiver's) house?

- ☐ Well kept, with good repair and exterior surface
- ☐ Fair condition
- ☐ Poor condition: with peeling paint and need of repair
- ☐ Badly deteriorated

BG15: Is this dwelling owned by a member of this household (even if it is being paid for)?

☐ Yes ☐ No

BG16: How many bedrooms are there in this dwelling?

☐☐ **Number of bedrooms**

BG17: Does ... have his/her own bedroom?

☐ Yes ☐ No

2. BACKGROUND INFORMATION ON THE YOUTH'S CAS PROTECTION WORKER

BG18: CAS protection worker's project ID number (assigned for record-keeping purposes only; please leave blank):

☐☐☐☐☐☐

BG19: CAS protection worker's gender:

☐ Male ☐ Female

BG20: CAS protection worker's current age category:

☐ 20-29 years ☐ 30-39 years ☐ 40-49 years ☐ 50-59 years ☐ 60 years or older

BG21: Total length of time CAS protection worker has worked with this youth, not counting interruptions:

☐☐ **Years** ☐☐ **Months**

BG22: Total length of time CAS protection worker has worked in child welfare:

☐☐ **Years** ☐☐ **Months**

BG23: Total length of time CAS protection worker has worked for this CAS:

☐☐ **Years** ☐☐ **Months**

BG24: Has the CAS protection worker ever used the old or new AAR with this youth before?

- ☐ No (If no, go to question BG31)
- ☐ Yes (If yes, the CAS protection worker is asked to answer questions BG25 to BG30, to indicate how often he/she has used the AAR in various ways with this youth during the past 12 months)

During the past 12 months, have you (the CAS protection worker) used the information contained in the AAR:

BG25: To produce or revise this youth's plan of care?

☐ Never ☐ Once ☐ Twice ☐ Three times ☐ More than three times

BG26: To work directly with this youth (e.g., on meeting his/her needs, solving problems, managing crises)?

☐ Never ☐ Once ☐ Twice ☐ Three times ☐ More than three times

BG27: To collaborate with this youth's foster parent(s) or other adult caregiver(s)?
☐ Never ☐ Once ☐ Twice ☐ Three times ☐ More than three times

BG28: To discuss this youth's needs or situation with your CAS supervisor?
☐ Never ☐ Once ☐ Twice ☐ Three times ☐ More than three times

BG29: To monitor this youth's progress?
☐ Never ☐ Once ☐ Twice ☐ Three times ☐ More than three times

BG30: To report on this youth's progress to a third party (e.g., a judge, lawyer, teacher, health professional)?
☐ Never ☐ Once ☐ Twice ☐ Three times ☐ More than three times

BG31: HIGHEST LEVEL OF EDUCATION: Highest degree, certificate, or diploma the CAS protection worker has ever attained in any field:
☐ No postsecondary degree, certificate or diploma
☐ Trades certificate - Vocational school - Apprenticeship training
☐ Non-university certificate or diploma from a community college, CEGEP, school of nursing, etc.
☐ University certificate or diploma below bachelor's level
☐ Bachelor's degree
☐ University certificate or diploma above bachelor's level
☐ Master's degree
☐ Doctoral degree

BG32: HIGHEST LEVEL OF EDUCATION IN SOCIAL WORK: Highest degree, certificate, or diploma the CAS protection worker has ever attained in the field of social work:
☐ Community college ☐ DSW or PhD in social work
☐ BSW ☐ None
☐ MSW

BG33: CURRENT EDUCATIONAL ENROLMENT: Is CAS protection worker currently enrolled in:
☐ Bachelor's program (other than BSW) ☐ PhD program (other than in social work)
☐ BSW program ☐ DSW or PhD program in social work
☐ Master's program (other than MSW) ☐ None
☐ MSW program

BG34: LANGUAGE: Language(s) in which the CAS protection worker can conduct a conversation (**mark all that apply**).
☐ English ☐ French ☐ First Nations language ☐ Other(s) ☐☐☐☐☐☐☐☐☐☐ Specify

BG35: ETHNICITY: To which ethnic or cultural group(s) did the CAS protection worker's ancestors belong? (For example: French, British, Chinese; **mark all that apply**.)

☐ Canadian
☐ French
☐ English
☐ North American Indian
☐ Inuit / Eskimo
☐ Métis
☐ German
☐ Irish
☐ Scottish
☐ Italian
☐ Jewish
☐ Ukranian
☐ Dutch (Netherlands)
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Polish
☐ Latin American
☐ Portugese
☐ Black (e.g., African, Haitian, Jamaican, Somali)
☐ South Asian (e.g., East Indian, Pakistani, Punjabi, Sri Lankan)
☐ South East Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese)
☐ Arab/West Asian (e.g., Armenian, Egyptian, Lebanese, Moroccan)
☐ Other ☐☐☐☐☐☐☐☐☐☐☐ Specify

3. BACKGROUND INFORMATION ON THE YOUTH'S FOSTER PARENT (OR OTHER ADULT CAREGIVER)

*Note to the CAS protection worker: Here, the terms **"foster parent"** or **"other adult caregiver"** refer to the foster parent or other adult caregiver who is considered the most knowledgeable about the youth, usually because he/she is the caregiver most actively involved in the youth's care. He/she is to participate in the AAR interview. (If two or more foster parent or other adult caregivers know the child equally well and are equally involved in his/her care, then they are asked to nominate one person as the foster parent or other adult caregiver who will take part in the AAR interview.)*

BG36: Foster parent's (or other adult caregiver's) project ID number **(assigned for record-keeping purposes only; please leave blank):**

BG37: Foster parent's (or other adult caregiver's) telephone number:

( ) -

BG38: Foster parent's (or other adult caregiver's) e-mail address (if he/she has one):

@

BG39: Is the current address of the foster parent (or other adult caregiver) the same as that of the youth's placement (on cover page)?

☐ Yes ☐ No **If no, please specify:**

Address: apartment number, unit number, street

Town - City - Province

Postal Code

BG40: How long has the foster parent (or other adult caregiver) lived at his/her current address?

Years **Months**

BG41: Language of AAR interview:

☐ English ☐ French ☐ Other **Specify**

BG42: HOUSEHOLD INCOME: What is the foster parent (or other adult caregiver)'s best estimate of the total income, before taxes and deductions, of all household members from all sources in the past 12 months?

- ☐ Less than $10,000
- ☐ $10,000-$14,999
- ☐ $15,000-$19,999
- ☐ $20,000-$29,999
- ☐ $30,000-$39,999
- ☐ $40,000-$49,999
- ☐ $50,000-$59,999
- ☐ $60,000-$79,999
- ☐ $80,000-$99,999
- ☐ Over $100,000

BG43: LANGUAGE: What language(s) are spoken most often in the foster parent's (or other adult caregiver's) home? **(Mark all that apply.)**

☐ English ☐ French ☐ First Nations language ☐ Other

Specify

BG44: ETHNICITY: To which ethnic or cultural group(s) did the foster parent's (or other adult caregiver's) ancestors belong? (For example: French, British, Chinese) **(Mark all that apply.)**

- ☐ Canadian
- ☐ French
- ☐ English
- ☐ North American Indian
- ☐ Inuit / Eskimo
- ☐ Métis
- ☐ German
- ☐ Irish
- ☐ Scottish
- ☐ Italian
- ☐ Jewish
- ☐ Ukranian
- ☐ Dutch (Netherlands)
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Polish
- ☐ Latin American
- ☐ Portugese
- ☐ Black (e.g., African, Haitian, Jamaican, Somali)
- ☐ South Asian (e.g., East Indian, Pakistani, Punjabi, Sri Lankan)
- ☐ South East Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese)
- ☐ Arab/West Asian (e.g., Armenian, Egyptian, Lebanese, Moroccan)
- ☐ Other

☐☐☐☐☐☐☐☐☐☐☐ **Specify**

BG45: RELIGION: What, if any, is the foster parent's (or other adult caregiver's) religion? **(Mark one only.)**

- ☐ No religion
- ☐ First Nations/aboriginal religion
- ☐ Roman Catholic
- ☐ United Church
- ☐ Anglican
- ☐ Presbyterian
- ☐ Lutheran
- ☐ Baptist
- ☐ Eastern Orthodox
- ☐ Jewish
- ☐ Islam (Muslim)
- ☐ Buddhist
- ☐ Hindu
- ☐ Sikh
- ☐ Jehovah's Witnesses
- ☐ Other

☐☐☐☐☐☐☐☐☐☐☐☐☐ **Specify**

BG46: Other than on special occasions (such as weddings or funerals), how often did the foster parent (or other adult caregiver) attend religious services or meetings in the past 12 months?

- ☐ At least once a week
- ☐ At least once a month
- ☐ At least 3 or 4 times a year
- ☐ At least once a year
- ☐ Not at all

BG47: HEALTH: In general, would the foster parent (or other adult caregiver) say that his/her own health is:

☐ Excellent? ☐ Very Good? ☐ Good? ☐ Fair? ☐ Poor?

BG48: DISABILITY: Because of a long-term physical or mental condition (lasting or expected to last 6 months or more) or a health problem, is the foster parent (or other adult caregiver) limited in the kind or amount of activity he/she can do at home, in caring for children, or in leisure activities?

☐ Yes ☐ No

BG49: SMOKING: At present, does anyone in the foster parent's (or other adult caregiver's) household smoke cigarettes inside his/her home?

☐ Daily ☐ Occasionally ☐ Not at all

BG50: PEOPLE WHO USUALLY LIVE IN THIS DWELLING (<u>besides</u> the youth in care): The CAS protection worker is to ask the foster parent (or other adult caregiver) for the information needed to complete the following table. Please include up to 5 adults (defined here as persons aged 18 or older), including the foster parent (or other adult caregiver) himself/herself, and up to 5 children/youths (defined here as persons aged 17 or younger), <u>besides</u> the youth in care. Do not include the youth in care or write in people's names. In filling in each of the boxes in the last 4 columns, please select the appropriate number from the categories listed beneath the table. Thus, for **HIGHEST LEVEL OF EDUCATION EVER ATTAINED**, for example, write in "01" for "Grade school", "02" for "Some high school", etc.)

People usually living in dwelling	Sex	Age	Highest level of education ever attained	Occupation	Relationship to foster parent (or other adult caregiver)	Relationship to youth in care
Foster parent or other adult caregiver 18+	☐ M ☐ F	Years			(Not Applicable)	
Adult 2 (18+)	☐ M ☐ F	Years				
Adult 3 (18+)	☐ M ☐ F	Years				
Adult 4 (18+)	☐ M ☐ F	Years				
Adult 5 (18+)	☐ M ☐ F	Years				
Child 1 (17-)	☐ M ☐ F	Years				
Child 2 (17-)	☐ M ☐ F	Years				
Child 3 (17-)	☐ M ☐ F	Years				
Child 4 (17-)	☐ M ☐ F	Years				
Child 5 (17-)	☐ M ☐ F	Years				

HIGHEST LEVEL OF EDUCATION EVER ATTAINED: **01** Grade school **02** Some high school **03** High school graduation **04** Some trade, technical or vocational schoool or business college **05** Some community colllege, CEGEP or nursing school **06** Some university **07** Diploma or certificate from trade, technical or vocational school or business college **08** Diploma or certificate from community college, CEGEP, nursing school or university **09** Bachelor or undergraduate degree or teacher's college (e.g., BA, BSc, Bed, BSW) **10** Master's (e.g., MA, Msc, Med, MSW) **11** Degree in medicine (MD), dentistry (DDS, DMD), Veterinary medicine (DVM), Optometry (OD), or law (LLB) **12** Earned doctorate (e.g., PhD, DSc, DEd, DSW) **13** Other

OCCUPATION: Main current activity: **01** Caring for family, including foster youth **02** Working for pay or profit **03** Caring for family, including foster youth, and working for pay or profit **04** Going to school **05** Recovering from illness or being on disability **06** Looking for work **07** Retired **08** Other

RELATIONSHIP TO FOSTER PARENT(or other adult caregiver):
For adults: **01** Husband or wife **02** Common-law partner **03** Same-sex partner **04** Mother or father **05** Sister or brother **06** Other related **07** Unrelated
For children: **08** Birth child **09** Step child **10** Adopted child **11** Other

RELATIONSHIP TO YOUTH IN CARE:
For adults: **01** Foster father or mother **02** Grandfather or grandmother **03** Uncle or aunt **04** Other related **05** Unrelated caregiver
For children: **06** Biological brother or sister **07** Step brother or sister **08** Adopted brother or sister **09** Foster brother or sister **10** Other

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BG51: Total number of adults (aged 18 or older) who usually live in this dwelling, including youth in care if he/she is 18 or older:

☐☐ **Total number**

BG52: Total number of these adults who are actively involved in caring for youth in care:

☐☐ **Total number**

BG53: Total number of children or youths (aged 17 or younger) who usually live in this dwelling, including youth in care if he/she is 17 or younger:

☐☐ **Total number**

BG54: Total number of other foster children or youths besides youth in care who usually live in this dwelling:

☐☐ **Total number**

BG55: Total number of siblings of youth in care who usually live in this dwelling with him/her:

☐☐ **Total number**

Note to the CAS protection worker and foster parent (or other adult caregiver): *We plan to contact you in the Fall of 2001, 2002, and 2003 for your opinions about the implementation of Looking After Children in your local Children's Aid Society. We will be asking about your experience of training in the Looking After Children approach, your use of the Assessment and Action Record, etc. Your participation will be voluntary, although we would greatly appreciate your cooperation. Thank you.*

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ASSESSMENT AND ACTION RECORD (AAR)

As was mentioned earlier, the AAR is designed to help in the assessment of children and youths' progress, monitor the quality of care they are receiving, and make plans for improvements across seven developmental dimensions: **health**, **education**, **identity**, **family and social relationships**, **social presentation**, **emotional and behavioural development**, and **self-care skills**.

Note to the CAS protection worker: *Please give copies of the AAR to both the youth and the foster parent (or other adult caregiver), so that they may follow along easily. This will help the interview go more smoothly and efficiently. Also, in answering each item, please put only an "X" (or, when required, **a number**) in the appropriate box or boxes, so that the computer will be able to scan and read the questionnaire properly. Please do not put a check mark or any mark other than an "X" in the boxes. Also, in the left-hand column of the right-hand page, please mark an "X" in the box for a given item if you judge that further action needs to be taken and included in the youth's individualized Plan of Care for the coming year.*

Q1: Who are taking part in this AAR interview? **(Mark as many as apply.)**

- ☐ Youth on whom AAR is being completed
- ☐ CAS protection worker of youth
- ☐ One foster parent
- ☐ Two foster parents
- ☐ One adult caregiver other than a foster parent
- ☐ Two adult caregivers other than a foster parent
- ☐ Other **(Specify:)** ☐☐☐☐☐☐☐☐☐☐☐☐

Q2: The AAR is intended to be completed in a face-to-face interview, unless for some reason this is impossible. How is this AAR interview being completed? **(Mark as many as apply.)**

- ☐ In a face-to-face interview conducted by the CAS protection worker
- ☐ In a telephone interview conducted by the CAS protection worker
- ☐ Through self-administration by the foster parent (or other adult caregiver)
- ☐ Other **(Specify:)** ☐☐☐☐☐☐☐☐☐☐☐☐

Q3: The language in which the AAR is written is:

☐ English ☐ French

Q4: The age-group of this AAR is the following:

- ☐ 15 years of age and over
- ☐ 10-14 years
- ☐ 5-9 years
- ☐ 3-4 years
- ☐ 1-2 years
- ☐ 0-12 months

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The right-hand pages are designed to allow the CAS protection worker to prepare a first draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible).

Q1

Q2

Q3

Q4

These prompts are meant to help the youth, his/her CAS protection worker, and his/her foster parent (or other adult caregiver) to answer the various questions posed during the AAR interview.

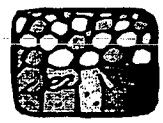
The Assessment and Action Record developmental dimensions:

Health

Education

Identity

Family and social relationships



Social presentation

Emotional and behavioural development

Self-care skills.

DEVELOPMENTAL DIMENSION 1: HEALTH

This dimension is about the health of the youth in care and the help he/she is getting to be and remain well. The questions in this section are designed to make sure that the youth 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 youth's health, such as diet, alcohol, drugs, and sex education.

Note to the CAS protection worker: Please mark an "X" in the box in the left-hand column of 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.

This next section is to be answered by the YOUTH IN CARE, with assistance, as needed, from the foster parent (or other adult caregiver) or the CAS protection worker.

H1: GENERAL HEALTH: In general, would you say your health is:

☐ Excellent? ☐ Very Good? ☐ Good? ☐ Fair? ☐ Poor?

H2: Over the past few months, how often have you been in good health?

☐ Almost all the time ☐ Often ☐ About half of the time ☐ Sometimes ☐ Almost never

H3: HEIGHT: What is your height in feet and inches or in metres and centimetres (without shoes on)?

☐ **Feet and** ☐☐ **Inches OR** ☐ **Metres and** ☐☐ **Centimetres**

H4: WEIGHT: What is your weight in pounds or kilograms?

☐☐☐ **Pounds OR** ☐☐☐ **Kilograms**

H5: PHYSICAL ACTIVITY LEVEL: In your opinion, how physically active are you compared to other youths of the same age and sex?

☐ Much more ☐ Moderately more ☐ Equally ☐ Moderately less ☐ Much less

H6: MEDICAL EXAM: When did you last have a medical exam?

☐ Less than a year ago ☐ More than a year ago ☐ Never had one

H7: Has everything the doctor may have recommended been done?

☐ Yes ☐ Uncertain ☐ No

H8: DENTAL EXAM: When did you last visit a dentist?

☐ Less than a year ago ☐ More than a year ago ☐ Never

H9: Have all treatments the dentist may have recommended been carried out?

☐ Yes ☐ Uncertain ☐ No

The next set of questions (also to be answered by the YOUTH IN CARE) asks about his/her day-to-day health. The questions are not about illnesses like colds that affect people for short periods of time. They are concerned with a person's usual abilities. You may feel that some of these questions do not apply to you, but it is important that we ask the same questions of everyone.

HUI-Q1: VISION: Are you usually able to see well enough to read ordinary newsprint without glasses or contact lenses?

☐ Yes **(Go to HUI-Q4)** ☐ No ☐ Don't know or refusal **(Go to question H10 on page 5)**

HUI-Q2: Are you usually able to see well enough to read ordinary newsprint with glasses or contact lenses?

☐ Yes **(Go to HUI-Q4)** ☐ No

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The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

H1 ☐

H2 ☐

H3 ☐

H4 ☐

H5 ☐

H6 ☐

H7 ☐

H8 ☐

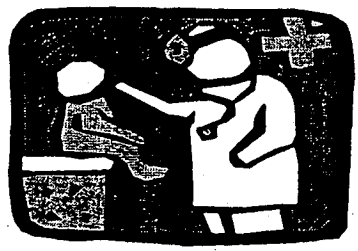
H9 ☐

HUI-Q1 ☐

HUI-Q2 ☐

DIMENSION 1: HEALTH

This dimension is about the health of the youth in care and the help he/she is getting to be and remain well.



Interest in child health has grown enormously in the last decade. Health policy makers nationally and internationally increasingly recognize the importance of children's health and development for the future.

In Looking After Children, health is identified as a key dimension of youth's lives and of parental care. Health is not seen as a stand-alone dimension, but rather as intertwined with and supporting all other dimensions of youth's upbringing and development.

For youth in care, special attention needs to be given to the key parental tasks of safeguarding and promoting their health.

A major objective of Looking After Children is to help with the task of keeping youth healthy when their care may be shared among a number of people.

HUI-Q3: Are you able to see at all?

☐ Yes ☐ No **(Go to HUI-Q6)** ☐ Don't know or refusal **(Go to HUI-Q6)**

HUI-Q4: Are you able to see well enough to recognize a friend on the other side of the street without glasses or contact lenses?

☐ Yes **(Go to HUI-Q6)** ☐ No ☐ Don't know or refusal **(Go to HUI-Q6)**

HUI-Q5: Are you usually able to see well enough to recognize a friend on the other side of the street with glasses or contact lenses?

☐ Yes ☐ No

HUI-Q6: HEARING: Are you usually able to hear what is said in a group conversation with at least 3 other people without a hearing aid?

☐ Yes **(Go to HUI-Q10)** ☐ No ☐ Don't know or refusal **(Go to HUI-Q10)**

HUI-Q7: Are you usually able to hear what is said in a group conversation with at least 3 other people with a hearing aid?

☐ Yes **(Go to HUI-Q8)** ☐ No

HUI-Q7A: Are you able to hear at all?

☐ Yes ☐ No **(Go to HUI-Q10)** ☐ Don't know or refusal **(Go to HUI-Q10)**

HUI-Q8: Are you usually able to hear what is said in a conversation with one other person in a quiet room without a hearing aid?

☐ Yes **(Go to HUI-Q10)** ☐ No ☐ Refusal **(Go to HUI-Q10)**

HUI-Q9: Are you usually able to hear what is said in a conversation with one other person in a quiet room with a hearing aid?

☐ Yes ☐ No

HUI-Q10: SPEECH: Are you usually able to be understood completely when speaking with strangers in your own language?

☐ Yes **(Go to HUI-Q14)** ☐ No ☐ Refusal **(Go to HUI-Q14)**

HUI-Q11: Are you able to be understood partially when speaking with strangers?

☐ Yes ☐ No

HUI-Q12: Are you able to be understood completely when speaking with those who know you well?

☐ Yes **(Go to HUI-Q14)** ☐ No ☐ Refusal **(Go to HUI-Q14)**

HUI-Q13: Are you able to be understood partially when speaking with those who know you well?

☐ Yes ☐ No

HUI-Q14: GETTING AROUND: Are you usually able to walk around the neighbourhood without difficulty and without mechanical support such as braces, a cane or crutches?

☐ Yes **(Go to HUI-Q21)** ☐ No ☐ Don't know or refusal **(Go to HUI-Q21)**

HUI-Q15: Are you able to walk at all?

☐ Yes ☐ No **(Go to HUI-Q18)** ☐ Don't know or refusal **(Go to HUI-Q18)**

HUI-Q16: Do you require mechanical support such as braces, a cane or crutches to be able to walk around the neighbourhood?

☐ Yes ☐ No

HUI-Q17: Do you require the help of another person to be able to walk?

☐ Yes ☐ No

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HUI-Q3 ☐
HUI-Q4 ☐
HUI-Q5 ☐
HUI-Q6 ☐
HUI-Q7 ☐
HUI-Q7A ☐
HUI-Q8 ☐
HUI-Q9 ☐
HUI-Q10 ☐
HUI-Q11 ☐
HUI-Q12 ☐
HUI-Q13 ☐
HUI-Q14 ☐
HUI-Q15 ☐
HUI-Q16 ☐
HUI-Q17 ☐

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The Health Utility Index (HUI3) is a generic measure of health-related quality of life. It was originally developed at McMaster University and is now used extensively in Canada and in 25 other countries around the world. With most children or adolescents, the HUI takes only about 2 to 4 minutes to complete.

The HUI3 provides a description of an individual's overall functional health, based on eight attributes: vision, hearing, speech, mobility (ability to get around), dexterity (use of hands and fingers), cognition (memory and thinking), emotion (feelings), and pain and discomfort.

If you have difficulty reading what is written on the blackboard at school or if you get headaches when you are watching television, it is a good idea to get your eyes tested, even if you have never needed glasses.

If you do wear glasses or contact lenses, your eyes should be tested by an eye specialist every 6 to 12 months.

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HUI-Q18: Do you require a wheelchair to get around?

☐ Yes ☐ No **(Go to HUI-Q21)** ☐ Don't know or refusal **(Go to HUI-Q21)**

HUI-Q19: How often do you use a wheelchair? **(Read list. Mark one only.)**

☐ Always ☐ Often ☐ Sometimes ☐ Never

HUI-Q20: Do you need the help of another person to get around in the wheelchair?

☐ Yes ☐ No

HUI-Q21: HANDS AND FINGERS: Are you usually able to grasp and handle small objects such as a pencil or scissors?

☐ Yes **(Go to HUI-Q25)** ☐ No ☐ Don't know or refusal **(Go to HUI-Q25)**

HUI-Q22: Do you require the help of another person because of limitations in the use of hands or fingers?

☐ Yes ☐ No **(Go to HUI-Q24)** ☐ Don't know or refusal **(Go to HUI-Q24)**

HUI-Q23: Do you require the help of another person with: **(Read list. Mark one only)**

☐ Some tasks? ☐ Most tasks? ☐ Almost all tasks? ☐ All tasks?

HUI-Q24: Do you require special equipment, for example, devices to assist in dressing, because of limitations in the use of hands or fingers?

☐ Yes ☐ No

HUI-Q25: FEELINGS: Would you describe yourself as being usually: **(Read list. Mark one only)**

☐ Happy and interested in life?
☐ Somewhat happy?
☐ Somewhat unhappy?
☐ Unhappy with little interest in life?
☐ So unhappy that life is not worthwhile?

HUI-Q26: MEMORY: How would you describe your usual ability to remember things? **(Read list. Mark one only.)**

☐ Able to remember most things?
☐ Somewhat forgetful?
☐ Very forgetful?
☐ Unable to remember anything at all?

HUI-Q27: THINKING: How would you describe your usual ability to think and solve day-to-day problems? **(Read list. Mark one only.)**

☐ Able to think clearly and solve problems
☐ Having a little difficulty
☐ Having some difficulty
☐ Having a great deal of difficulty
☐ Unable to think or solve problems

HUI-Q28: PAIN AND DISCOMFORT: Are you usually free of pain or discomfort?

☐ Yes **(Go to question H10, p. 5)** ☐ No ☐ Don't know or refusal **(Go to H10, p. 5)**

HUI-Q29: How would you describe the usual intensity of your pain or discomfort? **(Read list. Mark one only.)**

☐ Mild ☐ Moderate ☐ Severe

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HUI-Q18

HUI-Q19

HUI-Q20

HUI-Q21

HUI-Q22

HUI-Q23

HUI-Q24

HUI-Q25

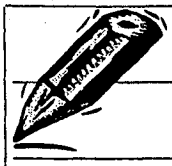
HUI-Q26

HUI-Q27

HUI-Q28

HUI-Q29

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).



The Looking After Children approach and the instrument that operationalizes it, the Assessment and Action Record, are designed to improve the quality and effectiveness of the substitute parenting provided under the supervision of local Children's Aid Societies to high-risk youth.

The intent of the Assessment and Action Record is to pinpoint youths' individual needs, enhance the timeliness of the services they receive, and optimize their developmental outcomes.

Corporate parenting is a term which recognizes the accountability of public agencies for carrying out responsibilities towards a youth in care.

Youth in care are a high risk group for many kinds of health threatening behaviours, such as smoking and drinking, sexually transmitted infections including HIV/AIDS, and, for girls, pregnancy at an early age. A methodical approach by corporate parents to ensure the provision of health education, such as the Looking After Children system provides, is critical.

HUI-Q30: How many activities does your pain or discomfort prevent? **(Read list. Mark one only.)**

☐ None ☐ A few ☐ Some ☐ Most

The next section is to be answered by the FOSTER PARENT (or other adult caregiver), with assistance, as needed, from the youth in care or the CAS protection worker.

H10: LONG-TERM CONDITIONS: In the following questions "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? **(Read the list and mark all that apply.)**

☐ Food or digestive allergies
☐ Respiratory allergies such as hay fever
☐ Any other allergies
☐ Asthma
☐ Bronchitis
☐ Heart condition or disease
☐ Epilepsy
☐ Cerebral palsy
☐ Kidney condition or disease
☐ Mental handicap
☐ Learning disability
☐ Attention deficit disorder
☐ Emotional, psychological or nervous difficulties
☐ Any other long-term condition
☐ None

H11: DISABILITY: Does ... have any long-term conditions or health problems which prevent or limit his/her participation in school, at play, or in any other activity for a child/youth of his/her age?

☐ Yes ☐ No

H12: SPECIAL HELP OR EQUIPMENT: Does ... have all the special help or equipment he/she may need for any long-term conditions or disabilities he/she may have?

☐ Yes ☐ No ☐ No special help or equipment needed

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.

H13: INJURIES: In the past 12 months, was ... injured?

☐ Yes ☐ No **(Go to question H19)**

H14: How many times was he/she injured? (Write in number of times.)

☐☐ **Times**

H15: For the most serious injury, what type of injury did he/she have? **(Do not read list. Mark one only.)**

☐ Broken or fractured bones
☐ Burn or scald
☐ Dislocation
☐ Sprain or strain
☐ Cut, scrape or bruise
☐ Multiple injuries
☐ Dental injury
☐ Concussion
☐ Poisoning by substance or liquid
☐ Internal injury
☐ Other

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HUI-Q30 ☐

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

H10 ☐

H11 ☐

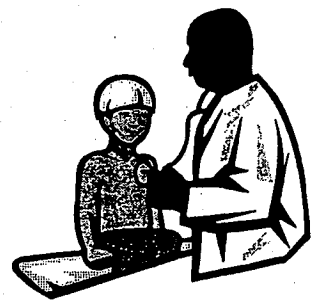
H12 ☐

H13 ☐

H14 ☐

H15 ☐

Your doctor will need to know about any problems or treatment you are having. Your CAS protection worker should check that illnesses, accidents, injuries, hospital stays, and operations have been noted on your Plan of Care.



"Injuries" refers to broken bones, bad cuts or burns, head injuries, poisoning, or a sprained ankle, that were serious enough to require medical attention by a doctor, nurse, or dentist.

One of the innovative features of Looking After Children is the close interaction between research and practice. The Assessment and Action Records, which form the core of the system, provides a means of assessing outcomes. In practice it provides data for use by policy makers.

H16: What part of ...'s body was injured? (**Do not read list. Mark one only.**)

- ☐ Eyes
- ☐ Face or scalp (excluding eyes)
- ☐ Head or neck (excluding eyes and face or scalp)
- ☐ Arms or hands
- ☐ Legs or feet
- ☐ Back or spine
- ☐ Trunk (excluding back or spine; include chest, internal organs, etc.)
- ☐ Shoulder
- ☐ Hip
- ☐ Multiple sites

H17: For the most serious injury, what happened? For example, was the injury the result of a fall, motor vehicle accident, a physical assault, etc.? (**Do not read list. Mark one only.**)

- ☐ Motor vehicle collision - passenger
- ☐ Motor vehicle collision - pedestrian
- ☐ Motor vehicle collision - riding bicycle
- ☐ Other bicycle accident
- ☐ Fall (excluding bicycle or sports)
- ☐ Sports (excluding bicycle)
- ☐ Physical assault
- ☐ Scalded by hot liquids or food
- ☐ Accidental poisoning
- ☐ Self-inflicted poisoning
- ☐ Other intentionally self-inflicted injuries
- ☐ Natural/environmental factors (eg., animal bite, sting)
- ☐ Fire/flames or resulting fumes
- ☐ Near drowning
- ☐ Other

H18: Where did the injury happen (for example, at home, on the street, in a playground, at school, etc.)? (**Do not read list. Mark one only.**)

- ☐ Inside biological parent's own home/apartment
- ☐ Inside foster parent's (or other adult caregiver's) own home/apartment
- ☐ Outside biological parent's home, apartment, including yard, driveway, parking lot or in shared areas related to home such as apartment hallway or laundry room
- ☐ Outside foster parent's (or other adult caregiver's) home, apartment, including yard, driveway, parking lot or in shared areas related to home such as apartment hallway or laundry room
- ☐ In or around other private residence
- ☐ Inside school/daycare centre or on school/centre grounds
- ☐ At an indoor or outdoor sports facility (other than school)
- ☐ Other building used by general public
- ☐ On sidewalk/street/highway in foster parent's (or other adult caregiver's) neighbourhood
- ☐ On any other sidewalk/street/highway
- ☐ In a playground/park (other than school)
- ☐ Other

H16

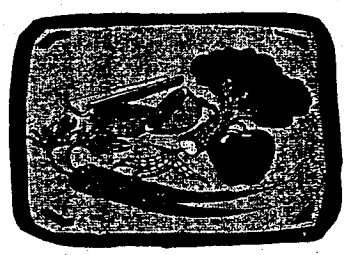
The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

H17

H18

Child welfare agencies should arrange regular medical examinations for all young people in their care. The purpose of the examination is to pick up health problems that can be treated and often cured while the youth is in care.

It is important that youth in care have a diet that relates to their ethnic background and culture so that they continue to be familiar with the customs and daily practices of their birth family.



H19: HOSPITALIZATIONS: In the past 12 months, was ... ever an overnight patient in the hospital?

☐ Yes ☐ No **(Go to question H21)**

H20: For what reason?

☐ Respiratory illness or disease ☐ Gastrointestinal illness or disease ☐ Injuries ☐ Other

H21: IMMUNIZATIONS: Are all of ...'s immunizations up to date?

☐ Yes ☐ No

H22: DIET: Does ... have a special diet for health, weight-control, religious, or cultural reasons?

☐ Yes ☐ No

H23: DIETARY ASSISTANCE: Is ... receiving all the help he/she requires to maintain a healthy daily diet, whether special or not?

☐ Yes ☐ No

▶ The next section is to be answered by the **YOUTH IN CARE**, with assistance, as needed, from the foster parent (or other adult caregiver) or the CAS protection worker.

(Read aloud): Your answers to the following questions will help build a picture of your general health.

H24: Which of the following are you trying to do?

☐ Lose weight
☐ Gain weight
☐ Stay the same weight
☐ I'm not trying to do anything about my weight

H25: During the past 7 days, did you do any of the following things to lose weight or stay the same weight?

a. Dieted (ate less or differently)?	☐ Yes	☐ No
b. Exercised (to burn carlories or fat)?	☐ Yes	☐ No
c. Took diet pills (e.g., Dexatrim)?	☐ Yes	☐ No
d. Smoked?	☐ Yes	☐ No
e. Other?	☐ Yes	☐ No

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Specify**

H26: During the past 7 days, did you do any of the following things in order to gain weight or muscle?

a. Ate more food or took food supplements?	☐ Yes	☐ No
b. Lifted weights or exercised to build muscles?	☐ Yes	☐ No
c. Used steroids?	☐ Yes	☐ No
d. Other?	☐ Yes	☐ No

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Specify**

H27: BREAKFAST: During school weeks, how many days a week do you normally eat breakfast?

☐ Never ☐ 1 or 2 days a week ☐ 3 to 4 days a week ☐ Every school day

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H19

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

H20

H21

H22

H23

H24

H25

H26

H27

There is provincial variation in the timing of the various immunizations required. If you have any questions about requirements in your province, please contact your public health office.

Your CAS protection worker should check that all immunizations have been noted on your Plan of Care. If there is no record of what you have had, it may be necessary for your doctor to check through your health records so that the information can be recorded by your child welfare agency.

This is important because if you change doctors, it can take a while for health records to catch up and the information may be urgently needed.

Youth rights: You can use this as an opportunity to talk about any health problems which may have been worrying you and which you may not have had a chance to discuss before. You can choose whether you want to see a male or female doctor.

H28: CIGARETTES: How often do you smoke cigarettes, if at all?

- ☐ I have never smoked
- ☐ I only tried once or twice
- ☐ I do not smoke now
- ☐ A few times a year
- ☐ About once or twice a month
- ☐ About once or twice a week
- ☐ About 3-5 times a week
- ☐ Every day

H29: How many of your close friends smoke cigarettes?

☐ None ☐ A few ☐ Most ☐ All

H30: Are you getting all the help you need to quit smoking?

☐ Does not smoke - no help required ☐ Yes ☐ No

H31: ALCOHOL: If you drink alcohol, how often do you do so?

- ☐ I have never had a drink of alcohol
- ☐ I only tried once or twice
- ☐ I do not drink alcohol anymore
- ☐ A few times a year
- ☐ About once or twice a month
- ☐ About once or twice a week
- ☐ About 3-5 times a week
- ☐ Every day

H32: How many of your close friends drink alcohol?

☐ None ☐ A few ☐ Most ☐ All

H33: Are you getting all the help you need to quit drinking alcohol?

☐ Does not drink alcohol - no help required ☐ Yes ☐ No

DRUGS: Which of the following best describes your experience with these drugs during the past 12 months:

H34: Marijuana and cannabis products (also known as a joint, pot, grass or hash)?

- ☐ I have never done it
- ☐ Not during the past 12 months
- ☐ A few times
- ☐ About once or twice a month
- ☐ About 1-2 days a week
- ☐ About 3-5 days a week
- ☐ About 6-7 days a week

H35: Glues or solvents?

- ☐ I have never done it
- ☐ Not during the past 12 months
- ☐ A few times
- ☐ About once or twice a month
- ☐ About 1-2 days a week
- ☐ About 3-5 days a week
- ☐ About 6-7 days a week

H36: Other drugs like crack, cocaine, heroin, speed or ecstasy, etc.?

- ☐ I have never done it
- ☐ Not during the past 12 months
- ☐ A few times
- ☐ About once or twice a month
- ☐ About 1-2 days a week
- ☐ About 3-5 days a week
- ☐ About 6-7 days a week

H37: How many of your close friends have tried drugs or sniffed glue or solvents?

☐ None ☐ A few ☐ Most ☐ All

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H28 ☐

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

H29 ☐

H30 ☐

H31 ☐

H32 ☐

H33 ☐

H34 ☐

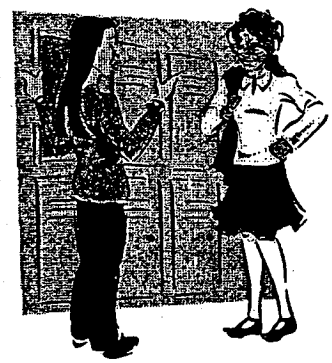
H35 ☐

H36 ☐

H37 ☐

Accurate factual knowledge about puberty, sex and contraception, as well as discussions about the part sex plays in relationships, are important to all young people who are developing into adulthood.

Young people who are in care or disabled are no exception to this but may miss out on some of the discussion in formal school lessons, or with their peers. This is especially true if they move schools frequently.



The contraceptive pill, if used properly, can prevent you from becoming pregnant, but it does not protect you from catching sexually transmitted diseases such as chlamydia, herpes, HIV, syphilis or gonorrhoea.

If you are pregnant, or you think you might be pregnant, it is important that you receive appropriate pre-natal care to ensure the future health of yourself and your baby.

H38: Are you getting all the help you need to quit using drugs or sniffing glue or solvents?

☐ Does not use drugs or solvents - no help required ☐ Yes ☐ No

H39: PUBERTY: Do you have any concerns related to body changes (e.g., acne, menstruation, voice, hair growth)?

☐ Yes ☐ No

H40: Are you getting all the help you need with concerns you may have related to body changes?

☐ No such concerns - no assistance required ☐ Yes ☐ No

H41: SEXUALITY: Do you have any concerns with issues related to sexuality, such as sexual relations, contraception, pregnancy, HIV and other sexually transmitted diseases, or sexual orientation? **(Note what these are on the right-hand page, opposite.)**

☐ Yes ☐ Not sure ☐ No

H42: PREGNANCY: Have you been pregnant or made someone pregnant?

☐ Yes ☐ Not sure ☐ No

H43: Are you receiving all the help you need with concerns related to sexuality, such as those just mentioned?

☐ No obvious concerns - no assistance required ☐ Yes ☐ No

▶ The following section is to be completed by the **CAS PROTECTION WORKER** based on the information obtained on this entire developmental dimension of health.

ATTAINMENT OF HEALTH OBJECTIVES OF THE CHILD WELFARE SYSTEM

H44: Objective 1: The youth is normally well.
(Note: "unwell" here means ill enough to be in bed or take some time off school)

☐ Normally well (i.e., unwell for 1 week or less in the last 6 months)
☐ Sometimes ill (i.e., unwell between 8 and 14 days in the last 6 months)
☐ Often ill (i.e., unwell between 15 and 28 days in the last 6 months)
☐ Frequently ill (i.e., unwell for more than 28 days in the last 6 months)

H45: Objective 2: The youth's weight is within normal limits for his/her height:

☐ Within normal limits ☐ Seriously underweight ☐ Seriously overweight

H46: Objective 3: All necessary preventive health measures, including immunizations, are being taken **(also see table on the following pages for services received by youth during the last year):**

☐ All ☐ Most ☐ A few ☐ None

H47: Objective 4: All ongoing health conditions and disabilities are being dealt with **(also see table on following pages for services received by youth during the last year):**

☐ No health condition or disability
☐ All being adequately dealt with
☐ Some being adequately dealt with
☐ None being adequately dealt with

H48: Objective 5: The youth does not put his/her health at risk:

☐ No risks taken ☐ Some risks taken ☐ Considerable risks taken ☐ Health placed seriously at

Note to the CAS protection worker :
If anyone disagrees with these answers to the Health objectives, please note the details on the opposite page.

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H38

H39

H40

H41

H42

H43

H44

H45

H46

H47

H48

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

The youth puts him/herself at risk by abusing nicotine, alcohol, drugs, or other substances.

Young people should be encouraged to give up smoking. Staff should not supply young people with cigarettes. If you or your foster parent(s) want more information, there are two small booklets, "Do you Know" and "Take Action," both of which you can get for free by telephoning the Addiction Research Foundation Drug and Alcohol Hotline at 1-800-463-6273. The call is also free.

DIRECT AND RESIDENTIAL SERVICES RECEIVED BY THE CHILD/YOUTH IN CARE DURING THE LAST 12 MONTHS

This section is to be completed by the FOSTER PARENT (or other adult caregiver), with assistance, as needed, from the CAS protection worker and the child/youth in care.

The purpose of this section is to identify the kind and amount of DIRECT and RESIDENTIAL SERVICES received by the youth during the last 12 months.

By DIRECT SERVICES, we mean those received by the youth from a service provider in a face-to-face encounter or by telephone. By RESIDENTIAL SERVICES, we mean the setting(s) in which he/she lived.

It is important to know the kind and amount of services received in order to be able to judge whether the youth's service needs have recently been met and to decide the kind and amount of services that should be specified in the revised Plan of Care, to guide interventions during the coming 12 months. The kind and amount of services received are also likely to be related to the youth's developmental progress, both last year and in the coming year.

For each of the direct service providers (or services) listed in the following table, please indicate (as in the example presented in the first row of the table):

> **WHETHER THE YOUTH HAS RECEIVED SERVICES** from such a provider during the last year;

> **The CATEGORY** of the service provider, that is, was the provider:

(1) a CAS agency staff member?
(2) a staff member of a publicly-funded agency other than the CAS (e.g., a school)?
(3) a private service provider, reimbursed by the provincial health plan (e.g., a family physician, reimbursed by OHIP, in Ontario)?
(4) a private service provider reimbursed by the CAS?
(5) another type of provider (e.g., an unpaid volunteer, such as a basketball coach)?

> **The FREQUENCY** with which the service was received; and,

> **The AVERAGE DURATION** of a single service session or "episode".

	Did youth receive service from such a provider during the last 12 Months?	(If yes): Mark category of provider (from list, above):	Frequency (i.e., number of times, days, or weeks the service was received during the last 12 months?	Average duration of a single session, unit, or episode.
DIRECT SERVICES:	**Services received by the youth from a service provider in a face-to-face encounter or by telephone. You may wish to indicate the name of the usual family physician, pediatrician, etc ,...**			
Example: Dentist	Yes [X] No [ ]	[ ] [ ] [ ] [X] [ ] (1 2 3 4 5)	0 2 times/last yr	0 4 5 Minutes
1. Family physician	Yes [ ] No [ ]	[ ] [ ] [ ] [ ] [ ] (1 2 3 4 5)	[ ] [ ] times/last yr	[ ] [ ] [ ] Minutes
2. Pediatrician	Yes [ ] No [ ]	[ ] [ ] [ ] [ ] [ ] (1 2 3 4 5)	[ ] [ ] times/last yr	[ ] [ ] [ ] Minutes

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Child welfare agencies should arrange regular medical examinations for all young people in their care. The purpose of the examination is to pick up health problems that can be treated and often cured while the youth is in care.

It is important to know the kind and amount of services received in order to be able to judge whether the youth's service needs have recently been met and to decide the kind and amount of services that should be specified in the revised Plan of Care, to guide interventions during the coming 12 months. The kind and amount of services received are also likely to be related to the youth's developmental progress, both last year and in the coming year.

	Did youth receive service from such a provider during the last 12 Months?	(If yes): Mark category of provider (from list, above):	Frequency (i.e., number of times, days, or weeks the service was received during the last 12 months)	Average duration of a single session, unit, or episode.

DIRECT SERVICES: Services received by the youth from a service provider in a face-to-face encounter or by telephone. You may wish to indicate the name of the usual family physician, pediatrician, etc.

3. Ophthalmologist	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
4. Psychiatrist	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
5. Other MD	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
6. Nurse	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
7. Dentist	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
8. Orthodontist	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
9. Optometrist	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
10. Audiologist	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
11. Speech therapist	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
12. Psychologist/ psychological associate	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
13. Physiotherapist	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
14. Occupational therapist	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
15. Lawyer	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes

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Children from families from low socio-economic status are twice as likely to die before the age of 15, as children from professional classes. They also tend to suffer higher incidence of child abuse, infectious disease, impaired growth, dental disease, respiratory conditions, accidents, substance abuse, mental illness, and behavioural and emotional disorders.

The effects of poor socio-economic, physical, and cultural environments tend to accumulate among children in families with low incomes, and persist into adult life.

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DIRECT SERVICES	Did youth receive service from such a provider during the last 12 months?	(IF YES): Mark category of provider (from list, above): (1)(2)(3)(4)(5)	Frequency (i.e., number of times, days, or weeks the service was received during the last 12 months):	Average duration of a single session, unit, or episode.
16. CAS protection worker	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
17. Non-CAS social worker	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
18. Early childhood worker/educator	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
19. Volunteer driver	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
20. Police officer	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
21. Employment specialist	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
22. Teacher (regular class)	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐☐ days/last yr	1 Day
23. Teacher (special ed.)	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐☐ days/last yr	1 Day
24. Teacher's aide	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐☐ days/last yr	1 Day
25. Educational tutor	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
26. Respite worker	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐☐ days/last yr	1 Day
27. Summer camp staff	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐☐ days/last yr	1 Day
28. Paid recreation/ sports instructor or coach	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
29. Volunteer (unpaid) recreation/sports instructor or coach	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
30. Other	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Specify				

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

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The importance of health education and especially, sex education, for children in care, has not been a priority in the past. Sex education is now compulsory in secondary schools. Research has shown that it can be effective in discouraging premature sexual activity and pregnancy.

The Looking After Children research team found that children in care often missed the relevant lessons because of frequent absences. This was one area where the use of the Assessment and Action Record has had a marked impact in raising awareness, improving the quality of information given to young people, and providing a forum for discussion about the issues associated with sexuality.

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	Did youth receive service from such a provider during the last 12 months?	(IF YES): Mark category of provider (from list, above): (1)(2)(3)(4)(5)	Frequency (i.e., number of times, days, or weeks the service was received during the last 12 months).	Average duration of a single session, unit, or episode.
RESIDENTIAL SERVICES: Services provided in the setting(s) in which the child/youth lived.				
31. Foster care	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐☐ days/last yr	**1 Day**
32. Group home	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐☐ days/last yr	**1 Day**
33. Residential treatment	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐☐ days/last yr	**1 Day**
34. In-patient hospitalization	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐☐ days/last yr	**1 Day**
35. Other	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐☐ days/last yr	**1 Day**

☐☐☐☐☐☐☐☐☐☐☐☐ **Specify**

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

31 ☐

32 ☐

33 ☐

34 ☐

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DEVELOPMENTAL DIMENSION 2: EDUCATION

This dimension is about the youth's experiences at school. The questions in this section are designed to find out if the youth 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 youth has opportunities to learn special skills and to take part in a wide range of activities, both in and out of school.

The next section is to be answered by the **FOSTER PARENT** (or other adult caregiver), with assistance, as needed, from the youth in care or the CAS protection worker.

E1: TYPE OF SCHOOL: What type of school is ... (i.e., the youth in care) currently in?

- ☐ Public high school
- ☐ Catholic high school, publicly funded
- ☐ Private high school
- ☐ Technical, trade or vocational school (above high school level)
- ☐ Community college or apprenticeship program
- ☐ Private business school or training institute (above high school level)
- ☐ University
- ☐ Other (above high school level) ☐☐☐☐☐☐☐☐☐☐☐☐ **Specify**
- ☐ Not in high school or post-secondary institution
- ☐ Taught in an institution (eg., hospital, young offender facility, child welfare facility)
- ☐ Not in school, youth is in an institution
- ☐ Taught at home (home schooling)

E2: GRADE: What grade is ... in?

- ☐ Grade 7
- ☐ Grade 8
- ☐ Grade 9
- ☐ Grade 10
- ☐ Grade 11
- ☐ Grade 12
- ☐ Grade 13
- ☐ Technical, trade or vocational school (above the high school level)
- ☐ Community college or apprenticeship program
- ☐ Private business school or training institute (above high school level)
- ☐ University
- ☐ Other (above high school level)

E3: Has ... ever repeated a grade at school (including kindergarten)?

☐ Yes ☐ No

E4: In what language is ... mainly taught?

☐ English ☐ French ☐ Both ☐ Other

E5: LEARNING-RELATED DIFFICULTIES: Has ... been assessed for possible learning-related problems (e.g., attention-deficit and hyperactivity disorder [ADHD]; learning disability; unsatisfactory progress?)

☐ He/she is currently on a waiting list for an assessment ☐ Yes ☐ No

E6: Does ... receive special/resource help at school because of a physical, emotional, behavioural, or some other problem that limits the kind or amount of school work he/she can do?

☐ Yes ☐ No

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

E1 ☐

E2 ☐

E3 ☐

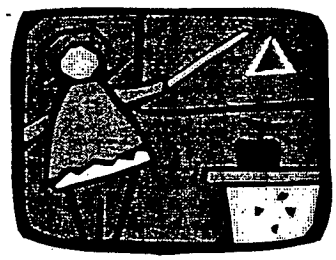
E4 ☐

E5 ☐

E6 ☐

DIMENSION 2: EDUCATION

This dimension is about the youth's experience at school.



A young person has a learning difficulty if he/she finds it much harder to learn than most people of the same age or if he/she has a disability which makes it difficult to use the normal educational facilities in the area.

For example, someone may have learning difficulties caused by conditions such as Down's syndrome, a problem with sight, hearing or speech, a learning disability, emotional or behavioural problems, a medical or health problem, difficulties with reading, writing, speaking or mathematics. Information on an individual education plan should be noted on your Plan of Care. A review should be undertaken regularly. Your CAS protection worker should make sure that information about an individual education plan, transition plans and statements of special educational needs has been noted on your Plan of Care or file. Details about specialized learning materials should also be recorded.

E7: Does ... receive any help or tutoring outside of school?

☐ Yes ☐ No

E7A: How often?

☐ Once a week or less ☐ Twice a week ☐ More than twice a week

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?

☐ Yes ☐ No

▶ 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, if this interview takes place during the summer or at the beginning of the new school year, how did he/she do during the last school year)?

E9A: Reading and other language arts (spelling, grammar, composition)?

☐ Very well ☐ Well ☐ Average ☐ Poorly ☐ Very Poorly ☐ Did not take it

E10: Mathematics?

☐ Very well ☐ Well ☐ Average ☐ Poorly ☐ Very Poorly ☐ Did not take it

E11A: Science

☐ Very well ☐ Well ☐ Average ☐ Poorly ☐ Very Poorly

E12: How is he/she doing overall?

☐ Very well ☐ Well ☐ Average ☐ Poorly ☐ Very Poorly

E13: HOMEWORK, OTHER SCHOOL ASSIGNMENTS AND EXAMS: Does ... have a satisfactory place to do his/her homework?

☐ Yes ☐ No

E14: On days when ... is assigned homework, how much time does he/she usually spend doing homework?

☐ 0-15 minutes
☐ 16-30 minutes
☐ 31 minutes to less than one hour
☐ 1.0 to less than 1.5 hours
☐ 1.5 to less than 2.0 hours
☐ 2.0 to less than 3.0 hours
☐ 3.0 to less than 4.0 hours
☐ 4.0 hours or more

E15: How often do you check his/her homework or provide help with his/her homework (or other school assignments)?

☐ Never or rarely
☐ Less than once a month
☐ Once a month
☐ A few times a month
☐ Once a week
☐ A few times a week
☐ Daily

E16: How well does ... prepare for tests or exams?

☐ Very Well ☐ Well ☐ Average ☐ Poorly ☐ Very Poorly

E17: READING: How often does ... read for pleasure?

☐ Most days
☐ A few times a week
☐ About once a week
☐ About once a month
☐ Almost never

E18: OTHER EDUCATION-RELATED MATTERS: How important is it to you that ... have good grades in school?

☐ Very important ☐ Important ☐ Somewhat important ☐ Not important at all

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E7

E7A

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E9A

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E11A

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E18

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

Please give details of all the courses you are taking, including your individual education plan.

A satisfactory place for studying has enough space and light and a suitable chair and table. It should not be too noisy, so that you can concentrate, and should prevent your being interrupted by other people.

It is important that an adult take an interest in your homework, making sure that you have enough things like pens, paper and pencils, and giving you help when you need it.

Foster homes and residential units should have reference books such as dictionaries, atlases, and encyclopedias. If they don't, you may need to ask your CAS protection worker about this.

E19: How far do you hope ... will go in school?

- ☐ Primary/elementary school
- ☐ Secondary or high school
- ☐ Community college, CEGEP, or nursing school
- ☐ Trade, technical, vocational school, or business college
- ☐ University
- ☐ Other

E20: Approximately how many books of his/her own does ... possess?

☐ None ☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-50 ☐ More than

E21: Approximately how many of your books does ... have access to?

- ☐ None
- ☐ 1-5
- ☐ 6-10
- ☐ 11-15
- ☐ 16-20
- ☐ 21-30
- ☐ 31-50
- ☐ 51-100
- ☐ More than 100

E22: Does ... have access to a computer at home? **(If no, go to question E25)**

☐ Yes ☐ No

E23: Does ... have access to a large area network (e.g., Internet) at home?

☐ Yes ☐ No

E24: Outside of school hours, how often does ... spend time on a computer?

☐ Most days ☐ A few times a week ☐ About once a week ☐ About once a month ☐ Almost never

E25: How often do you and ... talk about school work or behaviour in class?

- ☐ Daily
- ☐ A few times a week
- ☐ Once a week
- ☐ A few times a month
- ☐ Once a month
- ☐ Less than once a month
- ☐ Rarely

E26: How often do you and ... talk about his/her school friends or activities?

- ☐ Daily
- ☐ A few times a week
- ☐ Once a week
- ☐ A few times a month
- ☐ Once a month
- ☐ Less than once a month
- ☐ Rarely

E27: How often do you and ... talk about his or her plans for the future?

- ☐ Daily
- ☐ A few times a week
- ☐ Once a week
- ☐ A few times a month
- ☐ Once a month
- ☐ Less than once a month
- ☐ Rarely

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E19

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

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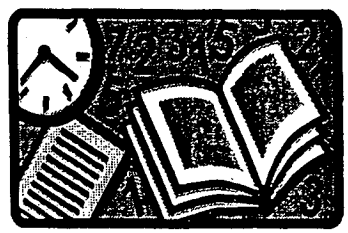
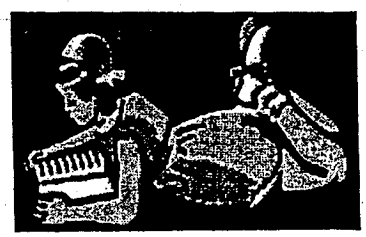
Despite the current emphasis on information technology, literacy is still the first requirement of employers. But it is also a crucial tool for independent learning and an important leisure skill.

Reading is inexpensive and does not require the co-operation of others or interfere with their activities. It can be pursued anywhere and offers recreation, instruction and vicarious experience.



We know that the conditions necessary for children to learn to read successfully are a ready supply of suitable reading material and the close attention of an adult.



E28: During the current or last school year, have you done any of the following? **(Read list and mark all that apply.)**

- ☐ Spoken to, visited, or corresponded with youth's teacher
- ☐ Visited youth's class
- ☐ Attended a school event in which youth participated, for example, a play, sports competition, or science fair
- ☐ Volunteered in youth's class or helped with a class trip
- ☐ Helped elsewhere in the school, such as in the library or computer room
- ☐ Fund-raising
- ☐ Attended a parent-school association, home and school liaison committee
- ☐ Other activities
- ☐ No activities

E29: CHANGES IN SCHOOLS: Other than the progression through the school system, how many times (if any) has ... changed schools? **(Write in the total no. of times.)**

☐☐ times (00 = none; 01 = once; 02 = twice; etc.)

E30: ABSENCES FROM SCHOOL: How many days, if any, was ... absent from school during the last 12 months?

- ☐ 0 days
- ☐ 1-3 days
- ☐ 4-6 days
- ☐ 7-10 days
- ☐ 11-20 days
- ☐ More than 20 days
- ☐ Not in school during the last 12 months

E31: What was the main reason for... being absent from school?

- ☐ Health reasons
- ☐ Problems with transportation
- ☐ Problems with weather
- ☐ Family vacation
- ☐ Fear of school
- ☐ Problem with the teacher
- ☐ Problem with youths at school
- ☐ Difficulty with childcare arrangements
- ☐ Other

E32: SUSPENSIONS FROM SCHOOL: During the current or last school year, how many times, if any, has ... been temporarily suspended from school?

☐ Never ☐ Once or twice ☐ 3 or 4 times ☐ 5 times or more ☐☐☐ write in total no. of days

E33: During the last 12 months, how many times, if any, has ... been permanently suspended from school?

☐ Never ☐ Once or twice ☐ 3 or 4 times ☐ 5 times or more ☐☐☐ write in total no. of days

E34: CHANGES IN PLACE OF RESIDENCE: Aside from school changes, 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.)**

☐☐ times (00 = none; 01 = once; 02 = twice; etc.)

The following questions are to be answered by the **YOUTH IN CARE.**

In the following questions, "school" includes high school and post-secondary education.

E35: SCHOOL: How do you feel about school?

- ☐ I like school very much
- ☐ I like school quite a bit
- ☐ I like school a bit
- ☐ I don't like school very much
- ☐ I hate school

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E28

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

E29

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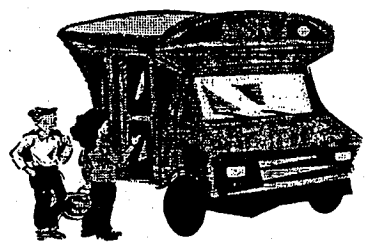
Unplanned changes are other than those that everyone experiences (e.g., from elementary to high school). Your CAS protection worker should check that all school changes have been noted in your file.

A change of placement may mean that you have moved away from your school. It is important to try not to change schools in the middle of a term, so your CAS protection worker may be able to arrange transportation to help you stay at the same school.



If you have changed schools in the middle of a term, it may be useful to ask your teacher where you might get some extra help.

School performance is the simplest indicator of cognitive functioning for school-aged children. It can be measured as the age to grade ratio, achievement on standardized tests (e.g., Math or English), placement in special education classes, or assessed risk of failure.

E36: How do you like Math?
☐ I hate it ☐ I don't like it very much ☐ I like it a little ☐ I like it a lot ☐ I don't take it

E37: How do you like Science?
☐ I hate it ☐ I don't like it very much ☐ I like it a little ☐ I like it a lot ☐ I don't take it

E38: How do you like English?
☐ I hate it ☐ I don't like it very much ☐ I like it a little ☐ I like it a lot ☐ I don't take it

E39: How do you like French?
☐ I hate it ☐ I don't like it very much ☐ I like it a little ☐ I like it a lot ☐ I don't take it

E40: How important is it to you to get good grades?
☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not important at all

E41: How important is it to you to participate in extra-curricular activities?
☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not important at all

E41A: How important is it to hand assignments in on time?
☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not important at all

E42: How important is it to you to always to show up to class on time?
☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not important at all

E43: How important is it to you to learn new things?
☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not important at all

E44: How important is it to you to express your opinion in class?
☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not important at all

E45A: How important is it to you to make friends?
☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not important at all

E45B: How important is it to you to take part in student council or other similar groups?
☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not important at all

E45C: In the last three months, how often have you taken part in a school club or group such as student council, yearbook club or photography club?
☐ Never ☐ Less than once a week ☐ 1 to 3 times a week ☐ 4 or more times a week

ACTIVITIES OUTSIDE OF SCHOOL HOURS: In the last 12 months, how often have you:

E46: Played sports or done physical activities without a coach or an instructor (e.g. biking, skate boarding, softball during recess, etc.)?
☐ Never ☐ Less than once a week ☐ 1 to 3 times a week ☐ 4 or more times a week

E47: Played sports with a coach or instructor, other than for gym class (e.g., swimming lessons, baseball, hockey, school teams, etc.)?
☐ Never ☐ Less than once a week ☐ 1 to 3 times a week ☐ 4 or more times a week

E48: Taken part in dance, gymnastics, karate or other groups or lessons, other than in gym class?
☐ Never ☐ Less than once a week ☐ 1 to 3 times a week ☐ 4 or more times a week

E49: Taken part in art, drama or music groups, clubs or lessons, outside of class?
☐ Never ☐ Less than once a week ☐ 1 to 3 times a week ☐ 4 or more times a week

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E41A

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E45A

E45B

E45C

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The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

There is evidence of serious discrimination against children in care in schools. Many complain of unfair treatment by teachers. At the extreme is the readiness of schools to exclude youth in care for relatively trivial offences, which has resulted in some being denied their right to education for long periods.

Exclusion disrupts not only their learning but also their social relationships and other activities and puts them at higher risk of offending and drug and alcohol misuse.

School success enhances self-esteem and can offer a channel of escape from disadvantage. This is particularly important for girls, who otherwise may take the route of early motherhood, which locks them into poverty and can block off further opportunities.

School is also the place where youth acquire social and leisure skills, making and keeping friends, negotiating agreements and relating to a variety of adults.

E50: Taken part in clubs or groups such as Guides or Scouts, 4-H club, community, church or other religious groups?

☐ Never ☐ Less than once a week ☐ 1 to 3 times a week ☐ 4 or more times a week

E51: Done a hobby or craft (drawing, model building, etc.)?

☐ Never ☐ Less than once a week ☐ 1 to 3 times a week ☐ 4 or more times a week

E52: TEACHERS OR PROFESSORS: In general, do your teachers or professors treat you fairly?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ Rarely ☐ Never

E53: If you need extra help, do your teachers or professors give it to you?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ Rarely ☐ Never

E54: HOMEWORK AND OTHER SCHOOL ASSIGNMENTS: When your teachers or professors give you homework (including course assignments), do you do it?

☐ All the time
☐ Most of the time
☐ Some of the time
☐ Rarely
☐ Never

E55: How often do your foster parents (or your other adult caregivers, if you are not in foster care) check your homework or provide help with homework (or other school assignments)?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ Rarely ☐ Never

E56A: How far do you hope to go in school?

☐ Not graduate from high school
☐ Secondary or high school graduation
☐ Technical, trade or vocational school (above the high school level)
☐ Community college or apprenticeship program
☐ University degree
☐ More than one university degree

E56B: How far do you expect to go in school?

☐ Not graduate from high school
☐ Secondary or high school graduation
☐ Technical, trade or vocational school (above the high school level)
☐ Community college or apprenticeship program
☐ University degree
☐ More than one university degree

E57: If you have problems at school, are your foster parents (or other adult caregivers) ready to help?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ Rarely ☐ Never ☐ No problems at school

E58: Do your foster parents (or other adult caregivers) encourage you to do well at school?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ Rarely ☐ Never

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E50

E51

E52

E53

E54

E55

E56A

E56B

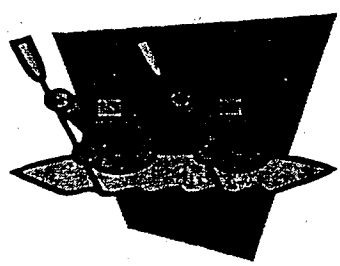
E57

E58

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

If a youth in care decides that he/she wants to study at a particular university, or become a doctor or a professional tennis player, who is to say that this is inappropriate? The job of the CAS protection worker as a good parent is to explain to the young person the necessary steps along the way, do everything possible to help, and encourage and build on their aspirations and talents.

An important thing is that youth in care have targets to aim for which they may be able to keep in view during their life experiences in the child welfare system. Research on high achievers who have been in care suggests that a good educational foundation is the key not only to employment but also to success in many other dimensions of adult life.



E59: Do your foster parents (or other adult caregivers) expect too much of you at school?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ Rarely ☐ Never

E60: How often do you read for fun (not for school)?

☐ Every day ☐ A few times a month
☐ A few times a week ☐ Less than once a month
☐ Once a week ☐ Almost never

E61: Are you enrolled as a full-time or part-time student in a post-secondary institution?

☐ Yes, full-time student ☐ Yes, part-time student ☐ No (Go to question E63)

E62: What program are you taking?

☐ Science or technology (e.g., chemistry, engineering, computer science)
☐ Social sciences (e.g., social work, political science, economics)
☐ Commerce/administration (e.g., management, marketing, accounting)
☐ General arts (e.g., literature, linguistics, communication, journalism)
☐ Fine arts (e.g., sculpture, music, theatre)
☐ Vocational trade (e.g., auto mechanics, electronics, haidressing)
☐ Other ____ Specify

E63: Did you ever drop out of high school for more than a week?

☐ Yes ☐ No (Go to question E67)

E64: The last time you dropped out of high school, how long was it for?

☐ Less than a month ☐ 1 to 3 months ☐ 4 to 6 months ☐ More than 6 months

E65: What was the main reason you dropped out of high school? **(Do not read list. Mark one only.)**

☐ Not interested/don't like school
☐ Problems with school work
☐ Problems with teachers
☐ Problems with other students
☐ Kicked out/expelled
☐ Not worth continuing/do not see future benefits
☐ Health problems
☐ Pregnancy/caring for own children
☐ Problems at home
☐ Had to work/money problems
☐ Wanted to work
☐ Other

____ Specify

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E59

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

E60

E61

E62

E63

E64

E65

Looking After Children places a high priority on education for four reasons.

1. When a child welfare agency acts as the corporate parent, the agency should place a priority on education, just as any reasonable parent would.

2. School plays a central role in the experience of childhood in our society.

3. Because education plays a key role in determining the quality of adult life.

4. Research suggests that in the past, social workers have not placed a high priority on education in their Plans of Care for youths.

E66: If, after dropping out, you returned to high school, what was the main reason for returning to high school? **(Do not read list. Mark one only.)**

- ☐ My parent(s), friend(s) or someone else convinced me to return
- ☐ Realized it was important to have an education
- ☐ Missed my friends
- ☐ Was allowed to go back to school
- ☐ Found a better or different school
- ☐ Found a job that allowed me to continue my studies
- ☐ Bored/missed school
- ☐ Other ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Specify**

The next two questions are about jobs or employment, which here are meant to include all types of work, paid or unpaid, full-time or part-time.

E67: Do you have a job now?

☐ Yes, full-time ☐ Yes, part-time ☐ No (Go to question E75)

E68: In an average week, how many hours in total do you usually work? **(Write in total number of hours, including zero, if applicable)**

☐☐ total hours

E69: Does working cause you to do less school work than you would like?

- ☐ Yes, a great deal less
- ☐ Yes, somewhat less
- ☐ No, not at all less
- ☐ I do not go to school anymore

The following section is to be filled out by the <u>CAS PROTECTION WORKER</u>, based on the information obtained on this entire developmental dimension of education.

ATTAINMENT OF GENERAL EDUCATION OBJECTIVES OF THE CHILD WELFARE SYSTEM

E70: Objective 1: The youth's educational performance matches his/her ability:

☐ Performance matches ability ☐ Performance somewhat below ability ☐ Performance seriously below ability

E71: Objective 2: The youth is acquiring special skills and interests:

☐ Many ☐ Some ☐ Few ☐ None

E72: Objective 3: The youth is participating in a wide range of activities:

☐ Wide range of activities ☐ Some activities ☐ Few activities ☐ No participation

E73: Objective 4: Adequate attention is being given to planning the youth's education:

☐ Satisfactory planning ☐ Some planning, but not enough ☐ Little or no planning

E74: Objective 5: The youth's has some educational qualifications:

☐ Yes ☐ No

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E66

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

E67

E68

E69

E70

E71

E72

E73

E74

Youth in care face great difficulties in continuing their education beyond compulsory school age. It may be only at this stage that they reach a state of emotional equilibrium and are able to start learning effectively. No assumptions should be made about the educational potential of young people whose childhood has been disrupted by abuse, neglect, and instability.

E75: Objective 6: The youth has developed skills useful for employment:

☐ Many skills ☐ Some skills ☐ Few skills

E76: Objective 7: The youth has a range of leisure interests:

☐ Wide range of leisure interests ☐ Some leisure interests ☐ Few leisure interests ☐ None

Note to the CAS protection worker :
If anyone disagrees with these answers to the Education objectives, please note the details on the opposite page.

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E75

E76

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

43849

DEVELOPMENTAL DIMENSION 3: IDENTITY.

This dimension is about the identity of the youth in care. The questions in this section are designed to make sure that the youth knows something about his/her birth family and their 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.

The YOUTH IN CARE is to answer this section, with assistance, as needed, from the foster parent (or other adult caregiver) or CAS protection worker.

ID1: BIRTH FAMILY: How many members of your birth family can you name (including parents, brothers and sisters, grandparents, cousins, aunts and uncles)?

☐ All or most ☐ Some ☐ None

ID2: Do you want to find out more about your birth family?

☐ Yes ☐ Uncertain ☐ No

ID3: BEING IN CARE: Do you understand why you are in care?

☐ Yes ☐ Uncertain ☐ No

ID4: If you feel awkward or uncomfortable when asked personal questions about your birth family, where you live, or why you are in care, are you getting all necessary assistance to deal with such questions in future?

☐ No assistance required ☐ Yes ☐ No

ID5: PAST EXPERIENCES: Do you have a personal album, containing photographs and mementoes about people and events that were important to you?

☐ Yes ☐ No

ID6: RELIGION: What, if any, is your religion? **(Do not read list. Mark one only.)**

☐ No religion
☐ First Nations/aboriginal religion
☐ Roman Catholic
☐ United Church
☐ Anglican
☐ Presbyterian
☐ Lutheran
☐ Baptist
☐ Eastern Orthodox
☐ Jewish
☐ Islam (Muslim)
☐ Buddhist
☐ Hindu
☐ Sikh
☐ Jehovah's Witnesses
☐ Other

ID7: Do you have enough opportunities to practice your religion (including religious services, festivals and holidays, prayers, clothing, diet)?

☐ Youth has no religious affiliation ☐ Yes ☐ No

ID8: 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.) **(Do not read list. Mark all that apply.)**

☐ English
☐ French
☐ Arabic
☐ Chinese
☐ German
☐ Greek
☐ Hungarian
☐ Italian
☐ Korean
☐ Persian (Farsi)
☐ Polish
☐ Portuguese
☐ Punjabi
☐ Spanish
☐ First Nations language
☐ Tagalog (Filipino)
☐ Ukrainian
☐ Vietnamese
☐ Other

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

ID1 ☐

ID2 ☐

ID3 ☐

ID4 ☐

ID5 ☐

ID6 ☐

ID7 ☐

ID8 ☐

DIMENSION 3: IDENTITY

This dimension is about the identity of the youth in care. It is designed to make sure that he/she knows about his/her birth family and culture, that he/she is being helped to understand and accept the reasons why he/she is in care, and that he/she feels increasingly confident about himself/herself.

If you were adopted as a baby and have had no contact with your birth family since then, questions in this section apply to your adoptive family.

ID9: What language do you speak most often at home? **(Mark all that apply.)**

☐ English ☐ French ☐ First Nations language ☐ Other ☐☐☐☐☐☐☐☐☐☐ **Specify**

ID10: Overall, do you have enough opportunities to speak your own first language (at home, at school, with friends, etc.)?

☐ Yes ☐ No

ID11: ETHNICITY: To which ethnic or cultural group(s) did your ancestors belong? (For example: French, British, Chinese) **(Mark all that apply.)**

☐ Canadian
☐ French
☐ English
☐ North American Indian
☐ Inuit / Eskimo
☐ Métis
☐ German
☐ Irish
☐ Scottish
☐ Italian
☐ Jewish
☐ Ukranian
☐ Dutch (Netherlands)
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Polish
☐ Latin American
☐ Portugese
☐ Black (e.g., African, Haitian, Jamaican, Somali)
☐ South Asian (e.g., East Indian, Pakistani, Punjabi, Sri Lankan)
☐ South East Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese)
☐ Arab/West Asian (e.g., Armenian, Egyptian, Lebanese, Moroccan)
☐ Other ☐☐☐☐☐☐☐☐☐☐☐ **Specify**

ID12: Overall, do you have enough opportunities to meet people from your own ethnic or cultural background (including, for First Nations youth, people from your own band or community)?

☐ Yes ☐ No

ID13: Are the ethnic/cultural backgrounds of the youth and at least one of his/her foster parents (or other adult caregivers):

☐ The same? ☐ Similar? ☐ Neither the same nor similar?

For each of the following statements, choose the answer that best describes how you feel.

ID14: In general, I like the way I am.

☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

ID15: Overall I have a lot to be proud of.

☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

ID16: A lot of things about me are good.

☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

ID17: When I do something, I do it well.

☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

ID18: I like the way I look.

☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

ID19: In general, I am happy with how things are for me in my life now.

☐ Strongly disagree ☐ Disagree ☐ Agree ☐ Strongly agree

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ID9

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

ID10

ID11

ID12

ID13

ID14

ID15

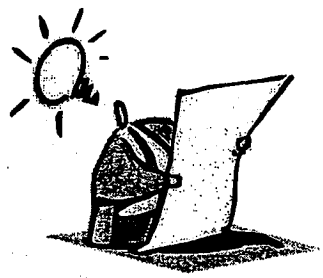
ID16

ID17

ID18

ID19

Even if a personal album is not being kept, it is important that photographs, certificates and mementoes be collected and that addresses be noted down. This is particularly valuable if there is a change of placement or CAS protection worker, as it may later prove impossible to gather lost information.



"Self-esteem" refers to the positive or negative regard in which one holds oneself, either globally, in the sense of an overall judgement, or specifically, in relation to one's different identities.

Most psychological research on the self has been concerned with self-esteem, perhaps because of its great importance to overall well-being. Recently, another aspect of self-evaluation, self-efficacy, has been studied, that is, the sense that one is competent and can solve one's problems.

Self-efficacy is likely to be particularly low in children in care, and the sections of the Record concerned with school success, hobbies, and self-care skills are important not only in themselves, but also because of their influence or self-efficacy and self-esteem

ID20: The next five years look good to me.

☐ Strongly disagree ☐ Disagree ☐ Agree ☐ Strongly agree

IDENTITY STYLES: In this next section are some statements about beliefs, attitudes, and ways of dealing with issues. Please use them to describe yourself. There are no right or wrong answers. Use the 1 to 5 point scale to indicate the degree to which you think each statement is uncharacteristic (1) or characteristic (5) of yourself. For instance, if the statement is not like you at all, give it a 1. If it is very much like you, give it a 5.

ID21: I've spent a great deal of time thinking seriously about what I should do with my life.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID22: I'm not really sure what I'm doing about school; I guess things will work themselves out.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID23: I've more or less always operated according to the values with which I was brought up.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID24: I've spent a good deal of time reading and talking to others about religious ideas.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID25: When I discuss an issue with someone, I try to assume their point of view and see the problem from their perspective.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID26: It doesn't pay to worry about values in advance; I decide things as they happen.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID27: I've always had purpose in my life; I was brought up to know what to strive for.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID28: Many times, by not concerning myself with personal problems, they work themselves out.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID29: I've spent a lot of time reading and trying to make some sense out of political issues.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID30: I'm not really thinking about my future now; it's still a long way off.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID31: I've spent a lot of time and talked to a lot of people trying to develop a set of values that make sense to me.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID32: Regarding religion, I've always known what I believe and don't believe; I never really had any serious doubts.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID33: I know that I am going to college/university and what I am going to major in.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID34: I think it's better to have a firm set of beliefs than to be open-minded

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

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ID20

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

ID21

ID22

ID23

ID24

ID25

ID26

ID27

ID28

ID29

ID30

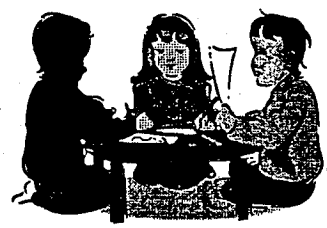
ID31

ID32

ID33

ID34

Identity: is fluid, dynamic, ridden with contradictions, and constructed from diverse experiences. Youth should be put in touch with a range of cultural experiences relevant to their family backgrounds and peer group so that they can construct identities that they feel comfortable with, bearing in mind that these may change in the course of development.



A youth with a positive view of self will be generally confident in new situations. He/she will take on challenges and expect to succeed. He/she will enjoy meeting new people and expect to be liked.

ID35: When I have to make decision, I try to wait as long as long as possible in order to see what will happen.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID36: When I have a personal problem, I try to analyze the situation in order to understand it.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID37: I find it's best to seek out advice from professionals (e.g., clergy, doctors, lawyers) when I have problems.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID38: It's best for me not to take life too seriously. I just try to enjoy it.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID39: I think it's better to use one set of values consistently all the time, rather than change them in different situations.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID40: I try not to think about or deal with problems for as long as I can.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID41: I find that personal problems often turn out to be interesting challenges.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID42: I try to avoid personal situations that will require me to think a lot and deal with them on my own.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID43: Once I know the correct way to handle a problem, I prefer to stick with it.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID44: When I have to make a decision, I like to spend a lot of time thinking about my options.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID45: I prefer to deal with situations the way that other people expect me to.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID46: I like to have the responsibility for handling problems in my life that require me to think on my own.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID47: Sometimes I refuse to believe a problem will happen, and things manage to work themselves out.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID48: When making important decisions I like to have as much information as possible.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID49: When I know a situation is going to cause me stress, I try to avoid it.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID50: I find it's best for me to rely on the advice of close friends or relatives when I have a problem.

☐ 1 (= not like me at all) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (= very much like me)

ID35

ID36

ID37

ID38

ID39

ID40

ID41

ID42

ID43

ID44

ID45

ID46

ID47

ID48

ID49

ID50

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

The following section is to be filled out by the CAS PROTECTION WORKER, based on the information obtained on this entire developmental dimension of identity.

ATTAINMENT OF GENERAL IDENTITY OBJECTIVES OF THE CHILD WELFARE SYSTEM

ID51: Objective 1: The youth has knowledge of his/her family of origin and current situation:

☐ Clear knowledge ☐ Some knowledge ☐ Little or no knowledge

ID52: Objective 2: The youth identifies with and is proud of his/her racial or ethnic background:

☐ To a great extent ☐ To some extent ☐ To little or no extent

ID53: Objective 3: The youth has a good level of self-esteem:

☐ High self-esteem ☐ Moderate self-esteem ☐ Low self-esteem

ID54: Objective 4: The youth has a clear understanding of his/her current situation:

☐ Clear understanding ☐ Some understanding ☐ Little or no knowledge

Note to the CAS protection worker: *If anyone disagrees with these answers to the Identity objectives, please note the details on the opposite page.*

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

ID51

ID52

ID53

ID54

DEVELOPMENTAL DIMENSION 4: FAMILY AND SOCIAL RELATIONSHIPS

This dimension is about the youth's relationship with friends, family, and others. The questions in this section are meant to find out if the youth has a close relationship with a parent or someone who acts as his/her parent, has a home where he/she is welcome, and knows an adult who will help him/her out if something goes wrong. The questions also ask if the youth has good friends he/she can rely on.

The next section is to be answered by the FOSTER PARENT (or other adult caregiver), with assistance, as needed, from the youth in care or the CAS social worker.

F1: At what age did ... start living with you?

☐☐ **years of age**

F2: How long has ... been living with you?

☐☐ **years and** ☐☐ **months**

F3: Is this a permanent placement for ... (i.e., until adulthood)?

☐ Yes ☐ Uncertain ☐ No

F4: Is all necessary action being taken to provide a permanent placement for ...?

☐ Yes ☐ Uncertain ☐ No

F5: How many different people have acted as ...'s main caregivers since birth? **(Try and give an estimate of the number, even if you are not certain.)**

☐☐ **caregivers (write in total number)**

F6: CONTACT WITH BIRTH FAMILY: What type of contact does ... have with his/her birth mother?

- ☐ Regular visiting, every week
- ☐ Regular visiting, every two weeks
- ☐ Regular visiting, monthly
- ☐ Irregular visiting, on holidays only
- ☐ Irregular visiting, without set pattern
- ☐ Telephone or letter contact only
- ☐ No contact at all
- ☐ Crown Ward, with no access

F7: What type of contact does ... have with his/her birth father?

- ☐ Regular visiting, every week
- ☐ Regular visiting, every two weeks
- ☐ Regular visiting, monthly
- ☐ Irregular visiting, on holidays only
- ☐ Irregular visiting, without set pattern
- ☐ Telephone or letter contact only
- ☐ No contact at all
- ☐ Crown Ward, with no access

F8: What type of contact does ... have with his/her brothers or sisters?

- ☐ Regular visiting, every week
- ☐ Regular visiting, every two weeks
- ☐ Regular visiting, monthly
- ☐ Irregular visiting, on holidays only
- ☐ Irregular visiting, without set pattern
- ☐ Telephone or letter contact only
- ☐ No contact at all
- ☐ Crown Ward, with no access
- ☐ Has no brothers or sisters

F9: What type of contact does ... have with any other relatives (e.g., aunts, uncles, grandparents)?

- ☐ Regular visiting, every week
- ☐ Regular visiting, every two weeks
- ☐ Regular visiting, monthly
- ☐ Irregular visiting, on holidays only
- ☐ Irregular visiting, without set pattern
- ☐ Telephone or letter contact only
- ☐ No contact at all

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

F1

F2

F3

F4

F5

F6

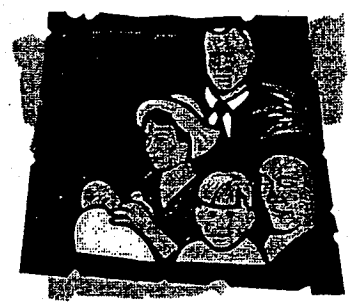
F7

F8

F9

DIMENSION 4: FAMILY AND SOCIAL RELATIONSHIPS

This dimension is about the youth's relationship with friends, family, and others. The questions ask about his/her relationships with foster parents or other adult caregivers, contacts with members of his/her birth family, ability to get along well with adults or other youths, and whether he/she has any close friends.



Your adult caregiver is anyone who has looked after you on more than a temporary basis. Research indicates that the need for continuity is most likely to be met by relatives such as siblings, grandparents, aunts, and uncles or other significant people.Continuity of contact with parents or the wider family is often a critical determinant of outcomes for youth.

Youth who find continuity of placement and attachments while in care are more likely to achieve stability in adulthood and experience improved educational chances which, in turn are likely to enhance later success in life.

F10: Is ... receiving all necessary assistance to remain in contact with his/her birth family?

☐ Yes ☐ No

F11: PREVIOUS FOSTER PARENTS: What type of contact does ... have with his/her previous foster parents?

☐ Regular visiting, every week
☐ Regular visiting, every two weeks
☐ Regular visiting, monthly
☐ Irregular visiting, on holidays only
☐ Irregular visiting, without set pattern
☐ Telephone or letter contact only
☐ No contact at all
☐ Has not had any previous foster parents

F12: CURRENT FRIENDSHIPS: About how many days a week does ... do things with friends?

☐ Never ☐ 1 day a week ☐ 2-3 days a week ☐ 4-5 days a week ☐ 6-7 days a week

F13: About how many close friends does he/she have?

☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or 5 ☐ 6 or more

F14: When it comes to meeting new children/youths and making new friends is he/she:

☐ Somewhat shy? ☐ About average? ☐ Very outgoing - makes friends easily

F15: GETTING ALONG WITH OTHERS: During the past 6 months, how well has ... gotten along with other children/youths, such as friends or classmates (excluding brothers or sisters)?

☐ Very well, no problems
☐ Quite well, hardly any problems
☐ Pretty well, occasional problems
☐ Not too well, frequent problems
☐ Not well at all, constant problems

F16: During the last school year, how well has he/she gotten along with his/her teacher(s) at school?

☐ Very well, no problems
☐ Quite well, hardly any problems
☐ Pretty well, occasional problems
☐ Not too well, frequent problems
☐ Not well at all, constant problems
☐ Is not attending school

F17: During the last few months, how well has he/she gotten along with his/her foster parent(s) (or other adult caregivers)?

☐ Very well, no problems
☐ Quite well, hardly any problems
☐ Pretty well, occasional problems
☐ Not too well, frequent problems
☐ Not well at all, constant problems

F18: During the last few months, how well has... gotten along with his/her brother(s)/sister(s) (or other children with whom he/she has been living)?

☐ Very well, no problems
☐ Quite well, hardly any problems
☐ Pretty well, occasional problems
☐ Not too well, frequent problems
☐ Not well at all, constant problems
☐ Not applicable

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F10 ☐

F11 ☐

F12 ☐

F13 ☐

F14 ☐

F15 ☐

F16 ☐

F17 ☐

F18 ☐

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

The next section is to be answered by the FOSTER PARENT (or other adult caregiver).

The next few questions have to do with different ways foster parents (or other adult caregivers) act towards the children/youth in their care. I would like you to tell me how often, in general, you act in the following ways.

F19: How often do you smile at ... ?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F20: How often do you want to know exactly where ... is and what he/she is doing?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F21: How often do you soon forget a rule that you have made?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F22: How often do you praise him/her?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F23: How often do you let ... go out any evening that he/she wants?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F24: How often do you tell him/her what time to be home when he/she goes out?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F25: How often do you nag ... about little things?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F26: How often do you listen to his/her ideas and opinions?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F27: How often do you solve a problem together when you disagree about something?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F28: How often do you keep rules only when it suits you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F29: How often do you get angry and yell at him/her?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F30: How often do you make sure that ... knows that he/she is appreciated?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F31: How often do you threaten punishment more often than you use it?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F32: How often do you speak of good things that he/she does?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F33: How often do you find out about ...'s misbehaviour?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F34: How often do you enforce a rule or do not enforce a rule depending on your mood?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

F19 ☐
F20 ☐
F21 ☐
F22 ☐
F23 ☐
F24 ☐
F25 ☐
F26 ☐
F27 ☐
F28 ☐
F29 ☐
F30 ☐
F31 ☐
F32 ☐
F33 ☐
F34 ☐

Parenting is a process which most parents learn as they experience the influence of their own parents and that of relatives, friends, the media, health professionals, and teachers.

Although there are wide variations in parenting practices, there are reliable research findings which show that authoritative parenting, which consists of warmth and acceptance of the youth as well as appropriate guidance and limit-setting, achieves the best results.

This knowledge about parenting styles has been incorporated into the Assessment and Action Record, to emphasize the need to show physical affection towards youth, to find things to praise in them, to guide them, and to recognize what they can do well.

F35: How often do you hit ... or threaten to do so?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F36: How often do you seem proud of the things he/she does?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F37: How often do you seem too busy to spend as much time with him/her as he/she would like?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F38: How often do you take an interest in where he/she is going and whom he/she is with?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

▶ The next section is also to be answered by the **FOSTER PARENT** (or other adult caregiver).

People often disagree with each other. The following sentences describe disagreements. Tell me how often you and your foster youth (or the youth in your care) do the following things.

F39: We make up easily when we have a fight.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F40: We disagree and fight.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F41: We bug each other or get on each other's nerves.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F42: We yell at each other.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F43: When we argue, we stay angry for a very long time.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F44: When we disagree, I refuse to talk to him/her.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F45: When we disagree, he/she stomps out of the room, or house, or yard.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F46: When we disagree about something, we solve the problems together.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F47: When we disagree about something, I give in just to end the argument.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F48: When we disagree, another person comes in to settle things or find a solution.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

▶ The next section is also to be answered by the **FOSTER PARENT** (or other adult caregiver).

Tell me how often per week you do the following activities with your foster youth (or the youth in your care).

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The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

Family activities: If youth feel settled, their educational chances are enhanced and this, in turn, will boost employment opportunities later. With a sound social network and good family relationships, the development of a secure identity is more likely, with an associated reduction in health problems. In other words, paying attention to the Family and Social Relationships section of the Assessment and Action Records will help with progress on the six other dimensions.

F49: How many days in a week do you eat together?

- ☐ Every day
- ☐ 5-6 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 1-2 times per month
- ☐ Rarely or never

F50: How many days a week do you watch television together?

- ☐ Every day
- ☐ 5-6 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 1-2 times per month
- ☐ Rarely or never

F51: How many days a week do you play sports together?

- ☐ Every day
- ☐ 5-6 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 1-2 times per month
- ☐ Rarely or never

F52: How many days a week do you play cards or games together?

- ☐ Every day
- ☐ 5-6 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 1-2 times per month
- ☐ Rarely or never

F53: How many days a week do you have a discussion together?

- ☐ Every day
- ☐ 5-6 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 1-2 times per month
- ☐ Rarely or never

F54: How many days a week do you do a family project or family chores together?

- ☐ Every day
- ☐ 5-6 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 1-2 times per month
- ☐ Rarely or never

F55: How many days a week do you have a family outing/entertainment together?

- ☐ Every day
- ☐ 5-6 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 1-2 times per month
- ☐ Rarely or never

F56: How many days a week do you visit relatives together?

- ☐ Every day
- ☐ 5-6 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 1-2 times per month
- ☐ Rarely or never

Sometimes different situations or circumstances arise which may affect family life. The next few questions are about some of these possible situations.

F57: How often does ... see television shows or movies that have a lot of violence in them?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

F58: How often does ... see adults or teenagers in your house physically fighting, hitting, or otherwise trying to hurt others?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

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F55

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F58

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

F59: How often does ... hang around with kids you think are frequently in trouble?
☐ Often ☐ Sometimes ☐ Seldom ☐ Never

F60: How many of ...'s close friends do you know by sight and by first and last name?
☐ All ☐ Most ☐ About half ☐ Only a few ☐ None

The next few sections are to be answered by the **YOUTH IN CARE.**

This section is about your relationship with friends, family, and others. The questions ask about your relationship with your foster parents (or other adult caregivers), your contacts with members of your birth family, your ability to get along well with adults and other children/youths, and whether you have any close friends.

The next few questions have to do with friends. Would you say:

F61: I have many friends.
☐ False ☐ Mostly false ☐ Sometimes true/Sometimes false ☐ Mostly true ☐ True

F62: I get along easily with others my age.
☐ False ☐ Mostly false ☐ Sometimes true/Sometimes false ☐ Mostly true ☐ True

F63: Others my age want me to be their friend.
☐ False ☐ Mostly false ☐ Sometimes true/Sometimes false ☐ Mostly true ☐ True

F64: Most others my age like me.
☐ False ☐ Mostly false ☐ Sometimes true/Sometimes false ☐ Mostly true ☐ True

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.

F65: I feel that my close friends really know who I am.
☐ False ☐ Mostly false ☐ Sometimes true/Sometimes false ☐ Mostly true ☐ True

F66: About how many days a week do you do things with close friends outside of school hours?
☐ Never
☐ Less than once a week
☐ 1 day a week
☐ 2 or 3 days a week
☐ 4 or 5 days a week
☐ 6 or 7 days a week

F67: How often do you share your secrets and private feelings with your close friends?
☐ All the time ☐ Most of the time ☐ Some of the time ☐ Rarely

F68: Other than your close friends, do you have anyone else in particular you can talk to about yourself or your problems?
☐ Yes ☐ No

F69: What is their relationship to you? **(Mark every person that the child/youth feels he/she can talk to about himself/herself or his/her problems.)**
☐ Foster mother
☐ Foster father
☐ Biological mother
☐ Biological father
☐ Brother
☐ Sister
☐ Grandparents
☐ Other relative
☐ Parent's boyfriend/girlfriend
☐ A friend of the family or a friend's parent
☐ Teacher
☐ Coach or leader (e.g. Scout, Guide or church leader)
☐ CAS protection worker
☐ Sitter or baby sitter
☐ Other (e.g., family doctor)

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F59

F60

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

F61

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F69

Friends: While there are some exceptions, youth who remain in touch with relatives and enjoy a stable social network, usually fare better than those who drift apart from home and neighbourhood.

F70: 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?

☐ Yes ☐ Not sure ☐ No

F71: During the past 6 months, how well have you gotten along with other young people such as friends or classmates?

☐ Very well, no problems
☐ Quite well, hardly any problems
☐ Pretty well, occasional problems
☐ Not too well, frequent problems
☐ Not well at all, constant problems

F72: During the past 6 months, how well have you gotten along with your foster mother (or other female caregiver)?

☐ Very well, no problems
☐ Quite well, hardly any problems
☐ Pretty well, occasional problems
☐ Not too well, frequent problems
☐ Not well at all, constant problems

F73: During the past 6 months, how well have you gotten along with your foster father (or other male caregiver)?

☐ Very well, no problems
☐ Quite well, hardly any problems
☐ Pretty well, occasional problems
☐ Not too well, frequent problems
☐ Not well at all, constant problems

F74: During the past 6 months, how well have you gotten along with your brothers and sisters or foster brothers and sisters living in the same house?

☐ Very well, no problems
☐ Quite well, hardly any problems
☐ Pretty well, occasional problems
☐ Not too well, frequent problems
☐ Not well at all, constant problems
☐ Not applicable - No other children/youths living in the same house

F75: Overall, do you have a good relationship with any other children/youths living in the same house?

☐ Yes ☐ Not sure ☐ No ☐ Not applicable - No other children/youths living in the same house F-1

Thinking of your foster mother (or other female caregiver):

F76: How well do you feel that your foster mother (or other female caregiver) understands you?

☐ A great deal ☐ Some ☐ Very little

F77: How much fairness do you receive from your foster mother (or other female caregiver)?

☐ A great deal ☐ Some ☐ Very little

F78: How much affection do you receive from your foster mother (or other female caregiver)?

☐ A great deal ☐ Some ☐ Very little

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F70

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

F71

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F78

Getting along with your foster parents: Research in the 1970s raised questions about the state's ability to parent and highlighted drift and instability for youth away from home.Given the significant risk within substitute care of placement change or disruption and their negative consequences, which can last well into adulthood, all sources of potential continuity - parents, relatives, schools and friends - need to be nurtured wherever possible.

Research indicates that the need for continuity is most likely to be met by relatives such as siblings, grandparents, aunts, and uncles or other significant people. Evidence exists that children/youth who remain in contact with their parents tend to do better in the short and in the long-term than those who grow apart.

F79: Overall, how would you describe your relationship with your foster mother (or other female caregiver)?

☐ Very close ☐ Somewhat close ☐ Not very close

Thinking of your foster father (or other male caregiver):

F80: How well do you feel that your foster father (or other male caregiver) understands you?

☐ A great deal ☐ Some ☐ Very little

F81: How much fairness do you receive from your foster father (or other male caregiver)?

☐ A great deal ☐ Some ☐ Very little

F82: How much affection do you receive from your foster father (or other male caregiver)?

☐ A great deal ☐ Some ☐ Very little

F83: Overall, how would you describe your relationship with your foster father (or other male caregiver)?

☐ Very close ☐ Somewhat close ☐ Not very close

CURRENT PLACEMENT: The next few questions have to do with your current living situation. Would you say that:

F84: You like living here?

☐ A great deal ☐ Some ☐ Very little

F85: You feel safe living in this home?

☐ A great deal ☐ Some ☐ Very little

F86: You feel safe living in this neighbourhood?

☐ A great deal ☐ Some ☐ Very little

F87: Your foster parents (or other adult caregivers) are interested in your activities and interests?

☐ A great deal ☐ Some ☐ Very little

F88: You would be pleased if you were to live here for a long time?

☐ A great deal ☐ Some ☐ Very little

F89: You are satisfied with the amount of privacy you have here?

☐ A great deal ☐ Some ☐ Very little

F90: You feel relaxed around the people with whom you are living?

☐ A great deal ☐ Some ☐ Very little

F91: You have a good relationship with other people with whom you are living?

☐ A great deal ☐ Some ☐ Very little

F92: Your current living situation meets your needs?

☐ A great deal ☐ Some ☐ Very little

F93: Overall, you are satisfied with your current living situation here?

☐ A great deal ☐ Some ☐ Very little

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F79

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

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Recent research demonstrates that the majority of youth eventually return home to live with parents or relatives. Continuing contact with parents or the wider family is often a critical determinant of outcomes for young people.

Youth who find continuity of placement and attachments while in care are more likely to achieve stability in adulthood and experience improved educational chances, which in turn boosts employment prospects.

The following section is to be filled out by the CAS PROTECTION WORKER, based on the information obtained on this entire developmental dimension of family and social relationships.

ATTAINMENT OF GENERAL SOCIAL AND FAMILY RELATIONSHIP OBJECTIVES OF THE CHILD WELFARE SYSTEM

F94: Objective 1: The child/youth has had continuity of care:

☐ Much continuity of care ☐ Some disruptions ☐ Serious disruptions

F95: Objective 2: The youth is definitely attached to at least one foster parent (or other adult carer):

☐ Definitely attached ☐ Some attachment ☐ Little or no attachment

F96: Objective 3: The youth's contact with his/her birth family strengthens his/her relationship with them:

☐ Most contacts are helpful

☐ Some contacts are unhelpful

☐ Most contacts are unhelpful

☐ No contacts

F97: Objective 4: The youth has has a stable relationship with at least one adult over a number of years:

☐ Long-term relationship (i.e., throughout life)

☐ Fairly long-term relationship (i.e., more than 3 years)

☐ Short-term relationship (i.e., 1-3 years)

☐ No stable relationship

F98A: Objective 5: The youth has a relationship with a person who is prepared to help him/her in times of need:

☐ A good relationship with someone he/she can call on regularly

☐ A fairly good relationship with someone he/she can call on in times of crisis

☐ No support of this kind

F99: Objective 6: The youth is able to make friendships with others of the same age:

☐ Several friends ☐ Some friends ☐ Few friends ☐ No friends

F100: Objective 7: The youth is receiving foster parenting (or other substitute parenting) of high quality:

☐ Definitely yes ☐ Yes ☐ No ☐ Definitely not

F101: Objective 8: Either the youth's current placement is permanent, or else all feasible action is being taken to create a permanent placement for him/her:

☐ Definitely yes ☐ Yes ☐ No ☐ Definitely not

Note to the CAS protection worker: *If anyone disagrees with these answers to the Family and Social Relationships objectives, please note the details on the opposite page.*

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

F94

F95

F96

F97

F98A

F99

F100

F101

DEVELOPMENTAL DIMENSION 5: SOCIAL PRESENTATION

This dimension is about making sure that the youth in care 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.

▶ The **FOSTER PARENT** (or other adult caregiver) is to answer this section.

P1: Does ... keep himself/herself clean (i.e., body, hair, teeth)?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

P2: Does ... take adequate care of his/her skin?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

P3: Overall, does ...'s personal appearance give people the impression that he/she takes care of himself/herself properly?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

P4: Does ... wear suitable clothes (e.g., at school, home, or parties, etc.)?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

P5: Can people understand what he/she is saying?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

P6: Does ... adjust his/her behaviour and conversation appropriately to different situations (e.g., at home, work, school, with friends and teachers)?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

▶ The next section is to be answered by the **YOUTH IN CARE**

P7: I am good looking.
☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

P8: I have a pleasant looking face.
☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

P9: Other kids think that I am good looking.
☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

P10: I have a good looking body.
☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

▶ The following section is to be filled out by the **CAS PROTECTION WORKER**, based on the information obtained on this entire developmental dimension of social presentation.

ATTAINMENT OF SOCIAL PRESENTATION OBJECTIVES OF THE CHILD WELFARE SYSTEM:

P11: Objective 1: The youth's appearance is acceptable to young people and adults.
☐ Acceptable to young people and adults
☐ Acceptable to young people only
☐ Acceptable to adults only
☐ Not acceptable to either young people or adults

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

P1
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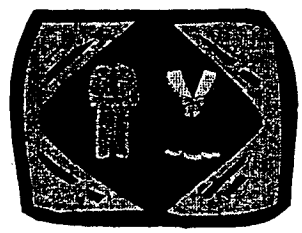
P8
P9
P10
P11

DIMENSION 5: SOCIAL PRESENTATION

This dimension is about making sure that the youth in care 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.



tive 2: The youth's behaviour is acceptable to young people and adults:

ɔle to young people and adults

ɔle to young people only

ɔle to adults only

ɨptable to either young people or adults

tive 3: The youth can communicate easily with others:

ily ☐ Easily ☐ With some difficulty ☐ With great difficulty

CAS protection worker: *If anyone disagrees with these answers to the Social Presentation objectives, the details on the opposite page.*

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P12

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

P13

Social presentation can be viewed as a combination of self-presentation and social skills which are learned throughout childhood.

A reasonable corporate parent will be as concerned about social presentation as about every other aspect of a youth's development.

Physical appearance affects how youth, especially adolescents, feel about themselves. They may also be stigmatized because of unattractive appearance, unlikeable personal habits, or inappropriate social behaviours.

DEVELOPMENTAL DIMENSION 6: EMOTIONAL AND BEHAVIOURAL DEVELOPMENT

This dimension is designed to assess how the youth in care has been feeling and how this may have affected the way he/she behaves.

This section is to be answered by the **YOUTH IN CARE.**
For each of the following statements, choose the answer that best describes you.

B1: I show sympathy to (I feel sorry for) someone who has made a mistake.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B2: I can't sit still, I am restless.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B3: I destroy my own things.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B4: I try to help someone who has been hurt.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B5: I steal at home.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B6: I am unhappy, sad or depressed.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B7: I get into many fights.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B8: I offer to help clear up a mess someone else has made.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B9: I am easily distracted, I have trouble sticking to any activity.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B10: When I'm mad at someone, I try to get others to dislike him/her.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B11: I am not as happy as other people my age.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B12: I destroy things belonging to my family or other young people.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B13: If there is an argument, I try to stop it.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B14: I fidget.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B15: I can't concentrate, I can't pay attention.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

B1 ☐
B2 ☐
B3 ☐
B4 ☐
B5 ☐
B6 ☐
B7 ☐
B8 ☐
B9 ☐
B10 ☐
B11 ☐
B12 ☐
B13 ☐
B14 ☐
B15 ☐

DIMENSION 6: EMOTIONAL AND BEHAVIOURAL DEVELOPMENT.

This dimension is designed to draw attention to how the youth in care has been feeling and how this has affected the way he/she behaves.

Maltreated youth are at risk for behavioural problems in school and in the community. Standardized measures of youth behaviour allow us to assess the progress of youth in care over time and compare their development with that of their age peers in the general population.

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B16: I am too fearful or anxious.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B17: When I'm mad at someone, I become friends with another as revenge.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B18: I am impulsive, I act without thinking.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B19: I tell lies or cheat.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B20: I offer to help young people (friend, brother or sister) who are having difficulty with a task.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B21: I worry a lot.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B22: I have difficulty waiting for my turn in games or group activities.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B23: When another young person accidently hurts me, I assume that he/she meant to do it, and I react with anger and fighting.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B24: When I am mad at someone, I say bad things behind his/her back.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B25: I physically attack people.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B26: I comfort another young person (friend, brother or sister) who is crying or upset.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B27: I cry a lot.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B28: I vandalize.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B29: I threaten people.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B30: I help to pick up things which another young person has dropped.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B31: I cannot settle to anything for more than a few moments.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B32: I feel miserable, unhappy, tearful, or distressed.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

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B16 ☐

B17 ☐

B18 ☐

B19 ☐

B20 ☐

B21 ☐

B22 ☐

B23 ☐

B24 ☐

B25 ☐

B26 ☐

B27 ☐

B28 ☐

B29 ☐

B30 ☐

B31 ☐

B32 ☐

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

B33: I am cruel, I bully or I am mean to others.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B34: When I'm mad at someone, I say to others: let's not be with him/her.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B35: I am nervous, highstrung or tense.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B36: I kick, bite, hit other people my age.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B37: When I'm playing with others, I invite bystanders to join in a game.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B38: I steal outside my home.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B39: I am inattentive, I have difficulty paying attention to someone.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B40: I have trouble enjoying myself.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B41: I help other people my age (friends, brother or sister) who are feeling sick.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B42: When I am mad at someone, I tell that person's secrets to a third person.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B43: I encourage other people my age who cannot do things as well as I can.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

Now, we have a few questions to ask you (i.e., the **YOUTH IN CARE**) 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 foster parent (or other adult caregiver), your CAS protection worker, or your family doctor.

B44: Has anyone in your school committed suicide?

☐ Yes, within the last year ☐ Yes, more than a year ago ☐ No, never ☐ I don't know

B45: Has anyone that you know personally committed suicide?

☐ Yes, within the last year ☐ Yes, more than a year ago ☐ No, never ☐ I don't know

B46: During the past 12 months, did you seriously consider attempting suicide?

☐ Yes ☐ No

B47: During the past 12 months, how many times did you attempt suicide?

☐ Never/none ☐ Once ☐ More than once

B48: 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)?

☐ I did not attempt suicide within the past 12 months ☐ Yes ☐ No

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B33

B34

B35

B36

B37

B38

B39

B40

B41

B42.

B43

B44

B45

B46

B47

B48

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

This next section is to be answered by the FOSTER PARENT (or other adult caregiver).

The youth has just told us how he/she usually feels and behaves. In addition, we would also like to have your perspective, as his/her foster parent (or other adult caregiver), on how he/she has recently felt and behaved. Please describe the youth's feelings and behaviour during the past week, including today, based on your personal observations and knowledge.

B49: ... (i.e., the youth in care) has headaches or feels dizzy.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B50: ... doesn't participate in activities that used to be fun.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B51: ... argues or speaks rudely to others.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B52: ... has a hard time finishing his/her assignments or does them carelessly.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B53: ... 's emotions are strong and change quickly.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B54: ... has physical fights (hitting, kicking, biting, or scratching) with his/her family or others his/her age.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B55: ... worries and can't get thoughts out of his/her mind.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B56: ... steals or lies.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B57: ... has a hard time sitting still (or has too much energy).
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B58: ... uses alcohol or drugs.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B59: ... is tense and easily startled (jumpy).
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B60: ... is sad or unhappy.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B61: ... has a hard time trusting friends, family members, or other adults.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B62: ... thinks that others are trying to hurt him/her even when they are not.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B63: ... has threatened to or has run away from home.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B64: ... physically fights with adults.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

B49 B50 B51 B52 B53 B54 B55 B56 B57 B58 B59 B60 B61 B62 B63 B64

B65: ...'s stomach hurts or feels sick more than others his/her age.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or alway

B66: ... does not have friends or does not keep friends for long.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or alway

B67: ... thinks about suicide or feels he/she would be better off dead.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or alway

B68: ... has nightmares, has trouble getting to sleep, oversleeps, or wakes up too early.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or alway

B69: ... complains about or questions rules, expectations, or responsibilities.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or alway

B70: ... breaks rules, laws, or does not meet others' expectations on purpose.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or alway

B71: ... feels irritated.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or alway

B72: ... gets angry enough to threaten others.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or alway

B73: ... gets into trouble when he/she is bored.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B74: ... destroys property on purpose.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or alway

B75: ... has a hard time concentrating, thinking clearly, or sticking to tasks.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B76: ... withdraws from family and friends?

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or alway

B77: ... acts without thinking and does not worry about what will happen.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B78: ... feels as though he/she does not have any friends or that no one likes him/her.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or alway

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B65

B66

B67

B68

B69

B70

B71

B72

B73

B74

B75

B76

B77

B78

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

The following section is to be filled out by the CAS PROTECTION WORKER, based on the information obtained on this entire developmental dimension of emotional and behavioural development.

ATTAINMENT OF EMOTIONAL AND BEHAVIOURAL DEVELOPMENT OBJECTIVES OF CHILD WELFARE SYSTEM:

B79: The youth is free of serious emotional and behavioural problems:

- ☐ No problems
- ☐ Minor problems
- ☐ Problems exist that need remedial action
- ☐ Serious problems exist which need specialized assistance

B80: The youth is receiving effective treatment for all persistent problems:

- ☐ Does not need treatment
- ☐ Is receiving effective treatment
- ☐ Is receiving some treatment
- ☐ Is not receiving effective treatment

Note to the CAS protection worker: *If anyone disagrees with these answers to the Emotional and Behavioural Development objectives, please note the details on the opposite page.*

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

B79

B80

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DEVELOPMENTAL DIMENSION 7: SELF-CARE SKILLS:

The questions in this dimension are designed to find out if the youth in care is learning to care for himself/herself at a level appropriate to his/her age and ability when given the necessary resources and support.

The questions in the section are to be answered by the FOSTER PARENT (or other adult caregiver).

Now, I would like to ask you some questions about ...'s self-care's responsibilities. How often does ... :

S1: Make his/her bed?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S2: Clean his/her own room?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S3: Pick up after himself/herself?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S4: Help keep shared living areas clean and straight?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S5: Do routine chores such as mow the lawn, help with dinner, wash dishes, etc.?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S6: Help manage his/her own time (get up on time, be ready for school, etc.)?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S7: Cook a meal?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S8: Wash/shower/bathe?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S9: Brush his/her teeth?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S10: Comb his/her hair?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S11: Sew on buttons or mend clothes?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S12: Use the vacuum cleaner?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S13: Use a washer/dryer or laundromat?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S14: Shop for food?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S15: Shop for clothes?

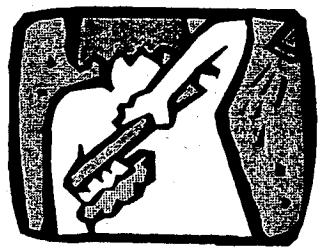
☐ Often ☐ Sometimes ☐ Seldom ☐ Never

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

S1
S2
S3
S4
S5
S6
S7
S8
S9
S10
S11
S12
S13
S14
S15

DIMENSION 7: SELF-CARE SKILLS:

The questions in this dimension are designed to find out if the youth in care is learning to care for himself/herself at a level appropriate to his/her age and ability, when given the necessary resources and support.



CAS protection workers and foster parents: If the youth in care is not learning to care for himself/herself, it is important that the youth practice these skills.

Daily living programs are specifically designed for youth with disabilities. They cover areas such as independent living skills, mobility skills, personal care skills, and continence management.

S16: Avoid common hazards related to poisons, tools, electricity, fire, etc.?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S17: Take reasonable precautions against attack (e.g., by avoiding walking in dangerous areas after dark, etc.)?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S18: Save money for things he/she wants to buy?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S19: Use a library card?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S20: Use a bank machine (automatic teller)?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S21: Find out about bus, train or airplane schedules?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

The questions in this section are to be answered by the **YOUTH IN CARE.**

Do you know how to:

S22: Use a public telephone?

☐ Yes ☐ No

S23: Undertake first aid, including knowing how to resuscitate someone?

☐ Yes ☐ No

S24: Apply for a driver's licence?

☐ Yes ☐ No

S25: Apply for a scholarship or bursary for further education?

☐ Yes ☐ No

S26: Make an appointment with a doctor or dentist?

☐ Yes ☐ No

S27: Look for a job?

☐ Yes ☐ No

S28: Fill in an application for a job?

☐ Yes ☐ No

S29: Write a resume for a job?

☐ Yes ☐ No

S30: Prepare for a job interview?

☐ Yes ☐ No

S31: Budget within the money you have?

☐ Yes ☐ No

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S16

S17

S18

S19

S20

S21

S22

S23

S24

S25

S26

S27

S28

S29

S30

S31

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

S32: Pay bills?

☐ Yes ☐ No

S33: Open a bank account?

☐ Yes ☐ No

S34: Obtain information regarding your rights and responsibilities as a tenant?

☐ Yes ☐ No

S35: File a tax return?

☐ Yes ☐ No

S36: Contact a landlord?

☐ Yes ☐ No

S37: Get legal advice?

☐ Yes ☐ No

S38: Apply for a social insurance number?

☐ Yes ☐ No

S39: Apply for day care subsidies?

☐ Yes ☐ No

S40: Apply for a passport?

☐ Yes ☐ No

Do you know:

S41: Where to go for information about social assistance?

☐ Yes ☐ No

S42: Where to go for contraceptive advice, help, or supplies?

☐ Yes ☐ No

S43: Where your birth certificate is kept?

☐ Yes ☐ No

S44: Where your Ontario medical care card (OHIP) is kept?

☐ Yes ☐ No

S45: Where you plan to live when you leave the care of the child welfare system? **(Mark one only.)**

☐ With a parent or guardian
☐ With another relative
☐ With current foster parents (or other adult caregivers)
☐ In rental accommodation shared with other young people, without supervision
☐ In rental accomodation by yourself, without supervision
☐ No plans made yet
☐ Other _____ Specify

S32 ☐

S33 ☐

S34 ☐

S35 ☐

S36 ☐

S37 ☐

S38 ☐

S39 ☐

S40 ☐

S41 ☐

S42 ☐

S43 ☐

S44 ☐

S45 ☐

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

S46: Are you currently following a formal daily living program that teaches independent living skills?

☐ Yes ☐ No

S47: Are you receiving all necessary assistance to learn independent living skills?

☐ Yes ☐ No

ATTAINMENT OF SELF-CARE OBJECTIVES OF THE CHILD WELFARE SYSTEM:

S48: Objective 1: The youth can function independently at a level appropriate to his/her age and ability:

☐ Competent to care for self independently ☐ Learning to care for self independently ☐ Not competent

Note to the CAS protection worker :
If anyone disagrees with these answers to the Self-care skills objectives, please note the details on the opposite page.

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S46 ☐

S47 ☐

S48 ☐

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

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CONCLUDING SECTION: WORKING TOGETHER AS A TEAM TO IMPLEMENT LOOKING AFTER CHILDREN

In the Looking After Children philosophy, the people who have collaborated in completing this Assessment and Action Record, namely, the youth in care, the foster parent (or other adult caregiver), and the CAS protection worker, are intended to form a team that works together in the best interests of the youth. Please indicate how accurate each of the following statements is as a description of your team's success to date in implementing key priorities and tasks from Looking After Children. The answer you provide to each item should reflect, as much as possible, agreement (consensus) among the people involved. If you cannot agree about a particular statement, mark "Uncertain."

In our work together as a team to date, we (the youth in care, foster parent or other adult caregiver, and CAS protection worker) have been successful in accomplishing the following priorities and tasks from Looking After Children:

T1: Keeping the needs of the youth ahead of those of the foster parent and the CAS protection worker.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T2: Providing a quality of parenting equal to that of other parents who have adequate resources.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T3: Filling out the Assessment and Action Record as carefully and completely as possible.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T4: Identifying clearly the needs of the youth in the Plan of Care.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T5: Implementing the objectives identified in the Plan of Care.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T6: Treating each other as full partners.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T7: Reaching out and cooperating with others who are involved in the youth's life (e.g., birth or adoptive parents, teachers, doctors).

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T8: Taking the youth's point of view into account.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T9: Planning according to the individualized needs of the youth.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T10: Providing opportunities to the youth to stay in touch with his/her birth family (unless there are specific reasons for not doing this).

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T11: Providing opportunities to the youth to stay in touch with the cultural traditions of his/her birth family.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T12: Promoting positive outcomes for children in care, rather than just preventing harm.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

T1 ☐

T2 ☐

T3 ☐

T4 ☐

T5 ☐

T6 ☐

T7 ☐

T8 ☐

T9 ☐

T10 ☐

T11 ☐

T12 ☐

Partnership is built into Looking After Children: Good Parenting, Good Outcomes.

Effective partnerships can be built between people of unequal power, provided that the relationship acknowledges and clarifies this inequality.

Partnership requires:

> Listening to users and carers

>Anti-discriminatory practices

>Agreements and recording of progress

>Providing sufficient information

>Honesty and openness

>Genuine participation

T13: Aiming at outcome targets for the youth in care that are on the same level as those for youths of a similar age in the general population.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T14: Setting goals for the youth in care at the same level as for youths of the same age in the general population, even while recognizing that youth in care may have needs that are more difficult to meet.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T15: Focusing on the everyday experiences and actions needed by the youth now to succeed later in adult life.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T16: Collaborating in a youth-centred, developmental approach rather than being governed by bureaucratic red-tape.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T17: Taking account of the perspectives of all those involved, paying particular attention to the wishes and feelings of the youth in care.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T18: Improving the youth's health and educational status.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T19: Helping this youth to develop his/her potential to a maximum rather than a minimum level.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T20: Collaborating on ambitious but achievable objectives in all areas of the youth's development.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T21: Making clear in our action plans who is responsible for doing what and by when.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T22: Believing that our work together can bring about positive change even in less than ideal situations.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T23: Promoting continuity and preventing disruptions and multiple placements for the youth.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T24: Focusing on the everyday goals of parenting.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T25: Focusing on the successes of the youth, not just on his/her problems.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

Thank you for your participation!

Q5. How many interview/sessions did it take to complete this AAR (including the Backgroud Information section)?

☐ 1 session ☐ 2 sessions ☐ 3 sessions ☐ 4 or more sessions

Q6. How long did it take to complete this AAR (including the Background Information section)?

☐ hours and ☐☐ minutes

9599

T13

T14

T15

T16

T17

T18

T19

T20

T21

T22

T23

T24

T25

The space below allows the CAS protection worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

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This second Canadian adaptation (February, 2001) was prepared by Robert Flynn and Hayat Ghazal, in consultation with Daniel Moore (Grey Children's Aid Society), Sandy Moshenko and Liane Westlake (Ontario Association of Children's Aid Societies), Beverly Burns, Francine Groulx, and Raymond Lemay (Children's Aid Society of Prescott-Russell), and Wendy James and Peter Dudding (Child Welfare League of Canada). Financial support was provided by the Social Sciences and Humanities Research Council of Canada and the Ministry of Community and Social Services of Ontario. Formatting in Teleform was done by Andreas Reichert.

Looking After Children in Ontario Project

Principal Investigator:	Robert Flynn, University of Ottawa
Co-investigators & Collaborators:	Tim Aubry, Marie Drolet, and Doug Angus, University of Ottawa Peter Dudding, Child Welfare League of Canada Sandy Moshenko, Ontario Association of Children's Aid Societies Raymond Lemay, Children's Aid Society of Prescott-Russell
Project Coordinators:	Hayat Ghazal Liane Westlake

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APPENDIX B

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LOOKING AFTER CHILDREN

Background Information & Assessment and Action Record (Second Canadian Adaptation) Ages 10-14

Child/youth's name:

(**Note:** After photocopying this document please white out only the child/youth's name before sending the photocopy to Hayat Ghazal or Louise Legault at the Centre for Research on Community Services, University of Ottawa, 34 Stewart St., Ottawa, Ontario, K1N 6N5. For more information, please contact us at ghazha@hotmail.com or louisel@ottawa.ca.)

Child/youth's initials: Initials of first and last name

Child/youth's official agency file number:

Child/youth's gender: Male Female

Child/youth's date of birth: Month / Day / Year / /

Current placement: initials, address, & phone number of foster parent or other adult caregiver: Initials of first and last name

Address: apartment number, unit number, street

Town - City - Province/Territory

Postal Code

Current placement telephone number: ( ) -

This assessment was coordinated by:

Initials of child welfare worker: Initials of first and last name

Position:

Agency or Organization:

Approved by:

Initials of Supervisor: Initials of first and last name

Date: / / Month / Day / Year

Date begun: / / Month / Day / Year

Date completed: / / Month / Day / Year

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INTRODUCTION

This document is in a format that allows it to be read by a computer scanner, for rapid processing. The purpose of the **Assessment and Action Record (AAR)** is to assess a child or youth'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 **self-care skills**.

It is to be completed by the child welfare worker in an interview in which the child/youth in care and the foster parent (or other adult caregiver) who knows him/her best both participate. Some questions are addressed to the child/youth in care, others to the foster parent (or other adult caregiver), and yet others to the child welfare worker.

BACKGROUND INFORMATION

The purpose of this background information section is to gather basic socio-demographic information on three key persons in the Looking After Children approach: the child/youth in care, the child welfare worker responsible for the child/youth in care, and the foster parent (or other adult caregiver, such as a group-home staff member) who knows the child/youth best.

Notes to the child welfare worker:

- > *In many cases, much of this background information section can probably be completed by you before the interview with the child/youth in care and his/her foster parent (or other adult caregiver).*
- > *For each item, please put only an **X** (or, as required, **a number**) in the appropriate box or boxes, so that the computer will be able to scan the questionnaire properly. Please do not put a check mark or any mark other than an **X** (or a number) in the boxes.*
- > *The symbol of three dots in a row [...] always refers to the child/youth on whom the AAR is being completed.*
- > *At the beginning of the interview, please give an AAR binder to the child/youth and another one to his/her foster parent (or other adult caregiver). This will allow them to follow along easily and permit the interview to proceed smoothly and quickly. Only your copy of the AAR is to be filled out.*

The present section is to be answered by the **CHILD WELFARE WORKER**, with assistance, as needed, from the child/youth in care and his/her foster parent (or other adult caregiver).

1. BACKGROUND INFORMATION ON THE CHILD/YOUTH IN CARE ON WHOM THE AAR IS TO BE COMPLETED

BG1: What is ...'s official case file number?

BG2: What is ...'s gender?

☐ Male ☐ Female

BG3: What is ...'s date of birth?

		/			/					Month / Day / Year

BG4: What is ...'s current age?

		Years			Months

BG5: What is ...'s current status as a client of the child welfare agency or organization?

☐ Voluntary, temporary care agreement

☐ Voluntary, permanent care agreement

☐ Court-ordered, temporary wardship/guardianship/custody

☐ Court-ordered, permanent wardship/guardianship/custody

☐ Other **Specify:**

BG6: How old was ... when he/she was first placed in out-of-home care for the very first time (at this or another child welfare agency or organization)?

		Years			Months

BG7: PRIMARY REASON FOR CURRENT ADMISSION TO SERVICE: Which of the following categories describes the primary reason why ... came into care on the most recent occasion? **(Mark one only.)**

- ☐ **Physical/sexual harm by commission** (i.e., the child/youth has been or is at risk of being physically or sexually harmed as a result of an act or action by a caregiver)
- ☐ **Harm by omission** (i.e., the child or youth has been or is at risk of being harmed as a result of the caregiver's failure to provide adequate care for him/her)
- ☐ **Emotional harm** (i.e., the child/youth has been or is at risk of being emotionally harmed as a result of specific behaviours of the caregiver towards him/her)
- ☐ **Abandonment/separation** (i.e., the child has been abandoned or is at risk of being separated from the family as a result of intentional or unintentional actions of the caregiver)
- ☐ **Caregiver capacity** (i.e., although no harm has yet come to the child, the caregiver's characteristics indicate that without intervention, the child would be at risk in one of the previous categories)
- ☐ **Extended care & maintenance** (i.e., requested by and granted to a former permanent ward)
- ☐ **Other Specify:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

BG8: CURRENT PLACEMENT. Which of the following best describes ...'s current placement? **(Mark one only.)**

- ☐ Foster home operated by child welfare organization
- ☐ Kinship care
- ☐ Group home operated by child welfare organization
- ☐ Foster home - outside purchased care
- ☐ Group home - outside purchased care
- ☐ Children's mental health residential facility
- ☐ Regular hospital (short-term)
- ☐ Psychiatric facility
- ☐ Young offenders facility
- ☐ With birth parent(s)
- ☐ Adoption probation
- ☐ With relatives (not in foster care)
- ☐ Independent living
- ☐ Extended care & maintenance
- ☐ Other

☐☐☐☐☐☐☐☐☐☐☐☐ **Specify:**

BG9: If ... is in a foster home (with or without relatives): What is the designation of this foster care placement?

- ☐ Provisional foster care (used for a specific child in care; usually the home of a relative, friend, or neighbour; may or may not evolve into a regular foster home.)
- ☐ Regular foster care
- ☐ Specialized foster care (mainly for children with special needs.)
- ☐ Treatment foster care (therapeutic; for children with especially challenging behaviour.)
- ☐ Other **Specify** ☐☐☐☐☐☐☐☐☐☐☐☐

BG10: If ... is in a foster home, for how many years in total have the foster parents been providing foster care to children/youth (i.e., including but not limited to ...)?

☐☐ **Years**

BG11: How long has ... been in his/her current placement?

☐☐ **Years** ☐☐ **Months**

BG12: What is the type of dwelling that best describes ...'s current placement? **(Mark one only.)**

- ☐ Single detached house
- ☐ Semi-detached or double (side-by-side)
- ☐ Mobile home
- ☐ Garden house, town-house or row house
- ☐ Duplex (one above the other)
- ☐ Institution
- ☐ Low-rise apartment (less than 5 stories)
- ☐ High-rise apartment (5 or more stories)
- ☐ Other

BG13: What is the size of the area of residence in which this dwelling is situated?

- ☐ Urban, population 500,000 or over
- ☐ Urban, population 100,000 to 499,000
- ☐ Urban, population 30,000 to 99,999
- ☐ Urban, population < 30,000
- ☐ Rural area

BG14: How would you rate the general condition of most of the buildings on the block or within 100 yards of the foster parent's (or other adult caregiver's) house?

- ☐ Well kept, with good repair and exterior surface
- ☐ Fair condition
- ☐ Poor condition, with peeling paint and need of repair
- ☐ Badly deteriorated

BG15: Is this dwelling owned by a member of this household (even if it is being paid for)?

☐ Yes ☐ No

BG16: How many bedrooms are there in this dwelling?

☐☐ **Number of bedrooms**

BG17: Does ... have his/her own bedroom?

☐ Yes ☐ No

2. BACKGROUND INFORMATION ON THE CHILD/YOUTH'S CHILD WELFARE WORKER

BG18: Child welfare worker's project ID number **(assigned for record-keeping purposes only, please leave blank):**

☐☐☐☐☐☐☐☐☐

BG19: Child welfare worker's gender:

☐ Male ☐ Female

BG20: Child welfare worker's current age category:

☐ 20-29 years ☐ 30-39 years ☐ 40-49 years ☐ 50-59 years ☐ 60 years or older

BG21: Total length of time child welfare worker has worked with this youth, not counting interruptions:

☐☐ Years ☐☐ Months

BG22: Total length of time child welfare worker has worked in child welfare:

☐☐ Years ☐☐ Months

BG23: Total length of time child welfare worker has worked for this child welfare agency or organization:

☐☐ Years ☐☐ Months

BG24: Has the child welfare worker ever used the old or new AAR with this child/youth before?

- ☐ No (If no, go to question BG31.)
- ☐ Yes (If yes, the child welfare worker is asked to answer questions BG25 to BG30, to indicate how often he/she has used the AAR in various ways with this child/youth during the past 12 months).

During the past 12 months, have you (the child welfare worker) used the information contained in the AAR:

BG25: To produce or revise this child/youth's plan of care?

☐ Never ☐ Once ☐ Twice ☐ Three times ☐ More than three times

BG26: To work directly with this child/youth (e.g., on meeting his/her needs, solving problems, managing crises)?

☐ Never ☐ Once ☐ Twice ☐ Three times ☐ More than three times

BG27: To collaborate with this child/youth's foster parent(s) or other adult caregiver(s)?

☐ Never ☐ Once ☐ Twice ☐ Three times ☐ More than three times

BG28: To discuss this child/youth's needs or situation with your supervisor?

☐ Never ☐ Once ☐ Twice ☐ Three times ☐ More than three times

BG29: To monitor this child/youth's progress?

☐ Never ☐ Once ☐ Twice ☐ Three times ☐ More than three times

BG30: To report on this child/youth's progress to a third party (e.g., a judge, lawyer, teacher, health professional)?

☐ Never ☐ Once ☐ Twice ☐ Three times ☐ More than three times

BG31: HIGHEST LEVEL OF EDUCATION: Highest degree, certificate, or diploma the child welfare worker has ever attained in any field:

☐ No postsecondary degree, certificate or diploma
☐ Trades certificate - Vocational school - Apprenticeship training
☐ Non-university certificate or diploma from a community college, CEGEP, school of nursing, etc.
☐ University certificate or diploma below bachelor's level
☐ Bachelor's degree
☐ University certificate or diploma above bachelor's level
☐ Master's degree
☐ Doctoral degree

BG32: HIGHEST LEVEL OF EDUCATION IN SOCIAL WORK OR CHILD & YOUTH CARE: Was the child welfare worker's highest degree, certificate, or diploma (i.e., the one identified in BG31) in the specific field of **(Mark one only)**:

☐ Social work? ☐ Other?
☐ Child & youth in care?
☐ Psychoeducation? **Specify:**

BG33: CURRENT EDUCATIONAL ENROLMENT: Is the child welfare worker currently enrolled in a:

☐ Bachelor's program (other than BSW)
☐ BSW program
☐ Master's program (other than MSW)
☐ MSW program
☐ PhD program (other than in social work)
☐ DSW or PhD program in social work
☐ None

BG34: LANGUAGE: Language(s) in which the child welfare worker can conduct a conversation **(Mark all that apply)**:

☐ English ☐ French ☐ First Nations language ☐ Other **Specify**

BG35: ETHNICITY: To which ethnic or cultural group(s) did the child welfare worker's ancestors belong? (For example: French, British, Chinese; **mark all that apply.**)

☐ Canadian
☐ French
☐ English
☐ North American Indian
☐ Inuit / Eskimo
☐ Métis
☐ German
☐ Irish
☐ Scottish
☐ Italian
☐ Jewish
☐ Ukranian
☐ Dutch (Netherlands)
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Polish
☐ Latin American
☐ Portugese
☐ Black (e.g., African, Haitian, Jamaican, Somali)
☐ South Asian (e.g., East Indian, Pakistani, Punjabi, Sri Lankan)
☐ South East Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese)
☐ Arab/West Asian (e.g., Armenian, Egyptian, Lebanese, Moroccan)
☐ Other

Specify

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3. BACKGROUND INFORMATION ON THE CHILD/YOUTH'S FOSTER PARENT (OR OTHER ADULT CAREGIVER)

*Note to the child welfare worker: Here, the terms "**foster parent**" or "**other adult caregiver**" refer to the foster parent or other adult caregiver who is considered the most knowledgeable about the child/youth, usually because he/she is the caregiver most actively involved in the child/youth's care. He/she is to participate in the AAR interview. (If two or more foster parent or other adult caregivers know the child equally well and are equally involved in his/her care, then they are asked to nominate one person as the foster parent or other adult caregiver who will take part in the AAR interview.)*

BG36: Foster parent's (or other adult caregiver's) project ID number **(assigned for record-keeping purposes only; please leave blank):**

BG37: Is the current address of the foster parent (or other adult caregiver) the same as that of the child/youth's placement (on cover page)?

☐ Yes **(If yes, go to question BG39)** ☐ No **(If no, please specify current address and telephone number)**

Address: apartment number, unit number, street

Town - City - Province/Territory

Postal Code

BG38: Foster parent's (or other adult caregiver's) telephone number:

( ) -

BG39: Foster parent's (or other adult caregiver's) e-mail address (if he/she has one)

@

BG40: If current placement is foster home or kinship care, how long has the foster parent (or kinship parent) lived at his/her current address?

Years **Months**

BG41: Language of AAR interview

☐ English ☐ French ☐ Other **Specify**

BG42: HOUSEHOLD INCOME: If current placement is foster home or kinship care, what is the foster parent's (or kinship parent's) best estimate of the total income, before taxes and deductions, of all household members from all sources in the past 12 months?

- ☐ Less than $10,000
- ☐ $10,000-$14,999
- ☐ $15,000-$19,999
- ☐ $20,000-$29,999
- ☐ $30,000-$39,999
- ☐ $40,000-$49,999
- ☐ $50,000-$59,999
- ☐ $60,000-$79,999
- ☐ $80,000-$99,999
- ☐ Over $100,000

BG43: LANGUAGE: What language(s) are spoken most often in the foster parent's (or other adult caregiver's) home? **(Mark all that apply.)**

☐ English ☐ French ☐ First Nations language ☐ Other

Specify

BG44: ETHNICITY: To which ethnic or cultural group(s) did the foster parent's (or other adult caregiver's) ancestors belong? (For example: French, British, Chinese) **(Mark all that apply.)**

- ☐ Canadian
- ☐ French
- ☐ English
- ☐ North American Indian
- ☐ Inuit / Eskimo
- ☐ Métis
- ☐ German
- ☐ Irish
- ☐ Scottish
- ☐ Italian
- ☐ Jewish
- ☐ Ukranian
- ☐ Dutch (Netherlands)
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Polish
- ☐ Latin American
- ☐ Portugese
- ☐ Black (e.g., African, Haitian, Jamaican, Somali)
- ☐ South Asian (e.g., East Indian, Pakistani, Punjabi, Sri Lankan)
- ☐ South East Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese)
- ☐ Arab/West Asian (e.g., Armenian, Egyptian, Lebanese, Moroccan)
- ☐ Other

☐☐☐☐☐☐☐☐☐☐☐ **Specify**

BG45: RELIGION: What, if any, is the foster parent's (or other adult caregiver's) religion? **(Mark one only.)**

- ☐ No religion
- ☐ First Nations/aboriginal religion
- ☐ Roman Catholic
- ☐ United Church
- ☐ Anglican
- ☐ Presbyterian
- ☐ Lutheran
- ☐ Baptist
- ☐ Eastern Orthodox
- ☐ Jewish
- ☐ Islam (Muslim)
- ☐ Buddhist
- ☐ Hindu
- ☐ Sikh
- ☐ Jehovah's Witnesses
- ☐ Other

☐☐☐☐☐☐☐☐☐☐☐☐ **Specify**

BG46: Other than on special occasions (such as weddings or funerals), how often did the foster parent (or other adult caregiver) attend religious services or meetings in the past 12 months?

- ☐ At least once a week
- ☐ At least once a month
- ☐ At least 3 or 4 times a year
- ☐ At least once a year
- ☐ Not at all

BG47: HEALTH: In general, would the foster parent (or other adult caregiver) say that his/her own health is:

☐ Excellent? ☐ Very good? ☐ Good? ☐ Fair? ☐ Poor?

BG48: DISABILITY: Because of a long-term physical or mental condition (lasting or expected to last 6 months or more) or a health problem, is the foster parent (or other adult caregiver) limited in the kind or amount of activity he/she can do at home, in caring for children, or in leisure activities?

☐ Yes ☐ No

BG49: SMOKING: At present, does anyone in the foster parent's (or other adult caregiver's) household smoke cigarettes inside the home?

☐ Daily ☐ Occasionally ☐ Not at all

BG50: PEOPLE WHO USUALLY LIVE IN THIS DWELLING (<u>besides</u> the child/youth in care): The child welfare worker is to ask the foster parent (or other adult caregiver) for the information needed to complete the following table. Please include up to 5 adults (defined here as persons aged 18 or older), including the foster parent (or other adult caregiver) himself/herself, and up to 5 children/youths (defined here as persons aged 17 or younger), <u>besides</u> the child/youth in care. Do not include the child/youth in care or write in people's names. In filling in each of the boxes in the last 4 columns, please select the appropriate number from the categories listed beneath the table. Thus, for **HIGHEST LEVEL OF EDUCATION EVER ATTAINED**, for example, write in "01" for "Grade school", "02" for "Some high school", etc.)

People usually living in dwelling	Sex	Age	Highest level of education ever attained	Occupation	Relationship to foster parent (or other adult caregiver)	Relationship to child/ youth in care
Foster parent or other adult caregiver 18+	☐ M ☐ F	Years			(Not Applicable)	
Adult 2 (18+)	☐ M ☐ F	Years				
Adult 3 (18+)	☐ M ☐ F	Years				
Adult 4 (18+)	☐ M ☐ F	Years				
Adult 5 (18+)	☐ M ☐ F	Years				
Child 1 (17-)	☐ M ☐ F	Years				
Child 2 (17-)	☐ M ☐ F	Years				
Child 3 (17-)	☐ M ☐ F	Years				
Child 4 (17-)	☐ M ☐ F	Years				
Child 5 (17-)	☐ M ☐ F	Years				

HIGHEST LEVEL OF EDUCATION EVER ATTAINED: **01** Grade school **02** Some high school **03** High school graduation **04** Some trade, technical or vocational schoool or business college **05** Some community college, CEGEP or nursing school **06** Some university **07** Diploma or certificate from trade, technical or vocational school or business college **08** Diploma or certificate from community college, CEGEP, nursing school or university **09** Bachelor or undergraduate degree or teacher's college (e.g., BA, BSc, Bed, BSW) **10** Master's (e.g., MA, Msc, Med, MSW) **11** Degree in medicine (MD), dentistry (DDS, DMD), Veterinary medicine (DVM), Optometry (OD), or law (LLB) **12** Earned doctorate (e.g., PhD, DSc, DEd, DSW) **13** Other

OCCUPATION: Main current activity: **01** Caring for family, including foster child/youth **02** Working for pay or profit **03** Caring for family, including foster child/youth, and working for pay or profit **04** Going to school **05** Recovering from illness or being on disability **06** Looking for work **07** Retired **08** Other

RELATIONSHIP TO FOSTER PARENT (or other adult caregiver):
For adults: **01** Husband or wife **02** Common-law partner **03** Same-sex partner **04** Mother or father **05** Sister or brother **06** Other related **07** Unrelated
For children: **08** Birth child **09** Step child **10** Adopted child **11** Other

RELATIONSHIP TO CHILD/YOUTH IN CARE:
For adults: **01** Foster father or mother **02** Grandfather or grandmother **03** Uncle or aunt **04** Other related **05** Unrelated caregiver
For children: **06** Biological brother or sister **07** Step brother or sister **08** Adopted brother or sister **09** Foster brother or sister **10** Other

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BG51: Total number of adults (aged 18 or older) who usually live in this dwelling:

☐☐ **Total number**

BG52: Total number of these adults who are actively involved in caring for child/youth in care:

☐☐ **Total number**

BG53: Total number of children or youths (aged 17 or younger) who usually live in this dwelling, including the child/youth in care:

☐☐ **Total number**

BG54: Total number of other foster children/youths besides child/youth in care who usually live in this dwelling:

☐☐ **Total number**

BG55: Total number of siblings of child/youth in care who usually live in this dwelling with him/her:

☐☐ **Total number**

4. BACKGROUND INFORMATION ON LAST YEAR'S ASSESSMENT (IF APPLICABLE) OF THIS CHILD/YOUTH WITH THIS REVISED VERSION OF THE ASSESSMENT AND ACTION RECORD (AAR).

BG56: Was the child/youth assessed with this revised AAR a year or so ago?

☐ No (If no, please go to next page.)

☐ Yes (If yes, the **child welfare worker** is to answer questions BG57 to BG60.)

BG57: Was the child/youth residing in the same placement last year as he/she is in this year?

☐ Yes ☐ No

BG58: Did the child/youth have the same child welfare worker last year as he/she has this year?

☐ Yes ☐ No

BG59: Did the child/youth have the same foster parent or other adult cargiver last year as he/she has this year?

☐ Yes ☐ No

BG60: Is it the same foster parent or other adult caregiver who was the main respondent in last year's and this year's AAR interviews?

☐ Yes ☐ No

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ASSESSMENT AND ACTION RECORD (AAR)

As was mentioned earlier, the AAR is designed to help in the assessment of children and youths' progress, monitor the quality of care they are receiving, and make plans for improvements across seven developmental dimensions: **health, education, identity, family and social relationships, social presentation, emotional and behavioural development**, and **self-care skills**.

Note to the child welfare worker: *Please give copies of the AAR to both the child/youth and the foster parent (or other adult caregiver), so that they may follow along easily. This will help the interview go more smoothly and efficiently. Also, in answering each item, please put only an "**X**" (or, when required, **a number**) in the appropriate box or boxes, so that the computer will be able to scan and read the questionnaire properly. Please do not put a check mark or any mark other than an "**X**" in the boxes. Also, in the left-hand column of the right-hand page, please mark an "**X**" in the box for a given item if you judge that further action needs to be taken and included in the child/youth's individualized Plan of Care for the coming year.*

Q1: Who are taking part in this AAR interview? **(Mark as many as apply.)**

- ☐ Child/youth on whom AAR is being completed
- ☐ Child welfare worker of child/youth
- ☐ One foster parent
- ☐ Two foster parents
- ☐ One adult caregiver other than a foster parent
- ☐ Two adult caregivers other than a foster parent
- ☐ Other **Specify:** ☐☐☐☐☐☐☐☐☐☐☐☐

Q2: The AAR is intended to be completed in a face-to-face interview, unless for some reason this is impossible. How is this AAR interview being completed? **(Mark as many as apply.)**

- ☐ In a face-to-face interview conducted by the child welfare worker
- ☐ In a telephone interview conducted by the child welfare worker
- ☐ Through self-administration by the foster parent (or other adult caregiver)
- ☐ Other **Specify:** ☐☐☐☐☐☐☐☐☐☐☐☐

Q3: The language in which the AAR is written is:

☐ English ☐ French

Q4: The age-group of this AAR is the following:

- ☐ 15 years of age and over
- ☐ 10-14 years
- ☐ 5-9 years
- ☐ 3-4 years
- ☐ 1-2 years
- ☐ 0-12 months

Q5: The province/territory of the child's placement:

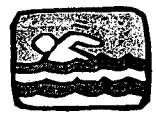
- ☐ Alberta
- ☐ British Columbia
- ☐ Manitoba
- ☐ New Brunswick
- ☐ Newfoundland and Labrador
- ☐ Northwest Territories
- ☐ Nova Scotia
- ☐ Nunavut
- ☐ Ontario
- ☐ Prince Edward Island
- ☐ Québec
- ☐ Saskatchewan
- ☐ Yukon

The right-hand pages are designed to allow the child welfare worker to prepare a first draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible).

These prompts are meant to help the child/youth, his/her child welfare worker, and his/her foster parent (or other adult caregiver) to answer the various questions posed during the AAR interview.

The Assessment and Action Record developmental dimensions:

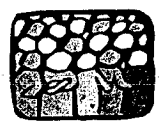
Health



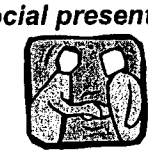
Education

Identity

Family and social relationships



Social presentation



Emotional and behavioural development

Self-care skills.

DEVELOPMENTAL DIMENSION 1: HEALTH

This dimension is about the health of the child/youth in care and the help he/she is getting to be and remain well. The questions in this section are designed to make sure that the child/youth 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 child/youth's health, such as diet, alcohol, drugs, and sex education.

Note to the child welfare worker: *Please mark an "**X**" in the box in the left-hand column of 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.*

This next section is to be answered by the **CHILD/YOUTH IN CARE**, with assistance, as needed, from the foster parent (or other adult caregiver) or the child welfare worker.

H1: GENERAL HEALTH: In general, would you say your health is:

☐ Excellent? ☐ Very good? ☐ Good? ☐ Fair? ☐ Poor?

H2: Over the past few months, how often have you been in good health?

☐ Almost all the time ☐ Often ☐ About half of the time ☐ Sometimes ☐ Almost never

H3: HEIGHT: What is your height in feet and inches or in metres and centimetres (without shoes on)?

☐ **Feet and** ☐☐ **Inches OR** ☐ **Metres and** ☐☐ **Centimetres**

H4: WEIGHT: What is your weight in pounds or kilograms?

☐☐☐ **Pounds OR** ☐☐☐ **Kilograms**

H5: PHYSICAL ACTIVITY LEVEL: In your opinion, how physically active are you compared to other children of the same age and sex?

☐ Much more ☐ Moderately more ☐ Equally ☐ Moderately less ☐ Much less

H6: MEDICAL EXAM: When did you last have a medical exam?

☐ Less than a year ago ☐ More than a year ago ☐ Never had one

H7: Has everything the doctor may have recommended been done?

☐ Yes ☐ Uncertain ☐ No

H8: DENTAL EXAM: When did you last visit a dentist?

☐ Less than a year ago ☐ More than a year ago ☐ Never

H9: Have all treatments the dentist may have recommended been carried out?

☐ Yes ☐ Uncertain ☐ No

The next set of questions (also to be answered by the **CHILD/YOUTH IN CARE**) asks about his/her day-to-day health. The questions are not about illnesses like colds that affect people for short periods of time. They are concerned with a person's usual abilities. You may feel that some of these questions do not apply to you, but it is important that we ask the same questions of everyone.

HUI-Q1: VISION: Are you usually able to see well enough to read ordinary newsprint without glasses or contact lenses?

☐ Yes **(Go to HUI-Q4)** ☐ No ☐ Don't know or refusal **(Go to question H10 on page 5)**

HUI-Q2: Are you usually able to see well enough to read ordinary newsprint with glasses or contact lenses?

☐ Yes **(Go to HUI-Q4)** ☐ No

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The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

H1

H2

H3

H4

H5

H6

H7

H8

H9

HUI-Q1

HUI-Q2

DIMENSION 1: HEALTH

This dimension is about the health of the child/youth in care and the help he/she is getting to be and remain well.

Interest in child health has grown enormously in the last decade. Health policy makers nationally and internationally increasingly recognize the importance of children's health and development for the future.

In Looking After Children, health is identified as a key dimension of children's lives and of parental care. Health is not seen as a stand-alone dimension, but rather as intertwined with and supporting all other dimensions of children's upbringing and development.

For children/youth in care, special attention needs to be given to the key parental tasks of safeguarding and promoting their health.

A major objective of Looking After Children is to help with the task of keeping children healthy when their care may be shared among a number of people.

HUI-Q3: Are you able to see at all?

☐ Yes ☐ No **(Go to HUI-Q6)** ☐ Don't know or refusal **(Go to HUI-Q6)**

HUI-Q4: Are you able to see well enough to recognize a friend on the other side of the street without glasses or contact lenses?

☐ Yes **(Go to HUI-Q6)** ☐ No ☐ Don't know or refusal **(Go to HUI-Q6)**

HUI-Q5: Are you usually able to see well enough to recognize a friend on the other side of the street with glasses or contact lenses?

☐ Yes ☐ No

HUI-Q6: HEARING: Are you usually able to hear what is said in a group conversation with at least 3 other people without a hearing aid?

☐ Yes **(Go to HUI-Q10)** ☐ No ☐ Don't know or refusal **(Go to HUI-Q10)**

HUI-Q7: Are you usually able to hear what is said in a group conversation with at least 3 other people with a hearing aid?

☐ Yes **(Go to HUI-Q8)** ☐ No

HUI-Q7A: Are you able to hear at all?

☐ Yes ☐ No **(Go to HUI-Q10)** ☐ Don't know or refusal **(Go to HUI-Q10)**

HUI-Q8: Are you usually able to hear what is said in a conversation with one other person in a quiet room without a hearing aid?

☐ Yes **(Go to HUI-Q10)** ☐ No ☐ Refusal **(Go to HUI-Q10)**

HUI-Q9: Are you usually able to hear what is said in a conversation with one other person in a quiet room with a hearing aid?

☐ Yes ☐ No

HUI-Q10: SPEECH: Are you usually able to be understood completely when speaking with strangers in your own language?

☐ Yes **(Go to HUI-Q14)** ☐ No ☐ Refusal **(Go to HUI-Q14)**

HUI-Q11: Are you able to be understood partially when speaking with strangers?

☐ Yes ☐ No

HUI-Q12: Are you able to be understood completely when speaking with those who know you well?

☐ Yes **(Go to HUI-Q14)** ☐ No ☐ Refusal **(Go to HUI-Q14)**

HUI-Q13: Are you able to be understood partially when speaking with those who know you well?

☐ Yes ☐ No

HUI-Q14: GETTING AROUND: Are you usually able to walk around the neighbourhood without difficulty and without mechanical support such as braces, a cane or crutches?

☐ Yes **(Go to HUI-Q21)** ☐ No ☐ Don't know or refusal **(Go to HUI-Q21)**

HUI-Q15: Are you able to walk at all?

☐ Yes ☐ No **(Go to HUI-Q18)** ☐ Don't know or refusal **(Go to HUI-Q18)**

HUI-Q16: Do you require mechanical support such as braces, a cane or crutches to be able to walk around the neighbourhood?

☐ Yes ☐ No

HUI-Q17: Do you require the help of another person to be able to walk?

☐ Yes ☐ No

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HUI-Q3

HUI-Q4

HUI-Q5

HUI-Q6

HUI-Q7

HUI-Q7A

HUI-Q8

HUI-Q9

HUI-Q10

HUI-Q11

HUI-Q12

HUI-Q13

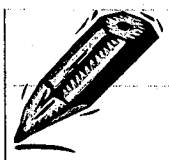
HUI-Q14

HUI-Q15

HUI-Q16

HUI-Q17

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).



The Health Utility Index (HUI3) is a generic measure of health-related quality of life. It was originally developed at McMaster University and is now used extensively in Canada and in 25 other countries around the world. With most children or adolescents, the HUI takes only about 2 to 4 minutes to complete.

The HUI3 provides a description of an individual's overall functional health, based on eight attributes: vision, hearing, speech, mobility (ability to get around), dexterity (use of hands and fingers), cognition (memory and thinking), emotion (feelings), and pain and discomfort.

If you have difficulty reading what is written on the blackboard at school or if you get headaches when you are watching television, it is a good idea to get your eyes tested, even if you have never needed glasses.

If you do wear glasses or contact lenses, your eyes should be tested by an eye specialist every 6 to 12 months.

HUI-Q18: Do you require a wheelchair to get around?

☐ Yes ☐ No **(Go to HUI-Q21)** ☐ Don't know or refusal **(Go to HUI-Q21)**

HUI-Q19: How often do you use a wheelchair? **(Read list. Mark one only.)**

☐ Always ☐ Often ☐ Sometimes ☐ Never

HUI-Q20: Do you need the help of another person to get around in the wheelchair?

☐ Yes ☐ No

HUI-Q21: HANDS AND FINGERS: Are you usually able to grasp and handle small objects such as a pencil or scissors?

☐ Yes **(Go to HUI-Q25)** ☐ No ☐ Don't know or refusal **(Go to HUI-Q25)**

HUI-Q22: Do you require the help of another person because of limitations in the use of hands or fingers?

☐ Yes ☐ No **(Go to HUI-Q24)** ☐ Don't know or refusal **(Go to HUI-Q24)**

HUI-Q23: Do you require the help of another person with: **(Read list. Mark one only)**

☐ Some tasks? ☐ Most tasks? ☐ Almost all tasks? ☐ All tasks?

HUI-Q24: Do you require special equipment, for example, devices to assist in dressing, because of limitations in the use of hands or fingers?

☐ Yes ☐ No

HUI-Q25: FEELINGS: Would you describe yourself as being usually: **(Read list. Mark one only)**

☐ Happy and interested in life?
☐ Somewhat happy?
☐ Somewhat unhappy?
☐ Unhappy with little interest in life?
☐ So unhappy that life is not worthwhile?

HUI-Q26: MEMORY: How would you describe your usual ability to remember things? **(Read list. Mark one only.)**

☐ Able to remember most things?
☐ Somewhat forgetful?
☐ Very forgetful?
☐ Unable to remember anything at all?

HUI-Q27: THINKING: How would you describe your usual ability to think and solve day-to-day problems? **(Read list. Mark one only.)**

☐ Able to think clearly and solve problems
☐ Having a little difficulty
☐ Having some difficulty
☐ Having a great deal of difficulty
☐ Unable to think or solve problems

HUI-Q28: PAIN AND DISCOMFORT: Are you usually free of pain or discomfort?

☐ Yes **(Go to question H10, p. 5)** ☐ No ☐ Don't know or refusal **(Go to H10, p. 5)**

HUI-Q29: How would you describe the usual intensity of your pain or discomfort? **(Read list. Mark one only.)**

☐ Mild ☐ Moderate ☐ Severe

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HUI-Q18

HUI-Q19

HUI-Q20

HUI-Q21

HUI-Q22

HUI-Q23

HUI-Q24

HUI-Q25

HUI-Q26

HUI-Q27

HUI-Q28

HUI-Q29

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

The Looking After Children approach and the instrument that operationalizes it, the Assessment and Action Record, are designed to improve the quality and effectiveness of the substitute parenting provided under the supervision of local child welfare agencies or organizations to high-risk children and youth.

The intent of the Assessment and Action Record is to pinpoint children and youths' individual needs, enhance the timeliness of the services they receive, and optimize their developmental outcomes.

Corporate parenting is a term which recognizes the accountability of public agencies for carrying out responsibilities towards a child or youth in care.

Children/youth in care are a high risk group for many kinds of health threatening behaviours, such as smoking and drinking, sexually transmitted infections including HIV/AIDS, and, for girls, pregnancy at an early age. A methodical approach by corporate parents to ensure the provision of health education, such as the Looking After Children system provides, is critical.

HUI-Q30: How many activities does your pain or discomfort prevent? **(Read list. Mark one only.)**

☐ None ☐ A few ☐ Some ☐ Most

The next section is to be answered by the **FOSTER PARENT** (or other adult caregiver), with assistance, as needed, from the child/youth in care or the child welfare worker.

H10: LONG-TERM CONDITIONS: In the following questions "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? **(Read the list and mark all that apply.)**

☐ None
☐ Food or digestive allergies
☐ Respiratory allergies such as hay fever
☐ Any other allergies
☐ Asthma
☐ Bronchitis
☐ Heart condition or disease
☐ Epilepsy
☐ Cerebral palsy
☐ Kidney condition or disease
☐ Mental handicap
☐ Learning disability
☐ Attention deficit disorder
☐ Emotional, psychological or nervous difficulties
☐ Any other long-term condition

Specify:

H11: DISABILITY: Does ... have any long-term conditions or health problems which prevent or limit his/her participation in school, at play, or in any other activity for a child/youth of his/her age?

☐ Yes ☐ No

H12: SPECIAL HELP OR EQUIPMENT: Does ... have all the special help or equipment he/she may need for any long-term conditions or disabilities he/she may have?

☐ Yes ☐ No ☐ No special help or equipment needed

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.

H13: INJURIES: In the past 12 months, was ... injured?

☐ Yes ☐ No **(Go to question H19)**

H14: How many times was he/she injured? (Write in number of times.)

☐☐ **Times**

H15: For the most serious injury, what type of injury did he/she have? **(Do not read list. Mark one only.)**

☐ Broken or fractured bones
☐ Burn or scald
☐ Dislocation
☐ Sprain or strain
☐ Cut, scrape or bruise
☐ Dental injury
☐ Concussion
☐ Poisoning by substance or liquid
☐ Internal injury
☐ Multiple injuries
☐ Other

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HUI-Q30 ☐

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

H10 ☐

H11 ☐

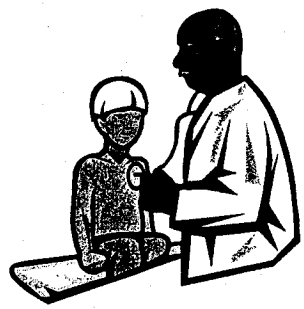
H12 ☐

H13 ☐

H14 ☐

H15 ☐

Your doctor will need to know about any problems or treatment you are having. Your child welfare worker should check that illnesses, accidents, injuries, hospital stays, and operations have been noted on your Plan of Care.



"Injuries" refers to broken bones, bad cuts or burns, head injuries, poisoning, or a sprained ankle, that were serious enough to require medical attention by a doctor, nurse, or dentist.

H16: What part of ...'s body was injured? (**Do not read list. Mark one only.**)

- ☐ Eyes
- ☐ Face or scalp (excluding eyes)
- ☐ Head or neck (excluding eyes and face or scalp)
- ☐ Arms or hands
- ☐ Legs or feet
- ☐ Back or spine
- ☐ Trunk (excluding back or spine; include chest, internal organs, etc.)
- ☐ Shoulder
- ☐ Hip
- ☐ Multiple sites

H17: For the most serious injury, what happened? For example, was the injury the result of a fall, motor vehicle accident, a physical assault, etc.? (**Do not read list. Mark one only.**)

- ☐ Motor vehicle collision - passenger
- ☐ Motor vehicle collision - pedestrian
- ☐ Motor vehicle collision - riding bicycle
- ☐ Other bicycle accident
- ☐ Fall (excluding bicycle or sports)
- ☐ Sports (excluding bicycle)
- ☐ Physical assault
- ☐ Scalded by hot liquids or food
- ☐ Accidental poisoning
- ☐ Self-inflicted poisoning
- ☐ Other intentionally self-inflicted injuries
- ☐ Natural/environmental factors (e.g., animal bite, sting)
- ☐ Fire/flames or resulting fumes
- ☐ Near drowning
- ☐ Other

Specify:

H18: Where did the injury happen (for example, at home, on the street, in a playground, at school, etc.)? (**Do not read list. Mark one only.**)

- ☐ Inside biological parent's own home/apartment
- ☐ Inside foster parent's (or other adult caregiver's) own home/apartment
- ☐ Outside biological parent's home, apartment, including yard, driveway, parking lot or in shared areas related to home such as apartment hallway or laundry room
- ☐ Outside foster parent's (or other adult caregiver's) home, apartment, including yard, driveway, parking lot or in shared areas related to home such as apartment hallway or laundry room
- ☐ In or around other private residence
- ☐ Inside school/daycare centre or on school/centre grounds
- ☐ At an indoor or outdoor sports facility (other than school)
- ☐ Other building used by general public
- ☐ On sidewalk/street/highway in foster parent's (or other adult caregiver's) neighbourhood
- ☐ On any other sidewalk/street/highway
- ☐ In a playground/park (other than school)
- ☐ Other

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H16

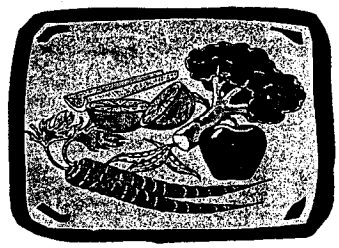
The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

Child welfare agencies or organizations should arrange regular medical examinations for all children and young people in their care. The purpose of the examination is to pick up health problems that can be treated and often cured while the child/youth is in care.

H17

H18

It is important that children in care have a diet that relates to their ethnic background and culture so that they continue to be familiar with the customs and daily practices of their birth family.



H19: HOSPITALIZATIONS: In the past 12 months, was ... ever an overnight patient in the hospital?

☐ Yes ☐ No **(Go to question H21)**

H20: For what reason?

☐ Respiratory illness or disease ☐ Gastrointestinal illness or disease ☐ Injuries ☐ Other

H21: IMMUNIZATIONS: Are all of ...'s immunizations up to date?

☐ Yes ☐ No

H22: DIET: Does ... have a special diet for health, weight control, religious, or cultural reasons?

☐ Yes ☐ No

H23: DIETARY ASSISTANCE: Is ... receiving all the help he/she requires to maintain a healthy daily diet, whether special or not?

☐ Yes ☐ No

The next section is to be answered by the **CHILD/YOUTH IN CARE**, with assistance, as needed, from the foster parent (or other adult caregiver) or the child welfare worker.

(Read aloud): Your answers to the following questions will help build a picture of your general health.

H24: BREAKFAST: During school weeks, how many days a week do you eat breakfast?

☐ Never ☐ 1 or 2 days a week ☐ 3 to 4 days a week ☐ Every school day

H25: WEIGHT: Which of the following are you trying to do?

☐ Lose weight ☐ Gain weight ☐ Stay the same weight ☐ I'm not trying to do anything about my weight

H26: CIGARETTES: How often do you smoke cigarettes, if at all?

☐ I have never smoked
☐ I only tried once or twice
☐ I do not smoke now
☐ A few times a year
☐ About once or twice a month
☐ About once or twice a week
☐ About 3-5 times a week
☐ Every day

H27: How many of your close friends smoke cigarettes?

☐ None ☐ A few ☐ Most ☐ All

H28: Are you getting all the help you need to quit smoking?

☐ Does not smoke - no help required ☐ Yes ☐ No

H29: ALCOHOL: If you drink alcohol, how often do you do so?

☐ I have never had a drink of alcohol
☐ I only tried once or twice
☐ I do not drink alcohol anymore
☐ A few times a year
☐ About once or twice a month
☐ About once or twice a week
☐ About 3-5 times a week
☐ Every day

H30: How many of your close friends drink alcohol?

☐ None ☐ A few ☐ Most ☐ All

H31: Are you getting all the help you need to quit drinking alcohol?

☐ Does not drink alcohol - no help required ☐ Yes ☐ No

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H19

H20

H21

H22

H23

H24

H25

H26

H27

H28

H29

H30

H31

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

There is provincial or territorial variation in the timing of the various immunizations required. If you have any questions about requirements in your jurisdiction, please contact your public health office.

Your child welfare worker should check that all immunizations have been noted on your Plan of Care. If there is no record of what you have had, it may be necessary for your doctor to check through your health records so that the information can be recorded by your child welfare agency or organization.

This is important because if you change doctors, it can take a while for health records to catch up and the information may be urgently needed.

Child/youth rights: You can use this as an opportunity to talk about any health problems which may have been worrying you and which you may not have had a chance to discuss before. You can choose whether you want to see a male or female doctor.

DRUGS: Which of the following best describes your experience with these drugs during the past 12 months:

H32: Marijuana and cannabis products (also known as a joint, pot, grass or hash)?

- ☐ I have never done it
- ☐ Not during the past 12 months
- ☐ A few times
- ☐ About once or twice a month
- ☐ About 1-2 days a week
- ☐ About 3-5 days a week
- ☐ About 6-7 days a week

H33: Glues or solvents?

- ☐ I have never done it
- ☐ Not during the past 12 months
- ☐ A few times
- ☐ About once or twice a month
- ☐ About 1-2 days a week
- ☐ About 3-5 days a week
- ☐ About 6-7 days a week

H34: Other drugs like crack, cocaine, heroin, speed or ecstasy, etc.?

- ☐ I have never done it
- ☐ Not during the past 12 months
- ☐ A few times
- ☐ About once or twice a month
- ☐ About 1-2 days a week
- ☐ About 3-5 days a week
- ☐ About 6-7 days a week

H35: How many of your close friends have tried drugs or sniffed glue or solvents?

☐ None ☐ A few ☐ Most ☐ All

H36: Are you getting all the help you need to quit using drugs or sniffing glue or solvents?

☐ Does not use drugs or solvents - no help required ☐ Yes ☐ No

H37: PUBERTY: Do you have any concerns related to body changes (e.g., acne, menstruation, voice, hair growth)?

☐ Yes ☐ No

H38: Are you getting all the help you need with concerns you may have related to body changes?

☐ No such concerns - no assistance required ☐ Yes ☐ No

H39: SEXUALITY: Do you have any concerns with issues related to sexuality, such as sexual relations, contraception, pregnancy, HIV and other sexually transmitted diseases, or sexual orientation? (**Note what these are on the right-hand page, opposite.**)

☐ Yes ☐ Not sure ☐ No

H40: Are you receiving all the help you need with concerns related to sexuality, such as those just mentioned?

☐ No obvious concerns - no assistance required ☐ Yes ☐ No

The following section is to be completed by the **CHILD WELFARE WORKER**, based on the information obtained on this entire developmental dimension of health.

ATTAINMENT OF HEALTH OBJECTIVES OF THE CHILD WELFARE SYSTEM

H41: Objective 1: The child/youth is normally well.
(Note: "unwell" here means ill enough to be in bed or take some time off school)

- ☐ Normally well (i.e. unwell for 1 week or less in the last 6 months)
- ☐ Sometimes ill (i.e., unwell between 8 and 14 days in the last 6 months)
- ☐ Often ill (i.e., unwell between 15 and 28 days in the last 6 months)
- ☐ Frequently ill (i.e., unwell for more than 28 days in the last 6 months)

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H32

H33

H34

H35

H36

H37

H38

H39

H40

H41

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

Accurate factual knowledge about puberty, sex and contraception, as well as discussions about the part sex plays in relationships, are important to all young people who are developing into adulthood.

Young people who are in care or disabled are no exception to this but may miss out on some of the discussion in formal school lessons, or with their peers. This is especially true if they move schools frequently.

The contraceptive pill, if used properly, can prevent you from becoming pregnant, but it does not protect you from catching sexually transmitted diseases such as chlamydia, herpes, HIV, syphilis or gonorrhoea.

If you are pregnant, or you think you might be pregnant, it is important that you receive appropriate pre-natal care to ensure the future health of yourself and your baby.

H42: Objective 2: The child/youth's weight is within normal limits for his/her height:

☐ Within normal limits ☐ Seriously underweight ☐ Seriously overweight

H43: Objective 3: All necessary preventive health measures, including immunizations, are being taken. **(also see Table on the following pages for services received by child/youth during the last year):**

☐ All ☐ Most ☐ A few ☐ None

H44: Objective 4: All ongoing health conditions and disabilities are being dealt with (**also see Table on following pages for services received by child/youth during the last year**):

☐ No health condition or disability
☐ All being adequately dealt with
☐ Some being adequately dealt with
☐ None being adequately dealt with

H45: Objective 5: The child/youth does not put his/her health at risk:

☐ No risks taken ☐ Some risks taken ☐ Considerable risks taken ☐ Health placed seriously at risk

Note to the child welfare worker: *If anyone disagrees with these answers to the Health objectives, please note the details on the opposite page.*

DIRECT AND RESIDENTIAL SERVICES RECEIVED BY THE CHILD/YOUTH IN CARE DURING THE LAST 12 MONTHS

This section is to be completed by the **FOSTER PARENT** (or other adult caregiver), with assistance, as needed, from the child welfare worker and the child/youth in care.

The purpose of this section is to identify the kind and amount of **DIRECT**and **RESIDENTIAL SERVICES** received by the child/youth during the last 12 months.

By **DIRECT SERVICES**, we mean those received by the child/youth from a service provider in a face-to-face encounter or by telephone. By **RESIDENTIAL SERVICES**, we mean the setting(s) in which he/she lived.

It is important to know the kind and amount of services received in order to be able to judge whether the child/youth's service needs have recently been met and to decide the kind and amount of services that should be specified in the revised Plan of Care, to guide interventions during the coming 12 months. The kind and amount of services received are also likely to be related to the child/youth's developmental progress, both last year and in the coming year.

For each of the direct service providers (or services) listed in the following Table, please indicate (as in the example presented in the first row of the Table):

> **WHETHER THE CHILD/YOUTH HAS RECEIVED SERVICES** from such a provider during the last year;

> **The CATEGORY** of the service provider, that is, was the provider:

(1) a child welfare agency or organization staff member?
(2) a staff member of a publicly-funded agency other than the child welfare agency or organization (e.g., a school)?
(3) a private service provider, reimbursed by the provincial/territorial health plan(e.g., a family physician)?
(4) a private service provider reimbursed by the child welfare agency or organization?
(5) another type of provider (e.g., an unpaid volunteer, such as a basketball coach)?

> **The FREQUENCY** with which the service was received; and,

> **The AVERAGE DURATION** of a single service session or "episode".

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H42 ☐

H43 ☐

H44 ☐

H45 ☐

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The child/youth puts him/herself at risk by abusing nicotine, alcohol, drugs, or other substances.

Young people should be encouraged to give up smoking. Staff should not supply young people with cigarettes. If you or your foster parent(s) want more information, there are two small booklets, "Do you Know" and "Take Action," both of which you can get for free by telephoning the Addiction Research Foundation Drug and Alcohol Hotline at 1-800-463-6273. The call is also free.

	Did child/youth receive service from such a provider during last 12 Months?	(If yes): Mark category of provider (from list, above):	Frequency (i.e., number of times, days, or weeks the service was received during the last 12 months?	Average duration of a single session, unit, or episode.
DIRECT SERVICES:	Services received by the child/youth from a service provider in a face-to-face encounter or by telephone. You may wish to indicate the name of the usual family physician, pediatrician, etc.			
Example: Dentist	Yes [X] No [ ]	[ ][ ][ ][X][ ] 1 2 3 4 5	[0][2] times/last yr	[0][4][5] Minutes
1. Family physician	Yes [ ] No [ ]	[ ][ ][ ][ ][ ] 1 2 3 4 5	[ ][ ] times/last yr	[ ][ ][ ] Minutes
2. Pediatrician	Yes [ ] No [ ]	[ ][ ][ ][ ][ ] 1 2 3 4 5	[ ][ ] times/last yr	[ ][ ][ ] Minutes
3. Ophthalmologist	Yes [ ] No [ ]	[ ][ ][ ][ ][ ] 1 2 3 4 5	[ ][ ] times/last yr	[ ][ ][ ] Minutes
4. Psychiatrist	Yes [ ] No [ ]	[ ][ ][ ][ ][ ] 1 2 3 4 5	[ ][ ] times/last yr	[ ][ ][ ] Minutes
5. Other MD	Yes [ ] No [ ]	[ ][ ][ ][ ][ ] 1 2 3 4 5	[ ][ ] times/last yr	[ ][ ][ ] Minutes
6. Nurse	Yes [ ] No [ ]	[ ][ ][ ][ ][ ] 1 2 3 4 5	[ ][ ] times/last yr	[ ][ ][ ] Minutes
7. Dentist	Yes [ ] No [ ]	[ ][ ][ ][ ][ ] 1 2 3 4 5	[ ][ ] times/last yr	[ ][ ][ ] Minutes
8. Orthodontist	Yes [ ] No [ ]	[ ][ ][ ][ ][ ] 1 2 3 4 5	[ ][ ] times/last yr	[ ][ ][ ] Minutes
9. Optometrist	Yes [ ] No [ ]	[ ][ ][ ][ ][ ] 1 2 3 4 5	[ ][ ] times/last yr	[ ][ ][ ] Minutes
10. Audiologist	Yes [ ] No [ ]	[ ][ ][ ][ ][ ] 1 2 3 4 5	[ ][ ] times/last yr	[ ][ ][ ] Minutes
11. Speech therapist	Yes [ ] No [ ]	[ ][ ][ ][ ][ ] 1 2 3 4 5	[ ][ ] times/last yr	[ ][ ][ ] Minutes
12. Psychologist/ psychological associate	Yes [ ] No [ ]	[ ][ ][ ][ ][ ] 1 2 3 4 5	[ ][ ] times/last yr	[ ][ ][ ] Minutes

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Child welfare agencies or organizations should arrange regular medical examinations for all children and young people in their care. The purpose of the examination is to pick up health problems that can be treated and often cured while the child/youth is in care.

It is important to know the kind and amount of services received in order to be able to judge whether the child/youth's service needs have recently been met and to decide the kind and amount of services that should be specified in the revised Plan of Care, to guide interventions during the coming 12 months. The kind and amount of services received are also likely to be related to the child/youth's developmental progress, both last year and in the coming year.

DIRECT SERVICES:	Did child/youth receive service from such a provider during the last 12 months?	(IF YES): Mark category of provider (from list, above): (1)(2)(3)(4)(5)	Frequency (i.e., number of times, days, or weeks the service was received during the last 12 months):	Average duration of a single session, unit, or episode.
13. Physiotherapist	Yes ☐ No ☐	1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
14. Occupational therapist	Yes ☐ No ☐	1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
15. Lawyer	Yes ☐ No ☐	1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
16. Child welfare worker	Yes ☐ No ☐	1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
17. Social worker (not from child welfare agency or organization)	Yes ☐ No ☐	1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
18. Early childhood worker/educator	Yes ☐ No ☐	1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
19. Volunteer driver	Yes ☐ No ☐	1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
20. Police officer	Yes ☐ No ☐	1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
21. Employment specialist	Yes ☐ No ☐	1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
22. Teacher (regular class)	Yes ☐ No ☐	1 2 3 4 5	☐☐☐ days/last yr	1 Day
23. Teacher (special ed)	Yes ☐ No ☐	1 2 3 4 5	☐☐☐ days/last yr	1 Day
24. Teacher's aide	Yes ☐ No ☐	1 2 3 4 5	☐☐☐ days/last yr	1 Day
25. Educational tutor	Yes ☐ No ☐	1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
26. Respite worker	Yes ☐ No ☐	1 2 3 4 5	☐☐☐ days/last yr	1 Day
27. Summer camp staff	Yes ☐ No ☐	1 2 3 4 5	☐☐☐ days/last yr	1 Day
28. Paid recreation/ sports instructor or coach	Yes ☐ No ☐	1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes

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DIRECT SERVICES:	Did child/youth receive service from such a provider during the last 12 months?	(IF YES): Mark category of provider (from list, above): (1)(2)(3)(4)(5)	Frequency (i.e., number of times, days, or weeks the service was received during the last 12 months).	Average duration of a single session, unit, or episode.
29. Volunteer (unpaid) recreation/sports instructor or coach	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
30. Other direct service	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐ times/last yr	☐☐☐ Minutes
	☐☐☐☐☐☐☐☐☐☐☐☐ Specify			

RESIDENTIAL SERVICES: Services provided in the setting(s) in which the child/youth lived.

31. Foster care	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐☐ days/last yr	1 Day
32. Group home	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐☐ days/last yr	1 Day
33. Residential treatment	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐☐ days/last yr	1 Day
34. In-patient hospitalization	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐☐ days/last yr	1 Day
35. Other residential service	Yes ☐ No ☐	☐☐☐☐☐ 1 2 3 4 5	☐☐☐ days/last yr	1 Day
	☐☐☐☐☐☐☐☐☐☐☐☐ Specify			

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DEVELOPMENTAL DIMENSION 2: EDUCATION

This dimension is about the child/youth's experiences at school. The questions in this section are designed to find out if the child/youth 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 child/youth has opportunities to learn special skills and to take part in a wide range of activities, both in and out of school.

The next section is to be answered by the **FOSTER PARENT** (or other adult caregiver), with assistance, as needed, from the child/youth in care or the child welfare worker.

E1: TYPE OF SCHOOL: What type of school is ... (i.e., the child/youth in care) currently in?

- ☐ Public school
- ☐ Catholic school, publicly funded
- ☐ Private school
- ☐ Not in school
- ☐ Not in school - child/youth is in an institution
- ☐ Taught in an institution (e.g., hospital, young offender facility, child welfare facility)
- ☐ Taught at home (home schooling)
- ☐ Other **Specify** ☐☐☐☐☐☐☐☐☐☐☐☐

E2: GRADE: What grade is ... in?

- ☐ Grade 3
- ☐ Grade 4
- ☐ Grade 5
- ☐ Grade 6
- ☐ Grade 7 (Secondaire I in QC)
- ☐ Grade 8 (Secondaire II in QC)
- ☐ Grade 9 (Secondaire III in QC)
- ☐ Grade 10 (Secondaire IV in QC; Level 1 secondary in NFLD)
- ☐ Grade 11 (Secondaire V in QC; Level 2 secondary in NFLD)
- ☐ Ungraded
- ☐ Not in school

E3: Has ... ever repeated a grade at school (including kindergarten)?

☐ Yes ☐ No

E3A: If yes, has ... repeated a grade at school (including kindergarten) in the last 12 months?

☐ Yes ☐ No

E4: In what language is ... mainly taught?

☐ English ☐ French ☐ Both ☐ Other

E5: LEARNING-RELATED DIFFICULTIES: Has ... been assessed for possible learning-related problems (e.g., attention-deficit and hyperactivity disorder [ADHD], learning disability, unsatisfactory progress?)

☐ He/she is currently on a waiting list for an assessment ☐ Yes ☐ No

E6: Does ... receive special/resource help at school because of a physical, emotional, behavioural, or some other problem that limits the kind or amount of school work he/she can do?

☐ Yes ☐ No ☐ Not in school

E7: Does ... receive any help or tutoring outside of school?

☐ Yes ☐ No

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?

☐ Yes ☐ No

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E1 ☐

E2 ☐

E3 ☐

E3A ☐

E4 ☐

E5 ☐

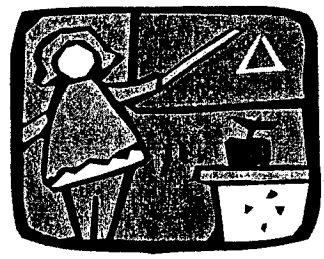
E6 ☐

E7 ☐

E8 ☐

DIMENSION 2: EDUCATION

This dimension is about the child/youth's experience at school.



A young person has a learning difficulty if he/she finds it much harder to learn than most people of the same age or if he/she has a disability which makes it difficult to use the normal educational facilities in the area.

For example, someone may have learning difficulties caused by conditions such as Down's syndrome, a problem with sight, hearing or speech, a learning disability, emotional or behavioural problems, a medical or health problem, difficulties with reading, writing, speaking or mathematics. Information on an individual education plan should be noted on your Plan of Care. A review should be undertaken regularly. Your child welfare worker should make sure that information about an individual education plan, transition plans and statements of special educational needs has been noted on your Plan of Care or file. Details about specialized learning materials should also be recorded.

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, if this interview takes place during the summer or at the beginning of the new school year, how did he/she do during the last school year)?

E9: Reading?
☐ Very well ☐ Well ☐ Average ☐ Poorly ☐ Very poorly

E10: Mathematics?
☐ Very well ☐ Well ☐ Average ☐ Poorly ☐ Very poorly

E11: Written work such as composition?
☐ Very well ☐ Well ☐ Average ☐ Poorly ☐ Very poorly

E12: How is he/she doing overall?
☐ Very well ☐ Well ☐ Average ☐ Poorly ☐ Very poorly

E13: HOMEWORK AND EXAMS: Does ... have a satisfactory place to do his/her homework?
☐ Yes ☐ No

E14: On days when ... is assigned homework, how much time does he/she usually spend doing homework?
☐ 0-15 minutes
☐ 16-30 minutes
☐ 31 minutes to less than one hour
☐ 1.0 to less than 1.5 hours
☐ 1.5 to less than 2.0 hours
☐ 2.0 to less than 3.0 hours
☐ 3.0 to less than 4.0 hours
☐ 4.0 hours or more

E15: How often do you check his/her homework or provide help with homework?
☐ Never or rarely
☐ Less than once a month
☐ Once a month
☐ A few times a month
☐ Once a week
☐ A few times a week
☐ Daily

E16: How well does ... prepare for tests or exams?
☐ Very Well ☐ Well ☐ Average ☐ Poorly ☐ Very poorly

E17: READING: How often does ... read for pleasure?
☐ Most days
☐ A few times a week
☐ About once a week
☐ About once a month
☐ Almost never

E18: OTHER EDUCATION-RELATED MATTERS: How important is it to you that ... have good grades in school?
☐ Very important ☐ Important ☐ Somewhat important ☐ Not important at all

E19: How far do you hope ... will go in school?
☐ Primary/elementary school
☐ Secondary or high school
☐ Community college, CEGEP, or nursing school
☐ Trade, technical, vocational school, or business college
☐ University
☐ Other

E20: Approximately how many books of his/her own does ... possess?
☐ None ☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-50 ☐ More than 50

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E9
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Please give details of all the courses you are taking, including your individual education plan.

A satisfactory place for studying has enough space and light and a suitable chair and table. It should not be too noisy, so that you can concentrate, and should prevent your being interrupted by other people.

It is important that an adult take an interest in your homework, making sure that you have enough things like pens, paper and pencils, and giving you help when you need it.

Foster homes and residential units should have reference books such as dictionaries, atlases, and encyclopedias. If they don't, you may need to ask your child welfare worker about this.

E21: Approximately how many of your books does ... have access to?

- ☐ None
- ☐ 1-5
- ☐ 6-10
- ☐ 11-15
- ☐ 16-20
- ☐ 21-30
- ☐ 31-50
- ☐ 51-100
- ☐ More than 100

E22: How often does ... borrow books from the school or public library?

- ☐ Once a week
- ☐ A few times a month
- ☐ Once a month
- ☐ Less than once a month
- ☐ Rarely or never

E23: Does ... have access to a computer at home? **(If no, go to question E25)**

☐ Yes ☐ No

E24: Does ... have access to a large area network (e.g., Internet) at home?

☐ Yes ☐ No

E25: How often do you and ... talk about school work or behaviour in class?

- ☐ Daily
- ☐ A few times a week
- ☐ Once a week
- ☐ A few times a month
- ☐ Once a month
- ☐ Less than once a month
- ☐ Rarely

E26: How often do you and ... talk about his/her school friends or activities?

- ☐ Daily
- ☐ A few times a week
- ☐ Once a week
- ☐ A few times a month
- ☐ Once a month
- ☐ Less than once a month
- ☐ Rarely

E27: How often do you and ... talk about his or her plans for the future?

- ☐ Daily
- ☐ A few times a week
- ☐ Once a week
- ☐ A few times a month
- ☐ Once a month
- ☐ Less than once a month
- ☐ Rarely

E28: During the current or last school year, have you done any of the following? **(Read list and mark all that apply.)**

- ☐ Spoken to, visited, or corresponded with child's teacher
- ☐ Visited child's class
- ☐ Attended a school event in which child participated, for example, a play, sports competition, or science fair
- ☐ Volunteered in child's class or helped with a class trip
- ☐ Helped elsewhere in the school, such as in the library or computer room
- ☐ Fund-raising
- ☐ Attended a parent-school association, home and school liaison committee
- ☐ Other activities
- ☐ No activities

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E21

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E22

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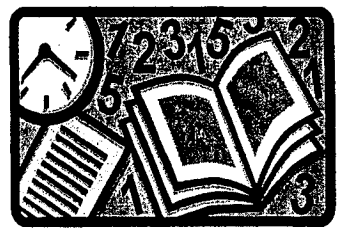
E28

Despite the current emphasis on information technology, literacy is still the first requirement of employers. But it is also a crucial tool for independent learning and an important leisure skill.

Reading is inexpensive and does not require the co-operation of others or interfere with their activities. It can be pursued anywhere and offers recreation, instruction and vicarious experience.



We know that the conditions necessary for children to learn to read successfully are a ready supply of suitable reading material and the close attention of an adult, normally a parent.

E29: CHANGES IN SCHOOLS: Other than natural progression through the school system, how many times (if any) has ... changed schools? (Write in the total no. of times.)

☐☐ **times (00 = none; 01 = once; 02 = twice; etc.)**

E29A: Other than natural progression through the school system, has ... changed schools in the last 12 months?
☐ Yes ☐ No

E30: ABSENCES FROM SCHOOL: How many days, if any, was ... absent from school during the last 12 months?

☐ 0 days
☐ 1-3 days
☐ 4-6 days
☐ 7-10 days
☐ 11-20 days
☐ More than 20 days
☐ Not in school during the last 12 months

E31: What was the main reason for ... being absent from school?

☐ Health reasons
☐ Problems with transportation
☐ Problems with weather
☐ Family vacation
☐ Fear of school
☐ Problem with the teacher
☐ Problem with children at school
☐ Difficulty with childcare arrangements
☐ Other

E32: SUSPENSIONS FROM SCHOOL: During the last 12 months, how many times, if any, has ... been temporarily suspended from school?

☐ Never ☐ Once or twice ☐ 3 or 4 times ☐ 5 times or more ☐☐☐ write in total no. of days

E33: During the last 12 months, how many times, if any, has ... been permanently suspended from school?

☐ Never ☐ Once or twice ☐ 3 or 4 times ☐ 5 times or more ☐☐☐ write in total no. of days

E34: CHANGES IN PLACE OF RESIDENCE: Aside from school changes, 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.)**

☐☐ **times (00 = none; 01 = once; 02 = twice; etc.)**

The following questions are to be answered by the **CHILD/YOUTH IN CARE.**

E35: SCHOOL: How do you feel about school?

☐ I like school very much
☐ I like school quite a bit
☐ I like school a bit
☐ I don't like school very much
☐ I hate school

E36: How do you like Math?

☐ I hate it ☐ I don't like it very much ☐ I like it a little ☐ I like it a lot ☐ I don't take it

E37: How do you like Science?

☐ I hate it ☐ I don't like it very much ☐ I like it a little ☐ I like it a lot ☐ I don't take it

E38: How do you like English?

☐ I hate it ☐ I don't like it very much ☐ I like it a little ☐ I like it a lot ☐ I don't take it

E39: How do you like French?

☐ I hate it ☐ I don't like it very much ☐ I like it a little ☐ I like it a lot ☐ I don't take it

E40: How important is it to you to get good grades?

☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not important at all

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E29

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

E29A

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E37

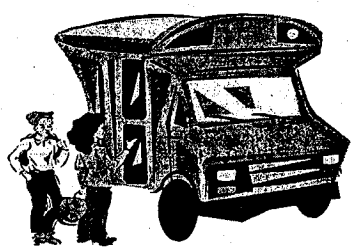
E38

E39

E40

Unplanned changes are other than those that everyone experiences (e.g., from elementary to high school). Your child welfare worker should check that all school changes have been noted in your file.

A change of placement may mean that you have moved away from your school. It is important to try not to change schools in the middle of a term, so your child welfare worker may be able to arrange transportation to help you stay at the same school.



If you have changed schools in the middle of a term, it may be useful to ask your teacher where you might get some extra help.

***School performance** is the simplest indicator of cognitive functioning for school-aged children. It can be measured as the age to grade ratio, achievement on standardized tests (e.g., Math or English), placement in special education classes, or assessed risk of failure.*

E41: How important is it to you to participate in extra-curricular activities?

☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not important at all

E42: How important is it to you to always to show up to class on time?

☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not important at all

E43: How important is it to you to learn new things?

☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not important at all

E44: How important is it to you to express your opinion in class?

☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not important at all

E45: Have you participated in any school trips or outings in the last 12 months?

☐ Never ☐ Once or twice ☐ 3 or 4 times ☐ 5 times or more

ACTIVITIES OUTSIDE OF SCHOOL HOURS: In the last 12 months, how often have you:

E46: Played sports or done physical activities without a coach or an instructor (e.g. biking, skate boarding, softball during recess, etc.)?

☐ Never ☐ Less than once a week ☐ 1 to 3 times a week ☐ 4 or more times a week

E47: Played sports with a coach or instructor, other than for gym class (e.g., swimming lessons, baseball, hockey, school teams, etc.)?

☐ Never ☐ Less than once a week ☐ 1 to 3 times a week ☐ 4 or more times a week

E48: Taken part in dance, gymnastics, karate or other groups or lessons, other than in gym class?

☐ Never ☐ Less than once a week ☐ 1 to 3 times a week ☐ 4 or more times a week

E49: Taken part in art, drama or music groups, clubs or lessons, outside of class?

☐ Never ☐ Less than once a week ☐ 1 to 3 times a week ☐ 4 or more times a week

E50: Taken part in clubs or groups such as Guides or Scouts, 4-H club, community, church or other religious groups?

☐ Never ☐ Less than once a week ☐ 1 to 3 times a week ☐ 4 or more times a week

E51: Done a hobby or craft (drawing, model building, etc.)?

☐ Never ☐ Less than once a week ☐ 1 to 3 times a week ☐ 4 or more times a week

E52: TEACHERS: In general, do your teachers treat you fairly?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ Rarely ☐ Never

E53: If you need extra help, do your teachers give it to you?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ Rarely ☐ Never

E54: HOMEWORK: When your teachers give you homework, do you do it?

☐ All the time ☐ Rarely
☐ Most of the time ☐ Never
☐ Some of the time

E55: How often do your foster parents (or your other adult caregivers, if you are not in foster care) check your homework or provide help with homework?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ Rarely ☐ Never

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E55

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

There is evidence of serious discrimination against children in care in schools. Many complain of unfair treatment by teachers. At the extreme is the readiness of schools to exclude children/youth in care for relatively trivial offences, which has resulted in some being denied their right to education for long periods.

Exclusion disrupts not only their learning but also their social relationships and other activities and puts them at higher risk of offending and drug and alcohol misuse.

School success enhances self-esteem and can offer a channel of escape from disadvantage. This is particularly important for girls, who otherwise may take the route of early motherhood, which locks them into poverty and can block off further opportunities.

School is also the place where children acquire social and leisure skills, making and keeping friends, negotiating agreements and relating to a variety of adults.

E56: LEVEL OF EDUCATION DESIRED: How far do you hope to go in school?

- ☐ Middle school/junior high
- ☐ High school
- ☐ College or CEGEP
- ☐ A university degree
- ☐ More than one university degree
- ☐ I don't know

E57: EXPECTANCIES OF FOSTER PARENTS (OR OTHER ADULT CAREGIVERS): If you have problems at school, are your foster parents (or other adult caregivers) ready to help?

- ☐ All the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Rarely
- ☐ Never
- ☐ No problems at school

E58: Do your foster parents (or other adult caregivers) encourage you to do well at school?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ Rarely ☐ Never

E59: Do your foster parents (or other adult caregivers) expect too much of you at school?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ Rarely ☐ Never

E60: READING: How often do you read for fun (not for school)?

- ☐ Every day
- ☐ A few times a week
- ☐ Once a week
- ☐ A few times a month
- ☐ Less than once a month
- ☐ Almost never

The following section is to be filled out by the **CHILD WELFARE WORKER**, based on the information obtained on this entire developmental dimension of education.

ATTAINMENT OF GENERAL EDUCATION OBJECTIVES OF THE CHILD WELFARE SYSTEM

E61: Objective 1: The child/youth's educational performance matches his/her ability:

☐ Performance matches ability ☐ Performance somewhat below ability ☐ Performance seriously below ability

E62: Objective 2: The child/youth is acquiring special skills and interests:

☐ Many ☐ Some ☐ Few ☐ None

E63: Objective 3: Adequate attention is being given to planning the child/youth's education:

☐ Satisfactory planning ☐ Some planning, but not enough ☐ 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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E56

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

E57

E58

E59

E60

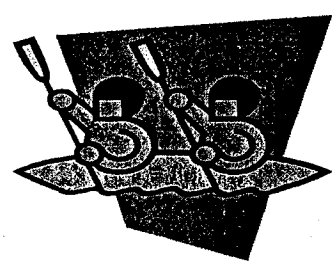
E61

E62

E63

If a child/youth in care decides that he/she wants to study at a particular university, or become a doctor or a professional tennis player, who is to say that this is inappropriate? The job of the child welfare worker as a good parent is to explain to the young person the necessary steps along the way, do everything possible to help, and encourage and build on their aspirations and talents.

An important thing is that children/youth in care have targets to aim for which they may be able to keep in view during their life experiences in the child welfare system. Research on high achievers who have been in care suggests that a good educational foundation is the key not only to employment but also to success in many other dimensions of adult life.



DEVELOPMENTAL DIMENSION 3: IDENTITY.

This dimension is about the identity of the child/youth in care. The questions in this section are designed to make sure that the child/youth knows something about his/her birth family and culture, that he/she understands and accepts the reasons why he/she is in care, and that he/she is being helped to feel increasingly confident about himself/herself.

The **CHILD/YOUTH IN CARE** is to answer this section, with assistance, as needed, from the foster parent (or other adult caregiver) or child welfare worker. If you were adopted as a baby and have no contact with your birth family since then, questions in this section apply to your adoptive family.

ID1: BIRTH FAMILY: How many members of your birth family can you name (including parents, brothers and sisters, grandparents, cousins, aunts and uncles)?
☐ All or most ☐ Some ☐ None

ID2: Do you want to find out more about your birth family?
☐ Yes ☐ Uncertain ☐ No

ID3: BEING IN CARE: Do you understand why you are in care?
☐ Yes ☐ Uncertain ☐ No

ID4: If you feel awkward or uncomfortable when asked personal questions about your birth family, where you live, or why you are in care, are you getting all necessary assistance to deal with such questions in future?
☐ No assistance required ☐ Yes ☐ No

ID5: PAST EXPERIENCES: Do you have a personal album, containing photographs and mementos about people and events that were important to you?
☐ Yes ☐ No

ID6: RELIGION: What, if any, is your religion? **(Do not read list. Mark one only.)**

☐ No religion	☐ Lutheran	☐ Hindu
☐ First Nations/ aboriginal religion	☐ Baptist	☐ Sikh
☐ Roman Catholic	☐ Eastern Orthodox	☐ Jehovah's Witnesses
☐ United Church	☐ Jewish	☐ Other
☐ Anglican	☐ Islam (Muslim)	
☐ Presbyterian	☐ Buddhist	

ID7: Do you have enough opportunities to practice your religion (including religious services, festivals and holidays, prayers, clothing, diet)?
☐ Child/youth has no religious affiliation ☐ Yes ☐ No

ID8: FIRST LANGUAGE: What is the language that you first learned at home in childhood and can still understand? **(If ... can no longer understand the first language learned, choose the second language learned.) (Do not read list. Mark all that apply.)**

☐ English	☐ Hungarian	☐ Punjabi	☐ Vietnamese
☐ French	☐ Italian	☐ Spanish	☐ Other
☐ Arabic	☐ Korean	☐ First Nations language	
☐ Chinese	☐ Persian (Farsi)	☐ Tagalog (Filipino)	
☐ German	☐ Polish	☐ Ukrainian	
☐ Greek	☐ Portuguese		

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The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

ID1

ID2

ID3

ID4

ID5

ID6

ID7

ID8

DIMENSION 3: IDENTITY

This dimension is about the identity of the child/youth in care. It is designed to make sure that he/she knows about his/her birth family and culture, that he/she is being helped to understand and accept the reasons why he/she is in care, and that he/she feels increasingly confident about himself/herself.

ID9: What language do you speak most often at home? **(Mark all that apply.)**

☐ English ☐ French ☐ First Nations language ☐ Other ☐☐☐☐☐☐☐☐☐☐ **Specify**

ID10: Overall, do you have enough opportunities to speak your own first language (at home, at school, with friends, etc.)?

☐ Yes ☐ No

ID11: ETHNICITY: To which ethnic or cultural group(s) did your ancestors belong? (For example: French, British, Chinese) **(Mark all that apply.)**

☐ Canadian
☐ French
☐ English
☐ North American Indian
☐ Inuit / Eskimo
☐ Métis
☐ German
☐ Irish
☐ Scottish
☐ Italian
☐ Jewish
☐ Ukranian
☐ Dutch (Netherlands)
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Polish
☐ Latin American
☐ Portugese
☐ Black (e.g., African, Haitian, Jamaican, Somali)
☐ South Asian (e.g., East Indian, Pakistani, Punjabi, Sri Lankan)
☐ South East Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese)
☐ Arab/West Asian (e.g., Armenian, Egyptian, Lebanese, Moroccan)
☐ Other ☐☐☐☐☐☐☐☐☐☐☐ **Specify**

ID12: Overall, do you have enough opportunities to meet people from your own ethnic or cultural background (including, for First Nations children/youth, people from your own band or community)?

☐ Yes ☐ No

ID13: Are the ethnic/cultural backgrounds of the child/youth and at least one of his/her foster parents (or other adult caregivers):

☐ The same? ☐ Similar? ☐ Neither the same nor similar?

For each of the following statements, choose the answer that best describes how you feel.

ID14: In general, I like the way I am.

☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

ID15: Overall, I have a lot to be proud of.

☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

ID16: A lot of things about me are good.

☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

ID17: When I do something, I do it well.

☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

ID18: I like the way I look.

☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

ID19: In general, I am happy with how things are for me in my life now.

☐ Strongly disagree ☐ Disagree ☐ Agree ☐ Strongly agree

ID20: The next five years look good to me.

☐ Strongly disagree ☐ Disagree ☐ Agree ☐ Strongly agree

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ID9

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

ID10

ID11

ID12

ID13

ID14

ID15

ID16

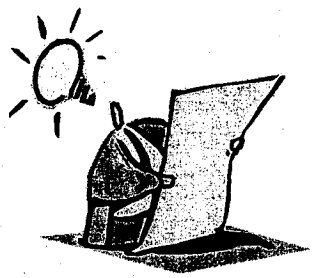
ID17

ID18

ID19

ID20

Even if a personal album is not being kept, it is important that photographs, certificates and mementos be collected and that addresses be noted down. This is particularly valuable if there is a change of placement or child welfare worker, as it may later prove impossible to gather lost information.



"Self-esteem" refers to the positive or negative regard in which one holds oneself, either globally, in the sense of an overall judgement, or specifically, in relation to one's different identities.

Most psychological research on the self has been concerned with self-esteem, perhaps because of its great importance to overall well-being. Recently, another aspect of self-evaluation, self-efficacy, has been studied, that is, the sense that one is competent and can solve one's problems.

Self-efficacy is likely to be particularly low in children in care, and the sections of the Record concerned with school success, hobbies, and self-care skills are important not only in themselves, but also because of their influence on self-efficacy and self-esteem.

The **CHILD/YOUTH IN CARE** is to answer these sections, with assistance, as needed, from the foster parent (or other adult caregiver) or child welfare worker.

QUESTIONS ABOUT YOUR GOALS: The six sentences below describe how children and 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.**

ID21: I think I am doing pretty well.

☐ None of the time ☐ A little of the time ☐ Some of the time ☐ A lot of the time ☐ Most of the time ☐ All of the time

ID22: I can think of many ways to get the things in life that are most important to me.

☐ None of the time ☐ A little of the time ☐ Some of the time ☐ A lot of the time ☐ Most of the time ☐ All of the time

ID23: I am doing just as well as other kids my age.

☐ None of the time ☐ A little of the time ☐ Some of the time ☐ A lot of the time ☐ Most of the time ☐ All of the time

ID24: When I have a problem, I can come up with lots of ways to solve it.

☐ None of the time ☐ A little of the time ☐ Some of the time ☐ A lot of the time ☐ Most of the time ☐ All of the time

ID25: I think the things I have done in the past will help me in the future.

☐ None of the time ☐ A little of the time ☐ Some of the time ☐ A lot of the time ☐ Most of the time ☐ All of the time

ID26: Even when others want to quit, I know that I can find ways to solve the problem.

☐ None of the time ☐ A little of the time ☐ Some of the time ☐ A lot of the time ☐ Most of the time ☐ All of the time

HOW YOU DEAL WITH PROBLEMS: Sometimes children or 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.

ID27: I listen to music or watch TV to feel better.

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID28: I say to myself that I can live with my problem.

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID29: I do things to make my problem better.

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID30: I tell myself that things really are not so bad.

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID31: I don't do anything that reminds me of my problem.

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID32: I ask my foster parent (or another adult) to help me with my problem.

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID33: I imagine that my problem has gotten better.

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID34: I take action to improve the situation.

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID35: I do something fun to take my mind off my problem.

☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

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The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

ID21

ID22

ID23

ID24

ID25

ID26

ID27

ID28

ID29

ID30

ID31

ID32

ID33

ID34

ID35

ID36: I think about possible answers to my problem.
☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID37: I stay away from the things that are upsetting me.
☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID38: I try to understand my problem better.
☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID39: I talk with a friend about my problem to feel better.
☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID40: I think about different ways of solving my problem.
☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID41: I talk to a foster parent (or another adult) to feel better about my situation.
☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID42: I work off my worries by playing sports, such as running, swimming, or playing soccer.
☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID43: I try not to think about my problem.
☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID44: I leave the situation that is upsetting me.
☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID45: I get advice from a brother, sister, or friend about how to solve my problem.
☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID46: I wish that my problem would go away.
☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID47: I try to learn more about what is causing my problem.
☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

ID48: I do physical activity, such as riding my bicycle, to feel less stressed.
☐ Never ☐ Sometimes ☐ Often ☐ Most of the time

The following section is to be filled out by the **CHILD WELFARE WORKER**, based on the information obtained on this entire developmental dimension of identity.

ATTAINMENT OF GENERAL IDENTITY OBJECTIVES OF THE CHILD WELFARE SYSTEM

ID49 Objective 1: The child/youth has knowledge of his/her family of origin and current situation:
☐ Clear knowledge ☐ Some knowledge ☐ Little or no knowledge

ID50 Objective 2: The child/youth identifies with and is proud of his/her racial or ethnic background:
☐ To a great extent ☐ To some extent ☐ To little or no extent

ID51 Objective 3: The child/youth has a good level of self-esteem:
☐ High self-esteem ☐ Moderate self-esteem ☐ Low self-esteem

ID52 Objective 4: The child/youth has a clear understanding of his/her current situation:
☐ Clear understanding ☐ Some understanding ☐ Little or no knowledge

Note to the child welfare worker: *If anyone disagrees with these answers to the Identity objectives, please note the details on the opposite page.*

ID36
ID37
ID38
ID39
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ID41
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ID43
ID44
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ID47
ID48
ID49
ID50
ID51
ID52

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

Identity: is fluid, dynamic, ridden with contradictions, and constructed from diverse experiences. Children/youth should be put in touch with a range of cultural experiences relevant to their family backgrounds and peer group so that they can construct identities that they feel comfortable with, bearing in mind that these may change in the course of development.

A child/youth with a positive view of self will be generally confident in new situations. He/she will take on challenges and expect to succeed. He/she will enjoy meeting new people and expect to be liked.

DEVELOPMENTAL DIMENSION 4: FAMILY AND SOCIAL RELATIONSHIPS

This dimension is about the childyouth'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 welcome, and if he/she knows an adult who will help out if something goes wrong.

➤ The next section is to be answered by the **FOSTER PARENT** (or other adult caregiver), with assistance, as needed, from the child/youth in care or the child welfare worker.

F1: At what age did ... start living with you?

☐☐ **years of age**

F2: How long has ... been living with you?

☐☐ **years and** ☐☐ **months**

F3: Is this a permanent placement for ... (i.e., until adulthood)?

☐ Yes ☐ Uncertain ☐ No

F4: Is all necessary action being taken to provide a permanent placement for ...?

☐ Yes ☐ Uncertain ☐ No

F5: How many different people have acted as ...'s main caregivers since birth? **(Try and give an estimate of the number, even if you are not certain.)**

☐☐ **caregivers (write in total number)**

F6: CONTACT WITH BIRTH FAMILY: What type of contact does ... have with his/her birth mother?

- ☐ Regular visiting, every week
- ☐ Regular visiting, every two weeks
- ☐ Regular visiting, monthly
- ☐ Irregular visiting, on holidays only
- ☐ Irregular visiting, without set pattern
- ☐ Telephone or letter contact only
- ☐ No contact at all
- ☐ Permanent ward, with no access

F7: What type of contact does ... have with his/her birth father?

- ☐ Regular visiting, every week
- ☐ Regular visiting, every two weeks
- ☐ Regular visiting, monthly
- ☐ Irregular visiting, on holidays only
- ☐ Irregular visiting, without set pattern
- ☐ Telephone or letter contact only
- ☐ No contact at all
- ☐ Permanent ward, with no access

F8: What type of contact does ... have with his/her brothers or sisters?

- ☐ Regular visiting, every week
- ☐ Regular visiting, every two weeks
- ☐ Regular visiting, monthly
- ☐ Irregular visiting, on holidays only
- ☐ Irregular visiting, without set pattern
- ☐ Telephone or letter contact only
- ☐ No contact at all
- ☐ Permanent ward, with no access
- ☐ Has no brothers or sisters

F9: What type of contact does ... have with any other relatives (e.g., aunts, uncles, grandparents)?

- ☐ Regular visiting, every week
- ☐ Regular visiting, every two weeks
- ☐ Regular visiting, monthly
- ☐ Irregular visiting, on holidays only
- ☐ Irregular visiting, without set pattern
- ☐ Telephone or letter contact only
- ☐ No contact at all

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The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

F1

F2

F3

F4

F5

F6

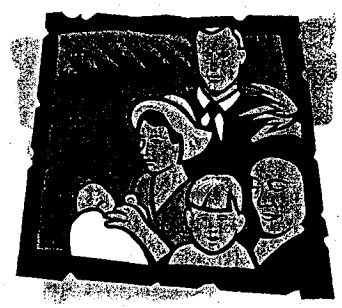
F7

F8

F9

DIMENSION 4: FAMILY AND SOCIAL RELATIONSHIPS

This dimension is about the child/youth's relationship with friends, family, and others. The questions ask about his/her relationships with foster parents or other adult caregivers, contacts with members of his/her birth family, ability to get along wel with adults or other children/ youths, and whether he/she has any close friends.



Your adult caregiver is anyone who has looked after you on more than a temporary basis. Research indicates that the need for continuity is most likely to be met by relatives such as siblings, grandparents, aunts and uncles or other significa people.Continuity of contact with parents or the wider family is often a critical determinant of outcomes for children/youth.

Children/youth who find continuity of placement and attachments while in care ar more likely to achieve stabili in adulthood and experience improved educational chances which, in turn are likely to enhance later success in life.

F10: Is ... receiving all necessary assistance to remain in contact with his/her birth family?

☐ Yes ☐ No

F11: PREVIOUS FOSTER PARENTS: What type of contact does ... have with his/her previous foster parents?

☐ Regular visiting, every week
☐ Regular visiting, every two weeks
☐ Regular visiting, monthly
☐ Irregular visiting, on holidays only
☐ Irregular visiting, without set pattern
☐ Telephone or letter contact only
☐ No contact at all
☐ Has not had any previous foster parents

F12: CURRENT FRIENDSHIPS: About how many days a week does ... do things with friends?

☐ Never ☐ 1 day a week ☐ 2-3 days a week ☐ 4-5 days a week ☐ 6-7 days a week

F13: About how many close friends does he/she have?

☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or 5 ☐ 6 or more

F14: When it comes to meeting new children/youths and making new friends is he/she:

☐ Somewhat shy? ☐ About average? ☐ Very outgoing - makes friends easily

F15: GETTING ALONG WITH OTHERS: During the past 6 months, how well has ... gotten along with other children/youths such as friends or classmates (excluding brothers or sisters)?

☐ Very well, no problems
☐ Quite well, hardly any problems
☐ Pretty well, occasional problems
☐ Not too well, frequent problems
☐ Not well at all, constant problems

F16: During the last school year, how well has he/she gotten along with his/her teacher(s) at school?

☐ Very well, no problems
☐ Quite well, hardly any problems
☐ Pretty well, occasional problems
☐ Not too well, frequent problems
☐ Not well at all, constant problems
☐ Is not attending school

F17: During the last few months, how well has he/she gotten along with his/her foster parent(s) (or other adult caregivers)?

☐ Very well, no problems
☐ Quite well, hardly any problems
☐ Pretty well, occasional problems
☐ Not too well, frequent problems
☐ Not well at all, constant problems

F18: During the last few months, how well has... gotten along with his/her brother(s)/sister(s) (or other children with whom he/she has been living)?

☐ Very well, no problems
☐ Quite well, hardly any problems
☐ Pretty well, occasional problems
☐ Not too well, frequent problems
☐ Not well at all, constant problems
☐ Not applicable

38493

F10

F11

F12

F13

F14

F15

F16

F17

F18

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

The next section is to be answered by the **FOSTER PARENT** (or other adult caregiver).

The next few questions have to do with different ways foster parents (or other adult caregivers) act towards the children/youth in their care. I would like you to tell me how often, in general, you act in the following ways.

F19: How often do you smile at ... ?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F20: How often do you want to know exactly where ... is and what he/she is doing?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F21: How often do you soon forget a rule that you have made?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F22: How often do you praise him/her?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F23: How often do you let ... go out any evening that he/she wants?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F24: How often do you tell him/her what time to be home when he/she goes out?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F25: How often do you nag ... about little things?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F26: How often do you listen to his/her ideas and opinions?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F27: How often do you solve a problem together when you disagree about something?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F28: How often do you keep rules only when it suits you?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F29: How often do you get angry and yell at him/her?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F30: How often do you make sure that ... knows that he/she is appreciated?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F31: How often do you threaten punishment more often than you use it?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F32: How often do you speak of good things that he/she does?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F33: How often do you find out about ...'s misbehaviour?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F34: How often do you enforce a rule or do not enforce a rule depending on your mood?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

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The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

F19 ☐

F20 ☐

F21 ☐

F22 ☐

F23 ☐

F24 ☐

F25 ☐

F26 ☐

F27 ☐

F28 ☐

F29 ☐

F30 ☐

F31 ☐

F32 ☐

F33 ☐

F34 ☐

Parenting is a process which most parents learn as they experience the influence of their own parents and that of relatives, friends, the media, health professionals, and teachers.

Although there are wide variations in parenting practices, there are reliable research findings which show that authoritative parenting, which consists of warmth and acceptance of the child as well as appropriate guidance and limit-setting, achieves the best results.

This knowledge about parenting styles has been incorporated into the Assessment and Action Record, to emphasize the need to show physical affection towards children, to find things to praise in them, to guide them, and to recognize what they can do well.

F35: How often do you hit ... or threaten to do so?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F36: How often do you seem proud of the things he/she does?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F37: How often do you seem too busy to spend as much time with him/her as he/she would like?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

F38: How often do you take an interest in where he/she is going and whom he/she is with?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

The next section is also to be answered by the **FOSTER PARENT** (or other adult caregiver).

People often disagree with each other. The following sentences describe disagreements. Tell me how often you and your foster child/youth (or the child/youth in your care) do the following things.

F39: We make up easily when we have a fight.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F40: We disagree and fight.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F41: We bug each other or get on each other's nerves.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F42: We yell at each other.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F43: When we argue, we stay angry for a very long time.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F44: When we disagree, I refuse to talk to him/her.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F45: When we disagree, he/she stomps out of the room, or house, or yard.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F46: When we disagree about something, we solve the problems together.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F47: When we disagree about something, I give in just to end the argument.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

F48: When we disagree, another person comes in to settle things or find a solution.

☐ Not at all ☐ A little ☐ Sometimes ☐ Pretty often ☐ Almost all or all of the time

The next section is also to be answered by the **FOSTER PARENT** (or other adult caregiver).

Tell me how often per week you do the following activities with your foster child/youth (or the child/youth in your care).

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F47

F48

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

Family activities: If children feel settled, their educational chances are enhanced and this, in turn, will boost employment opportunities later. With a sound social network and good family relationships, the development of a secure identity is more likely, with an associated reduction in health problems. In other words, paying attention to the Family and Social Relationships section of the Assessment and Action Records will help with progress on the six other dimensions.

F49: How many days in a week do you eat together?

- ☐ Every day
- ☐ 5-6 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 1-2 times per month
- ☐ Rarely or never

F50: How many days a week do you watch television together?

- ☐ Every day
- ☐ 5-6 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 1-2 times per month
- ☐ Rarely or never

F51: How many days a week do you play sports together?

- ☐ Every day
- ☐ 5-6 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 1-2 times per month
- ☐ Rarely or never

F52: How many days a week do you play cards or games together?

- ☐ Every day
- ☐ 5-6 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 1-2 times per month
- ☐ Rarely or never

F53: How many days a week do you have a discussion together?

- ☐ Every day
- ☐ 5-6 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 1-2 times per month
- ☐ Rarely or never

F54: How many days a week do you do a family project or family chores together?

- ☐ Every day
- ☐ 5-6 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 1-2 times per month
- ☐ Rarely or never

F55: How many days a week do you have a family outing/entertainment together?

- ☐ Every day
- ☐ 5-6 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 1-2 times per month
- ☐ Rarely or never

F56: How many days a week do you visit relatives together?

- ☐ Every day
- ☐ 5-6 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 1-2 times per month
- ☐ Rarely or never

Sometimes different situations or circumstances arise which may affect family life. The next few questions are about some of these possible situations.

F57: How often does ... see television shows or movies that have a lot of violence in them?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

F58: How often does ... see adults or teenagers in your house physically fighting, hitting, or otherwise trying to hurt others?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

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F49

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F55

F56

F57

F58

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

F59: How often does ... hang around with kids you think are frequently in trouble?

☐ Often ☐ Sometimes ☐ Seldom ☐ Never

F60: How many of ...'s close friends do you know by sight and by first and last name?

☐ All ☐ Most ☐ About half ☐ Only a few ☐ None

The next few sections are to be answered by the **CHILD/YOUTH IN CARE.**

This section is about your relationship with friends, family, and others. The questions ask about your relationship with your foster parents (or other adult caregivers), your contacts with members of your birth family, your ability to get along well with adults and other children/youths, and whether you have any close friends.

The next few questions have to do with friends. Would you say:

F61: I have many friends.

☐ False ☐ Mostly false ☐ Sometimes true/Sometimes false ☐ Mostly true ☐ True

F62: I get along easily with others my age.

☐ False ☐ Mostly false ☐ Sometimes true/Sometimes false ☐ Mostly true ☐ True

F63: Others my age want me to be their friend.

☐ False ☐ Mostly false ☐ Sometimes true/Sometimes false ☐ Mostly true ☐ True

F64: Most others my age like me.

☐ False ☐ Mostly false ☐ Sometimes true/Sometimes false ☐ Mostly true ☐ True

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.

F65: I feel that my close friends really know who I am.

☐ False ☐ Mostly false ☐ Sometimes true/Sometimes false ☐ Mostly true ☐ True

F66: About how many days a week do you do things with close friends outside of school hours?

☐ Never
☐ Less than once a week
☐ 1 day a week
☐ 2 or 3 days a week
☐ 4 or 5 days a week
☐ 6 or 7 days a week

F67: How often do you share your secrets and private feelings with your close friends?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ Rarely

F68: Other than your close friends, do you have anyone else in particular you can talk to about yourself or your problems?

☐ Yes ☐ No

F69: What is their relationship to you? **(Mark every person that the child/youth feels he/she can talk to about himself/herself or his/her problems.)**

☐ Foster mother
☐ Foster father
☐ Biological mother
☐ Biological father
☐ Brother
☐ Sister
☐ Grandparents
☐ Other relative
☐ Parent's boyfriend/girlfriend
☐ A friend of the family or a friend's parent
☐ Teacher
☐ Coach or leader (e.g. Scout, Guide or religious leader)
☐ Child welfare worker
☐ Sitter or baby sitter
☐ Other (e.g. family doctor)

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F59

F60

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

F61

F62

F63

F64

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F67

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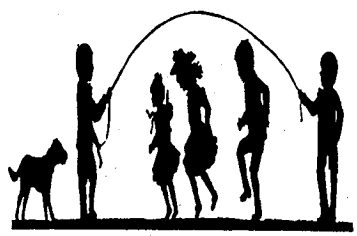
F69

Friends: While there are some exceptions, children who remain in touch with relatives and enjoy a stable social network, usually fare better than those who drift apart from home and neighbourhood.



F70: If you don't have anyone like this, would you like to be put in touch with someone who could give you support?

☐ Yes ☐ Not sure ☐ No

F71: During the past 6 months, how well have you gotten along with other young people such as friends or classmates?

☐ Very well, no problems
☐ Quite well, hardly any problems
☐ Pretty well, occasional problems
☐ Not too well, frequent problems
☐ Not well at all, constant problems

F72: During the past 6 months, how well have you gotten along with your foster mother (or other female caregiver)?

☐ Very well, no problems
☐ Quite well, hardly any problems
☐ Pretty well, occasional problems
☐ Not too well, frequent problems
☐ Not well at all, constant problems

F73: During the past 6 months, how well have you gotten along with your foster father (or other male caregiver)?

☐ Very well, no problems
☐ Quite well, hardly any problems
☐ Pretty well, occasional problems
☐ Not too well, frequent problems
☐ Not well at all, constant problems

F74: During the past 6 months, how well have you gotten along with your brothers and sisters or foster brothers and sisters living in the same house?

☐ Very well, no problems
☐ Quite well, hardly any problems
☐ Pretty well, occasional problems
☐ Not too well, frequent problems
☐ Not well at all, constant problems
☐ Not applicable - No other children/youths living in the same house

F75: Overall, do you have a good relationship with any other children/youths living in the same house?

☐ Yes ☐ Not sure ☐ No ☐ Not applicable - No other children/youths living in the same house

Thinking of your foster mother (or other female caregiver):

F76: How well do you feel that your foster mother (or other female caregiver) understands you?

☐ A great deal ☐ Some ☐ Very little

F77: How much fairness do you receive from your foster mother (or other female caregiver)?

☐ A great deal ☐ Some ☐ Very little

F78: How much affection do you receive from your foster mother (or other female caregiver)?

☐ A great deal ☐ Some ☐ Very little

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F70

F71

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F77

F78

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

Getting along with your foster parents: Research in the 1970s raised questions about the state's ability to parent and highlighted drift and instability for children/youth away from home.Given the significant risk within substitute care of placement change or disruption and their negative consequences, which can last well into adulthood, all sources of potential continuity - parents, relatives, schools and friends - need to be nurtured wherever possible.

Research indicates that the need for continuity is most likely to be met by relatives such as siblings, grandparents, aunts, and uncles or other significant people. Evidence exists that children/youth who remain in contact with their parents tend to do better in the short and in the long-term than those who grow apart.

F79: Overall, how would you describe your relationship with your foster mother (or other female caregiver)?

☐ Very close ☐ Somewhat close ☐ Not very close

Thinking of your foster father (or other male caregiver):

F80: How well do you feel that your foster father (or other male caregiver) understands you?

☐ A great deal ☐ Some ☐ Very little

F81: How much fairness do you receive from your foster father (or other male caregiver)?

☐ A great deal ☐ Some ☐ Very little

F82: How much affection do you receive from your foster father (or other male caregiver)?

☐ A great deal ☐ Some ☐ Very little

F83: Overall, how would you describe your relationship with your foster father (or other male caregiver)?

☐ Very close ☐ Somewhat close ☐ Not very close

CURRENT PLACEMENT: The next few questions have to do with your current living situation. Would you say that:

F84: You like living here?

☐ A great deal ☐ Some ☐ Very little

F85: You feel safe living in this home?

☐ A great deal ☐ Some ☐ Very little

F86: You feel safe living in this neighbourhood?

☐ A great deal ☐ Some ☐ Very little

F87: Your foster parents (or other adult caregivers) are interested in your activities and interests?

☐ A great deal ☐ Some ☐ Very little

F88: You would be pleased if you were to live here for a long time?

☐ A great deal ☐ Some ☐ Very little

F89: You are satisfied with the amount of privacy you have here?

☐ A great deal ☐ Some ☐ Very little

F90: You feel relaxed around the people with whom you are living?

☐ A great deal ☐ Some ☐ Very little

F91: You have a good relationship with other people with whom you are living?

☐ A great deal ☐ Some ☐ Very little

F92: Your current living situation meets your needs?

☐ A great deal ☐ Some ☐ Very little

F93: Overall, you are satisfied with your current living situation here?

☐ A great deal ☐ Some ☐ Very little

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F79

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

F80

F81

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F93

Recent research demonstrates that the majority of children/youth eventually return home to live with parents or relatives. Continuing contact with parents or the wider family is often a critical determinant of outcomes for children/young people.

Children/youth who find continuity of placement and attachments while in care are more likely to achieve stability in adulthood and experience improved educational chances, which in turn boosts employment prospects.

F93A: What improvements, if any, in your current living situation would you like to see happen in the coming year?

Specify:

The following section is to be filled out by the **CHILD WELFARE WORKER**, based on the information obtained on this entire developmental dimension of family and social relationships.

ATTAINMENT OF GENERAL SOCIAL AND FAMILY RELATIONSHIP OBJECTIVES OF THE CHILD WELFARE SYSTEM

F94: Objective 1: The child/youth has had continuity of care:

☐ Much continuity of care ☐ Some disruptions ☐ Serious disruptions

F95: Objective 2: The child/youth is definitely attached to at least one foster parent (or other adult carer):

☐ Definitely attached ☐ Some attachment ☐ Little or no attachment

F96: Objective 3: The child/youth's contact with his/her birth family strengthens his/her relationship with them:

☐ Most contacts are helpful ☐ Some contacts are unhelpful ☐ Most contacts are unhelpful ☐ No contacts

F97: Objective 4: The child/youth has had a stable relationship with at least one adult over a number of years:

☐ Long-term relationship (i.e., throughout life)
☐ Fairly long-term relationship (i.e., more than 3 years)
☐ Short-term relationship (i.e., 1-3 years)
☐ No stable relationship

F98: Objective 5: The child/youth is liked by adults and other children or youths:

☐ Usually liked by adults and other youths
☐ Usually liked by other youths
☐ Usually liked by adults only
☐ Not usually liked either by adults or other youths

F99: Objective 6: The child/youth is able to make friendships with others of the same age:

☐ Several friends ☐ Some friends ☐ Few friends ☐ No friends

F100: Objective 7: The child/youth is receiving foster parenting (or other substitute parenting) of high quality:

☐ Definitely yes ☐ Yes ☐ No ☐ Definitely not

F101: Objective 8: Either the child/youth's current placement is permanent, or else all feasible action is being taken to create a permanent placement for him/her:

☐ Definitely yes ☐ Yes ☐ No ☐ Definitely not

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.*

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

F94 ☐

F95 ☐

F96 ☐

F97 ☐

F98 ☐

F99 ☐

F100 ☐

F101 ☐

DEVELOPMENTAL DIMENSION 5: SOCIAL PRESENTATION

This dimension is about making sure that the child/youth in care 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.

The **FOSTER PARENT** (or other adult caregiver) is to answer this section.

P1: Does ... keep himself/herself clean (i.e., body, hair, teeth)?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

P2: Does ... take adequate care of his/her skin?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

P3: Overall, does ...'s personal appearance give people the impression that he/she takes care of himself/herself properly?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

P4: Does ... wear suitable clothes (e.g., at school, home, or parties, etc.)?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

P5: Can people understand what he/she is saying?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

P6: Does ... adjust his/her behaviour and conversation appropriately to different situations (e.g., at home, work, school, with friends and teachers)?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

The next section is to be answered by the **CHILD/YOUTH IN CARE**

P7: I am good looking.
☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

P8: I have a pleasant looking face.
☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

P9: Other kids think that I am good looking.
☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

P10: I have a good looking body.
☐ False ☐ Mostly false ☐ Sometimes false/Sometimes true ☐ Mostly true ☐ True

The following section is to be filled out by the **child welfare worker**, based on the information obtained on this entire developmental dimension of social presentation.

ATTAINMENT OF SOCIAL PRESENTATION OBJECTIVES OF THE CHILD WELFARE SYSTEM:

P11: Objective 1: The child/youth's appearance is acceptable to young people and adults:
☐ Acceptable to young people and adults
☐ Acceptable to young people only
☐ Acceptable to adults only
☐ Not acceptable to either young people or adults

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

P1

P2

P3

P4

P5

P6

P7

P8

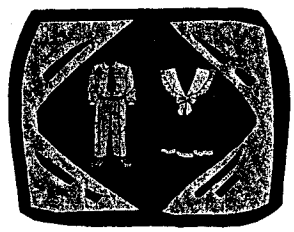
P9

P10

P11

DIMENSION 5: SOCIAL PRESENTATION

This dimension is about making sure that the child/youth in care 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.



P12: Objective 2: The child/youth's behaviour is acceptable to young people and adults:

- ☐ Acceptable to young people and adults
- ☐ Acceptable to young people only
- ☐ Acceptable to adults only
- ☐ Not acceptable to either young people or adults

P13: Objective 3: The child/youth can communicate easily with others:

☐ Very easily ☐ Easily ☐ With some difficulty ☐ With great difficulty

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.*

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P12

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

P13

Social presentation can be viewed as a combination of self-presentation and social skills which are learned throughout childhood.

A reasonable corporate parent will be as concerned about social presentation as about every other aspect of a child/youth's development.

Physical appearance affects how children/youth, especially adolescents, feel about themselves. They may also be stigmatized because of unattractive appearance, unlikeable personal habits, or inappropriate social behaviours.

DEVELOPMENTAL DIMENSION 6: EMOTIONAL AND BEHAVIOURAL DEVELOPMENT

This dimension is designed to assess how the child/youth in care has been feeling and how this may have affected the way he/she behaves.

This section is to be answered by the **CHILD/YOUTH IN CARE.**

For each of the following statements, choose the answer that best describes you.

B1: I show sympathy to (I feel sorry for) someone who has made a mistake.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B2: I can't sit still, I am restless.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B3: I destroy my own things.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B4: I try to help someone who has been hurt.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B5: I steal at home.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B6: I am unhappy, sad or depressed.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B7: I get into many fights.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B8: I offer to help clear up a mess someone else has made.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B9: I am easily distracted, I have trouble sticking to any activity.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B10: When I'm mad at someone, I try to get others to dislike him/her.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B11: I am not as happy as other people my age.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B12: I destroy things belonging to my family or other young people.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B13: If there is an argument, I try to stop it.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B14: I fidget.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B15: I can't concentrate, I can't pay attention.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

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The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

B1
B2
B3
B4
B5
B6
B7
B8
B9
B10
B11
B12
B13
B14
B15

DIMENSION 6: EMOTIONAL AND BEHAVIOURAL DEVELOPMENT.

This dimension is designed to draw attention to how the child/youth in care has been feeling and how this has affected the way he/she behaves.

Maltreated children are at risk for behavioural problems in school and in the community. Standardized measures of child behaviour allow us to assess the progress of children/youth in care over time and compare their development with that of their age peers in the general population.

B16: I am too fearful or anxious.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B17: When I'm mad at someone, I become friends with another as revenge.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B18: I am impulsive, I act without thinking.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B19: I tell lies or cheat.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B20: I offer to help young people (friend, brother or sister) who are having difficulty with a task.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B21: I worry a lot.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B22: I have difficulty waiting for my turn in games or group activities.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B23: When another young person accidently hurts me, I assume that he/she meant to do it, and I react with anger and fighting.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B24: When I am mad at someone, I say bad things behind his/her back.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B25: I physically attack people.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B26: I comfort another young person (friend, brother or sister) who is crying or upset.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B27: I cry a lot.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B28: I vandalize.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B29: I threaten people.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B30: I help to pick up things which another young person has dropped.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B31: I cannot settle to anything for more than a few moments.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B32: I feel miserable, unhappy, tearful, or distressed.

☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

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B16 ☐

B17 ☐

B18 ☐

B19 ☐

B20 ☐

B21 ☐

B22 ☐

B23 ☐

B24 ☐

B25 ☐

B26 ☐

B27 ☐

B28 ☐

B29 ☐

B30 ☐

B31 ☐

B32 ☐

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

B33: I am cruel, I bully or I am mean to others.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B34: When I'm mad at someone, I say to others: let's not be with him/her.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B35: I am nervous, highstrung or tense.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B36: I kick, bite, hit other people my age.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B37: When I'm playing with others, I invite bystanders to join in a game.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B38: I steal outside my home.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B39: I am inattentive, I have difficulty paying attention to someone.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B40: I have trouble enjoying myself.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B41: I help other people my age (friends, brother or sister) who are feeling sick.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B42: When I am mad at someone, I tell that person's secrets to a third person.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

B43: I encourage other people my age who cannot do things as well as I can.
☐ Never or not true ☐ Sometimes or somewhat true ☐ Often or very true

▶ Now, we have a few questions to ask you (i.e., the **CHILD/YOUTH IN CARE**) 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 foster parent (or other adult caregiver), your child welfare worker, or your family doctor.

B44: Has anyone in your school committed suicide?
☐ Yes, within the last year ☐ Yes, more than a year ago ☐ No, never ☐ I don't know

B45: Has anyone that you know personally committed suicide?
☐ Yes, within the last year ☐ Yes, more than a year ago ☐ No, never ☐ I don't know

B46: During the past 12 months, did you seriously consider attempting suicide?
☐ Yes ☐ No

B47: During the past 12 months, how many times did you attempt suicide?
☐ Never/none ☐ Once ☐ More than once

B48: 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)?
☐ I did not attempt suicide within the past 12 months ☐ Yes ☐ No

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B33

B34

B35

B36

B37

B38

B39

B40

B41

B42

B43

B44

B45

B46

B47

B48

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

This next section is to be answered by the **FOSTER PARENT** (or other adult caregiver).

The child/youth has just told us how he/she usually feels and behaves. In addition, we would also like to have your perspective, as his/her foster parent (or other adult caregiver), on how he/she has recently felt and behaved. Please describe the child/youth's feelings and behaviour during the past week, including today, based on your personal observations and knowledge.

B49: ... (i.e., the child/youth in care) has headaches or feels dizzy.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B50: ... doesn't participate in activities that used to be fun.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B51: ... argues or speaks rudely to others.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B52: ... has a hard time finishing his/her assignments or does them carelessly.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B53: ... 's emotions are strong and change quickly.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B54: ... has physical fights (hitting, kicking, biting, or scratching) with his/her family or others his/her age.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B55: ... worries and can't get thoughts out of his/her mind.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B56: ... steals or lies?
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B57: ... has a hard time sitting still (or has too much energy).
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B58: ... uses alcohol or drugs.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B59: ... is tense and easily startled (jumpy).
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B60: ... is sad or unhappy.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B61: ... has a hard time trusting friends, family members, or other adults.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B62: ... thinks that others are trying to hurt him/her even when they are not.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B63: ... has threatened to or has run away from home.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B64: ... physically fights with adults.
☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

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The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

B49

B50

B51

B52

B53

B54

B55

B56

B57

B58

B59

B60

B61

B62:

B63

B64

B65: ...'s stomach hurts or feels sick more than others his/her age.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B66: ... does not have friends or does not keep friends for long.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B67: ... thinks about suicide or feels he/she would be better off dead.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B68: ... has nightmares, has trouble getting to sleep, oversleeps, or wakes up too early.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B69: ... complains about or questions rules, expectations, or responsibilities.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B70: ... breaks rules, laws, or does not meet others' expectations on purpose.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B71: ... feels irritated.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B72: ... gets angry enough to threaten others.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B73: ... gets into trouble when he/she is bored.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B74: ... destroys property on purpose.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B75: ... has a hard time concentrating, thinking clearly, or sticking to tasks.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B76: ... withdraws from family and friends.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B77: ... acts without thinking and does not worry about what will happen.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

B78: ... feels as though he/she does not have any friends or that no one likes him/her.

☐ Never or almost never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always or always

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B65

B66

B67

B68

B69

B70

B71

B72

B73

B74

B75

B76

B77

B78

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

The following sections(B79 and B80) are to be answered jointly by the **CHILD/YOUTH**, **FOSTER PARENT** (or other adult caregiver) and the **CHILD WELFARE WORKER**.

B79: ADVERSE LIFE EVENTS: Which of the following adverse life events has ... experienced to the best of your knowledge: (a) in the last 12 months, and/or (b) since birth but more than 12 months ago? **(Mark all of which you are quite certain.)**

Death of birth parent	☐ Last 12 months	☐ Since birth but more than 12 months ago
Death of brother or sister	☐ Last 12 months	☐ Since birth but more than 12 months ago
Death of relative or close friend	☐ Last 12 months	☐ Since birth but more than 12 months ago
Divorce or separation of birth parents	☐ Last 12 months	☐ Since birth but more than 12 months ago
Serious physical illness of birth mother	☐ Last 12 months	☐ Since birth but more than 12 months ago
Serious physical illness of birth father	☐ Last 12 months	☐ Since birth but more than 12 months ago
Serious psychiatric disturbance of birth mother	☐ Last 12 months	☐ Since birth but more than 12 months ago
Serious psychiatric disturbance of birth father	☐ Last 12 months	☐ Since birth but more than 12 months ago
Birth mother's abuse of drugs or alcohol	☐ Last 12 months	☐ Since birth but more than 12 months ago
Birth father's abuse of drugs or alcohol	☐ Last 12 months	☐ Since birth but more than 12 months ago
Violence between birth parents	☐ Last 12 months	☐ Since birth but more than 12 months ago
Birth father spent time in jail	☐ Last 12 months	☐ Since birth but more than 12 months ago
Severe poverty	☐ Last 12 months	☐ Since birth but more than 12 months ago
Physical abuse	☐ Last 12 months	☐ Since birth but more than 12 months ago
Sexual abuse	☐ Last 12 months	☐ Since birth but more than 12 months ago
Emotional abuse	☐ Last 12 months	☐ Since birth but more than 12 months ago
Neglect	☐ Last 12 months	☐ Since birth but more than 12 months ago
Other adverse life event:	☐ Last 12 months	☐ Since birth but more than 12 months ago

Specify:

_____

_____

_____

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

B79 ☐

The Assessment and Action Record from the Looking After Children approach is a particularly promising vehicle for improving child protection practice because it assesses needs, suggest resilience-focused interventions and processes, and measures developmental outcomes in seven major dimensions of a child's or youth's health and human development.

Resilience is about successful adaptation, positive functioning and competence development in the face of adversity or risk.

Resiliency is a positive approach which identifies an individual's strengths in regards to his experiences and builds positive life events for children and youth in care while empowering them.

B80: POSITIVE LIFE EVENTS: What, to the best of the knowledge and in the joint opinion of the child/youth, the foster parent, and the child welfare worker, is the most positive life event that the child/youth has experienced in terms of promoting his/her positive development?

(a) in the last 12 months? Specify:

(b) since birth but more than 12 months ago? Specify:

The following section is to be filled out by the **CHILD WELFARE WORKER**, based on the information obtained on this entire developmental dimension of emotional and behavioural development.

ATTAINMENT OF EMOTIONAL AND BEHAVIOURAL DEVELOPMENT OBJECTIVES OF CHILD WELFARE SYSTEM:

B81: The child/youth is free of serious emotional and behavioural problems:

- ☐ No problems
- ☐ Minor problems
- ☐ Problems exist that need remedial action
- ☐ Serious problems exist which need specialized assistance

B82: The child/youth is receiving effective treatment for all persistent problems:

- ☐ Does not need treatment
- ☐ Is receiving effective treatment
- ☐ Is receiving some treatment
- ☐ Is not receiving effective treatment

Note to the child welfare worker: *If anyone disagrees with these answers to the Emotional and Behavioural Development objectives, please note the details on the opposite page.*

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The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

B80a ☐

B80b ☐

B81 ☐

B82 ☐

Resilience is normal development under difficult life circumstances.

A single positive experience or episode, such as the impact of a sports coach, foster parent, or teacher, can redirect a child or youth towards positive development. This can also be referred to as turning points in development.

Practionners must pay close attention to these positive events in order to improve planning and promote positive development. Those positive experiences have the potential of raising self-esteem, exposing children to new opportunities for positive growth, as well as favoring a chain of protective thinking.

DEVELOPMENTAL DIMENSION 7: SELF-CARE SKILLS:

The questions in this dimension are designed to find out if the child/youth in care is learning to care for himself/herself at a level appropriate to his/her age and ability when given the necessary resources and support.

The questions in the section are to be answered by the **FOSTER PARENT** (or other adult caregiver).

Now, I would like to ask you some questions about ...'s self-care's responsibilities. How often does ... :

S1: Make his/her bed?
☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S2: Clean his/her own room?
☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S3: Pick up after himself/herself?
☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S4: Help keep shared living areas clean and straight?
☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S5: Do routine chores such as mow the lawn, help with dinner, wash dishes, etc.?
☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S6: Help manage his/her own time (get up on time, be ready for school, etc.)?
☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S7: Use the vacuum cleaner?
☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S8: Use the washer and the dryer?
☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S9: Avoid common hazards related to poisons, tools, electricity, fire, etc.?
☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S10: Brush his/her teeth?
☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S11: Comb his/her hair?
☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S12: Undertake simple first aid?
☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S13: Use a public telephone?
☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S14: Save money for things he/she wants to buy?
☐ Often ☐ Sometimes ☐ Seldom ☐ Never

S15: Use a library card?
☐ Often ☐ Sometimes ☐ Seldom ☐ Never

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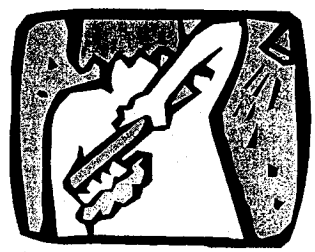
The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

S1 ☐
S2 ☐
S3 ☐
S4 ☐
S5 ☐
S6 ☐
S7 ☐
S8 ☐
S9 ☐
S10 ☐
S11 ☐
S12 ☐
S13 ☐
S14 ☐
S15 ☐

DIMENSION 7: SELF-CARE SKILLS:

The questions in this dimension are designed to find out if the child/youth in care is learning to care for himself/herself at a level appropriate to his/her age and ability, when given the necessary resources and support.



Child welfare workers and foster parents: If the child/youth in care is not learning to care for himself/herself, it is important that the child or youth practice these skills.

Daily living programs are specifically designed for children and youth with disabilities. They cover areas such as independent living skills, mobility skills, personal care skills, and continence management.

S16: DAILY LIVING PROGRAMS: Is ... following a formal daily living program that teaches independent living skills?

☐ Yes ☐ No

S17: Is ... receiving all necessary assistance to learn independent living skills that are appropriate for his/her age?

☐ Yes ☐ No

The following section is to be filled out by the **CHILD WELFARE WORKER**, based on the information obtained on this entire developmental dimension of self-care skills.

ATTAINMENT OF SELF-CARE OBJECTIVES OF THE CHILD WELFARE SYSTEM:

S18: Objective 1: The child/youth is learning to care for himself/herself at a level appropriate to his/her age and ability when given the necessary resources and support.

☐ Already competent ☐ Learning to care for himself/herself ☐ Not learning to care for himself/herself

Note to the child welfare worker: *If anyone disagrees with these answers to the Self-Care objectives, please note the details on the opposite page.*

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S16

S17

S18

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

CONCLUDING SECTION: WORKING TOGETHER AS A TEAM TO IMPLEMENT LOOKING AFTER CHILDREN

In the Looking After Children philosophy, the people who have collaborated in completing this Assessment and Action Record, namely, the child/youth in care, the foster parent (or other adult caregiver), and the child welfare worker, are intended to form a team that works together in the best interests of the child/youth. Please indicate how accurate each of the following statements is as a description of your team's success to date in implementing key priorities and tasks from Looking After Children. The answer you provide to each item should reflect, as much as possible, agreement (consensus) among the people involved. If you cannot agree about a particular statement mark, "Uncertain."

In our work together as a team to date, we (the child/youth in care, foster parent or other adult caregiver, and child welfare worker) have been successful in accomplishing the following priorities and tasks from Looking After Children:

T1: Keeping the needs of the child/youth ahead of those of the foster parent and the child welfare worker.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T2: Providing a quality of parenting equal to that of other parents who have adequate resources.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T3: Filling out the Assessment and Action Record as carefully and completely as possible.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T4: Identifying clearly the needs of the child/youth in the Plan of Care.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T5: Implementing the objectives identified in the Plan of Care.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T6: Treating each other as full partners.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T7: Reaching out and cooperating with others who are involved in the child/youth's life (e.g., birth or adoptive parents, teachers, doctors).

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T8: Taking the child/youth's point of view into account.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T9: Planning according to the individualized needs of the child/youth.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T10: Providing opportunities to the child/youth to stay in touch with his/her birth family (unless there are specific reasons for not doing this).

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T11: Providing opportunities to the child/youth to stay in touch with the cultural traditions of his/her birth family.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T12: Promoting positive outcomes for child/youth in care, rather than just preventing harm.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

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The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

T1
T2
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T4
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T8
T9
T10
T11
T12

Partnership is built into Looking After Children: Good Parenting, Good Outcomes.

Effective partnerships can be built between people of unequal power, provided that the relationship acknowledges and clarifies this inequality.

Partnership requires:

> Listening to users and carers

>Anti-discriminatory practices

>Agreements and recording of progress

>Providing sufficient information

>Honesty and openness

>Genuine participation

T13: Aiming at outcome targets for the child/youth in care that are on the same level as those for children/youth of a similar age in the general population.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T14: Setting goals for the child/youth in care at the same level as for youths of the same age in the general population, even while recognizing that child/youth in care may have needs that are more difficult to meet.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T15: Focusing on the everyday experiences and actions needed by the child/youth now to succeed later in adult life.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T16: Collaborating in a child/youth-centred, developmental approach rather than being governed by bureaucratic red-tape.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T17: Taking account of the perspectives of all those involved, paying particular attention to the wishes and feelings of the child/youth in care.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T18: Improving the child/youth's health and educational status.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T19: Helping this child/youth to develop his/her potential to a maximum rather than a minimum level.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T20: Collaborating on ambitious but achievable objectives in all areas of the child/youth's development.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T21: Making clear in our action plans who is responsible for doing what and by when.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T22: Believing that our work together can bring about positive change even in less than ideal situations.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T23: Promoting continuity and preventing disruptions and multiple placements for the child/youth.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T24: Focusing on the everyday goals of parenting.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

T25: Focusing on the successes of the child/youth, not just on his/her problems.

☐ Definitely true ☐ Mostly true ☐ Uncertain ☐ Mostly false ☐ Definitely false

Thank you for your participation!

Q6. How many interview/sessions did it take to complete this AAR (including the Background Information section)?

☐ 1 session ☐ 2 sessions ☐ 3 sessions ☐ 4 or more sessions

Q7. How long did it take to complete this AAR (including the Background Information section)?

☐ hours and ☐☐ minutes

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T13

The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).

T14

T15

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This second Canadian adaptation (last updated in March, 2002) was prepared by Robert Flynn and Hayat Ghazal, in consultation with Daniel Moore (Grey Children's Aid Society), Sandy Moshenko and Liane Westlake (Ontario Association of Children's Aid Societies), Beverly Burns, Francine Groulx, and Raymond Lemay (Services to Children and Adults of Prescott-Russell), Wendy James, Peter Dudding, Shannon Balla, and Victoria Norgaard (Child Welfare League of Canada) and Louise Legault (Centre for Research on Community Services, University of Ottawa). Financial support was provided by the Social Sciences and Humanities Research Council of Canada, the Ministry of Community and Social Services of Ontario, and Human Resources Development Canada. Formatting in Teleform was done by Andreas Reichert and Louise Legault.

Looking After Children in Ontario Project

Principal Investigator:	Robert Flynn, University of Ottawa
Co-investigators:	Tim Aubry, Marie Drolet, and Doug Angus, University of Ottawa
Collaborators:	Peter Dudding, Child Welfare League of Canada Gail Vandermeulen, and Sandy Moshenko, Ontario Association of Children's Aid Societies Raymond Lemay, Services to Children and Adults of Prescott-Russell
Project Coordinators:	Susan Petrick and Liane Westlake (Implementation) Hayat Ghazal (Research)

Looking After Children in Canada Project

Project Director:	Peter Dudding, Child Welfare League of Canada
Principal Investigator:	Robert Flynn, University of Ottawa
Co-investigators:	Sybelle Artz, University of Victoria Shirley Cole, Government of Prince Edward Island Marie-Andrée Poirier, Université de Montréal
Project Coordinators:	Victoria Norgaard and Shannon Balla (Implementation) Louise Legault (Research)

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Ottawa, March 2002

APPENDIX C

Université d'Ottawa · University of Ottawa

Faculté des sciences sociales
Centre de recherche sur les services communautaires

Faculty of Social Sciences
Centre for Research on Community Services

CONSENT FORM FOR FOSTER PARENTS

I, (name of foster parent) _____, wish to participate in this study of the Looking After Children approach in Ontario that is being carried out in collaboration with the Ontario Association of Children's Aid Societies (OACAS) and your local CAS. This research is directed by Dr. Robert Flynn of the School of Psychology at the University of Ottawa and funded by the Social Science and Humanities Research Council (SSHRC) and the Ministry of Community, Family and Children's Services of Ontario. This study has two purposes. The first purpose is to find out my opinion of the Looking After Children (LAC) approach, including the Assessment and Action Record (AAR), and learn how helpful this approach is to me as a foster parent. The second purpose of the study is to gather information on any out-of-pocket expenditures that are not reimbursed by the local Children's Aid Society (CAS) and not covered by CAS' monthly payments or per diem. My responses will be pooled with those of other foster parents in Ontario. The information will be used to provide summary feedback on the Looking After Children approach and the AAR from foster parents in the province and to estimate any costs of foster care that are not covered by the CAS.

If I agree to participate, I will complete the enclosed questionnaire. I will need approximately 10-15 minutes to respond to the questionnaire. It includes questions about the Looking After Children approach, including the Assessment and Action Record, and about non-reimbursed expenditures made by foster parents or others. My responses to the questionnaire will never be revealed to the local CAS or to the OACAS.

The information I provide will be locked up in the researchers' laboratory and only the researchers will have access to it. I have been assured that the information I share will remain strictly confidential and that my name will not be recorded with my responses or identified in any way. The only exception would be if I was to inform the research staff member that someone was hurting my foster child/youth physically or sexually or that he or she intended to hurt him/herself or another person. In that case, the person working on the study would have to take any steps necessary to protect my foster child/youth or the other person.

My participation is strictly voluntary and I am free to refuse to participate or withdraw from the study at any moment, without penalty. If I am uncomfortable with any question, I may refuse to answer it.

There are two copies of the consent form, one that I will keep and one that I will return to the researchers.

If I have any questions about this research study, I may call Dr. Robert Flynn at (613) 562-5800 (X1855) or the project coordinator, Ms. Hayat Ghazal (613-562-5800, X1857).

If I have questions about the ethical aspects of the research or I wish to make a complaint about how it being conducted, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, 550 Cumberland St, Room 160. Tel. (613) 562-5387; Fax. (613) 562-5318; e-mail: ethics@uottawa.ca

PARTICIPANT'S SIGNATURE: _____ DATE: _____

Robert J. Flynn _____
PhD, CPsych
Principal Investigator

Joan MacDonald _____
BA, PhD candidate

WE ARE AWARE THAT YOUR TIME IS PRECIOUS. THANK YOU FOR READING THIS MATERIAL AND FOR YOUR PARTICIPATION.

34, rue Stewart
Ottawa (Ontario) K1N 6N5 Canada

34 Stewart Street
Ottawa, Ontario K1N 6N5 Canada

(613) 562-5908 • Téléc./Fax (613) 562-5188

APPENDIX D

Ill-health Index

These questions are from the AAR, appropriate page numbers for the AAR are shown beside each question.

HUI-Q10 (p. 3 on the AAR): **SPEECH**: Are you usually able to be understood completely when speaking to strangers in your own language?

YES (Go to HUI-14) NO REFUSAL (Go to HUI-14)

HUI-Q28 (p. 4 on the AAR): **PAIN AND DISCOMFORT**: Are you usually free of pain and discomfort?

YES (Go to H-10) NO REFUSAL (Go to H10)

H11 (p. 5): **DISABILITY:** Does ... have any long-term conditions or health problems which prevent or limit his/her participation in school, at play, or in any other activity for a child/youth of his/her age?

YES NO

E6 (p. 14): Does ... receive any special help at school because of a physical, emotional, behavioural, or some other problem that limits the kind or amount of school work he/she can do?

YES NO

H10 (p. 5): **LONG-TERM CONDITIONS**: In the following questions "long-term conditions" refer o conditions that have lasted are are expect to last 6 months or more and have been diagnosed by a health professional. Does ... have nay of the following long-term conditions? **(Read the list and mark all that apply.)**

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
H. Cerebral palsy
J. Kidney condition or disease
K. Mental handicap
L. Learning disability
M. Attention deficit disorder
N. Emotional, psychological or nervous difficulties
O. Any other long-term condition
P. None

HUI-Q25 (p. 4 on the AAR): **FEELINGS**: Would you describe yourself as being usually: **(Read list. Mark one only)**?

Happy and interested in life?
Somewhat happy?
Somewhat unhappy?
Unhappy with little interest in life?
So unhappy that life is not worthwhile?

HUI-Q26 (p. 4 on the AAR): **MEMORY**: How would you describe your usual ability to remember things : **(Read list. Mark one only)**?

Able to remember most things?
Somewhat forgetful?
Very forgetful?
Unable to remember anything at all?

HUI-Q27 (p. 4 on the AAR): **THINKING**: How would you describe your usual ability to think and solve day-to-day problems: **(Read list. Mark one only)**?

Happy and interested in life?
Somewhat happy?
Somewhat unhappy?
Unhappy with little interest in life?
So unhappy that life is not worthwhile?

QUESTIONNAIRE FOR FOSTER PARENTS

The goal of the following questionnaire is to obtain your opinion of the Looking After Children approach, including the Assessment and Action Record (AAR). It also asks about any non-reimbursed expenditures that you or others may have made for the young people in your care. Thank you very much for your participation. Please put an X in the circle next to the response that best reflects your opinion or your experience.

Note: *Si vous préférez obtenir ce questionnaire et les documents qui l'accompagne en français, veuillez communiquer avec le Dr. Robert Flynn au (613) 562-5800 (poste 1855) ou avec la coordinatrice du projet, Mme Hayat Ghazal au (613) 562-5800 (poste 1857).*

SECTION I: LOOKING AFTER CHILDREN, INCLUDING THE ASSESSMENT AND ACTION RECORD (AAR)

1. For approximately how many young people in your care have you ever completed the Assessment and Action Record (or "**AAR**") in collaboration with the child welfare worker(s)? ***(The AAR is a questionnaire from Looking After Children that is completed annually with the young person's child welfare worker(s), to assess the young people's needs and progress)***. (Please put an X in the circle next to the response that best reflects your experience.)

   None ○ One ○ Two ○ Three ○ More than three ○

2. For how many years have you been using the AAR from the Looking After Children approach for the young people in your care in collaboration with their child welfare workers?

   Never used ○ Less than 1 yr. ○ 1 yr. ○ 2 yrs. ○ 3 yrs or more ○

3. Do you use the AAR with all or most of the young people in your care, or with only a few?

   All ○ Most ○ A few ○

4. How much training did you receive related to the **Looking After Children** approach, including the use of the AAR?

   None ○ Less than a day ○ One day ○ Two days ○ More than two days ○

5. How useful was this training in preparing you to use the AAR? (Please put an X in the circle that best matches your response.)

   Very useful ○ Useful ○ Not very useful ○ Not applicable (no training received) ○

6. How useful do you find the AAR in carrying out your responsibilities as a foster parent for the young person on whom the AAR has been completed? Please rate the usefulness of the AAR by responding to each of the following items.

   a) The AAR helps me to better understand the needs of the young person in care.

      Very useful ○ Useful ○ Not very useful ○

   b) The AAR helps me to collaborate better with the young person's child welfare worker.

      Very useful ○ Useful ○ Not very useful ○

   c) The AAR helps me to know more clearly what my responsibilities are as a foster parent.

      Very useful ○ Useful ○ Not very useful ○

(Over)

d) The AAR helps me to plan for the future of young person in care.

Very useful ○ Useful ○ Not very useful ○

e) The AAR helps me to be a more effective foster parent.

Very useful ○ Useful ○ Not very useful ○

f) The AAR helps me to improve my relationship with the young person.

Very useful ○ Useful ○ Not very useful ○

g) The AAR helps me to become more aware of the progress made by the young person.

Very useful ○ Useful ○ Not very useful ○

7. How often do you use the information in the **AAR** in the following ways? (Please put an X in the circle that best reflects your experience.)

a) I use the AAR to discuss the young person's needs with his/her child welfare worker.

Frequently ○ From time to time ○ Rarely or never ○

b) I use the AAR to work more effectively with the young person.

Frequently ○ From time to time ○ Rarely or never ○

c) I use the AAR to monitor the young person's progress.

Frequently ○ From time to time ○ Rarely or never ○

d) I use the AAR to work in closer partnership with the young person's child welfare worker.

Frequently ○ From time to time ○ Rarely or never ○

SECTION II – NON-REIMBURSED EXPENDITURES

1. *Non-reimbursed expenditure:* ***For the fiscal year 2002-2003 (i.e., April 1, 2002 - March 31, 2003), please estimate how much money was spent in an average month on each young person in your care by you or other people but that was NOT reimbursed by the Children's Aid Society (CAS) and was also NOT covered by the CAS's monthly payments to you or by per diem.*** These non-reimbursed expenditures may have been made by you the foster parent(s), by the young person in care, by his or her birth parents, or by any other adult. These expenditures may have been to cover the cost of medication, food, clothing, entertainment, equipment for special needs, transportation, gifts, etc. **Please record your best estimate of the non-reimbursed expenditures made in 2002-2003 for each foster young person in your care, in the appropriate boxes in the TABLE below. (Include $0.00, if applicable).** The initials, date of birth and gender of each young person have already been filled in below.

2. *Reduction in net monthly income from outside paid employment:.* ***When you became a foster parent, did you (or your spouse or partner) experience a decrease in your net monthly income (after taxes) from outside paid employment?*** (DO NOT INCLUDE YOUR FOSTER PARENT PAYMENTS AS PART OF YOUR NET MONTHLY INCOME.) Please record the reduction, if any, in the total net monthly income of you and your spouse or partner in the TABLE below. **(Include $0.00, if applicable).**

3. *Reduction in weekly volunteer (unpaid) work:* ***When you became a foster parent, did you (or your spouse or partner) reduce the number of hours of volunteer (unpaid) work that you engaged in during an average week?*** Please record the reduction, if any, in the total number of weekly volunteer hours worked by and your spouse or partner in the appropriate row in the TABLE below. **(Include 0 hours, if applicable).**

4. *Volunteer (unpaid) work by young people in care:* ***Did the foster young people in your care do any volunteer (unpaid) work in an average week during fiscal year 2002-2003?*** Please record the average number of weekly volunteer hours for each foster young person in the appropriate cells in the TABLE below. **(Include 0 hours, if applicable).**

		Foster young person no. 1	Foster young person no. 2	Foster young person no. 3	Foster child/ youth no. 4
Young person's initials (initial letters of first and last names)					
Young person's date of birth (dd/mm/yyyy)					
Young person's gender (male; female)					
1) **Monthly** non-reimbursed expenditures made during fiscal year 2002-2003 by:	Foster parents	$	$	$	$
	Foster young person	$	$	$	$
	Biological parent(s)	$	$	$	$
	Other adults, if any	$	$	$	$
2) Reduction in foster parents' net **monthly** income from outside paid employment		$ /mth	$ /mth	$ /mth	$ /mth
3) Reduction in foster parents' average **weekly** hours of volunteer work (unpaid)		hrs/wk	hrs/wk	hrs/wk	hrs/wk
4) Young person in care average **weekly** hours of volunteer work (unpaid)		hrs/wk	hrs/wk	hrs/wk	hrs/wk

(Over)

SECTION III – COMMENTS

1. Please add any comments that you may have about the Looking After Children Approach, the AAR or out-of-pocket expenditures for foster care.

Thanks again for your participation!

APPENDIX E

Variable	Service provider	Unit Cost	Unit duration	Source of Unit cost
bds1a	Family physician reassessment	$29.95	visit	2003 OHIP Schedule of Benefits (Pg. A1) Services are costed for a minimum of 20 min per visit
	Assessment	$54.10	visit	2003 OHIP Schedule of Benefits (Pg. A1) Services are costed for a minimum of 20 min per visit
bds2a	Pediatrician	$73.85	visit	Repeat consultation OHIP (pg. A46)
	Consultation	$112.35	visit	Consultation (OHIP Bulletin #4404 -- fee for 2002 to August 2003)
bds3a	Opthamologist	$58.25	visit	2003 OHIP Schedule of Benefits (Pg. A39)
bds4a	Psychiatrist Therapy	$108.30	1 hour	2003 OHIP Schedule of Benefits (Pg. A51)
	Consultation	$107.20	visit	Consultation (OHIP Bulletin #4404 -- fee for 2002 to August 2003)
bds5a	Other MD	$112.35	visit	Consultation (OHIP Bulletin #4404 -- fee for 2002 to August 2003)
bds6a	Nurse	$40.50	1 hour	Ontario Nurse's Association hospital nurses' rate of 33.75 + 14% in lieu of benefits + 6% vacation pay
bds7a	Dentist	$56.29	per visit	Ontario Dental Assocation rates: Assessment $56.29; Caries: $49.05 to $98.10
bds8a	Orthodontist	$192.00	1 hour	Ontario Dental Assocation guidelines for most services
bds9a	Optometrist	$39.10	1 visit	OHIP rates: Periodic Assessment of person under 19 years of age= $39.10
bds10a	Audiologist	$262.00	1 hour	OSLA fee schedule for hourly rate services
bds11a	Speech therapist	$120.00	1 hour	Large group private practice hourly fees for Grey & Waterloo
bds12a	Psychologist/Psych Assoc	$110.00	$24,405 /194 & /11 + 20 % for benefits	Rates reimbursed by Ontario Ministry of Health for hospital visits
bds13a	Physiotherapist	$110.00	vist	Rates reimbursed by Ontario Ministry of Health for hospital visits Ontario Physiotherapists Association guidelines for private practice: $150/hr
bds14a	Occupational therapist	$110.00	visit	Rates reimbursed by Ontario Ministry of Health for hospital visitsOn
bds15a	Lawyer	$78.00	1 hour	legal aid lawyer; Legal Aid Ontario (based on Tier 2 rates for 2002/2003)
	CAS protection worker	$30.38	1 hour	Social Worker salaries: $25.32 + 20 % for benefits
bds16a				Source: StatsCan (Average for Ontario
bds17a	Non-CAS social worker	$33.60	1 hour	Welfare Worker salaries: $28.00 + 20 % for benefits
bds18a	**Educateur/CYW**	$30.38	1 hour	Usually social workers: $25.32 + 20 % for benefits
bds19a	Volunteer driver	$6.85	1 hour	
bds20a	Police Officer	$55.00	1 hour	$65,000 annual average salary for all police officers; Ontario Solicitor General indicated $55/hr a reasonable estimate for staff working with youth, who need specialized training, so are paid above average
bds21a	**Employment specialist**	$30.38	1 hour	Usually social workers: $25.32 + 20 % for benefits
bds22a	Teacher, reg. Classroom Elem	$15.86	1 Day	$59,020 /194 & /23 (elementary)=cost per child per day + 20 % for benefits
	Secondary	$18.52	$24,405 /194 &	$62,940 /194 & /21 (secondary)=cost per youth per day + 20 % for benefits
bds23a	Teacher, spec Ed	$33.96	1 Day	$60,400 /194 & /11 (elementary)=cost per child per day + 20 % for benefits
	Secondary	$34.73	1 Day	$61,775 /194 & /11 (secondary)=cost per youth per day + 20 % for benefits
bds24a	Teacher's aide, spec ed, elem	$13.72	1 Day	$24,405 /194 & /11 + 20 % for benefits
	Teacher's aide, spec ed, second	$13.78	1 Day	$24,530 /194 & /11 + 20 % for benefits
bds25a	Educational Tutor	$40.00	1 hour	Average charges for Tutoring centres $40-$45/hr; with initial assessment and registration ranging from $200 to $240
bds26a	Respite worker	Actual amount	1 Day	
bds27a	Summer camp	Actual amount	1 Day	
bds28a	Pd. Recreation/coach	$6.85		
bds29a	Volunteer coach	$6.85		
bds30a	Other (See Below)			
	Massage Therapist	$60.00	1 hour	Ontario Massage Therapists Association Guidelines
	Ambulance Staff	$240.00	1 hour	OHIP out of province charge; charged by OHIP
	Emergency Visit	$190.75	$24,405 /194 & /11 + 20 % for benefits	Ministry of Health reimbursement for Emergency visit, plus $80.75 for Emergency medicine consultation reimbursed by OHIP
brs31a	Foster Care	Actual amount	1 Day	
brs32a	Group Care	Actual amount	1 Day	
brs33a	Residential Treatment	Actual amount	1 Day	
brs34a	In hospital	$800.00	1 Day	Average cost per bed provided by Ontario Hospital Association
brs35a	Other (See Below)			
	Youth Detention Secure Custody (Eastern Region)	$363.00	1 Day	Average cost per bed provided by Ontario Ministry of Children
	Youth Detention Open Custody (Eastern Region)	$269.00	1 Day	Average cost per bed provided by Ontario Ministry of Children
	Independent Living	Actual amount	1 Day	
	ECM	Actual amount	1 Day	
bedcq75	Weekly hours FC works	$6.35	hour	Minimum wage for under 18

***Actual amount = amount included in Agency's accounting information for each child

APPENDIX F

COSTING VARIABLES DICTIONARY

INDIVIDUAL/ FAMILY	SOCIETY				
Foster parents	**CAS**	**Ministry of Education**	**Ministry of Health**	**Social services**	**Other organizations**
Living expenses: rent food furniture clothes, etc. transportation medication leisure activities holidays volunteer work Income/tax	staff (salaries, direct & indirect services, travel time, paper work, training, benefits) operating costs foster parent payments allowances to foster children reimbursed expenses: medication summer camp leisure activities transportation legal services	staff (salaries, direct & indirect services, travel time, paper work, training, benefits) operating costs	Hospitalization Medication (while in hosp.) Emergency Room Outpatient Hearing aids Health prof. Clinics	Social funds Dental care Glasses Hearing aids Professionals Home services Staff	Support services Community Ctr Social club lawyer leisure volunteers

APPENDIX G

COSTING DATA QUESTIONNAIRE

PART I

Data concerning the children and foster family

Date data collected: _____

Collected by: _____

1. DEMOGRAPHIC DATA

(Source: AAR and CAS file)

1.1 File number (AAR, ques. BG1)

1.2 Date of birth (AAR, ques. BG3)

1.3 Gender (AAR, ques. BG2)

1.4 Referral date: ____/___/_____

(YY/MM/DD)

1.5 Source of referral: _____

1.6 Primary reason for current admission to Care (AAR, ques. BG7)

1.7 Legal status of the child (AAR, ques. BG5)

1.8 Date of first contact with the agency ____/__/_____

(YY/MM/DD)

1.9 Date file was closed (if applicable) ____/__/_____

(YY/MM/DD)

1.10 First language (AAR, ques. ID8)

1.11 Language spoken in the foster home (AAR, ques. BG43)

1.12 Highest level of education obtained by foster parent (AAR, ques. BG50, p. 7)

1.13 If applicable, highest level of education obtained by other foster parent or adult over 18 in household (AAR, ques. BG50, p. 7)

1.14 Main current activity of foster parent (AAR, ques. BG50, p. 7)

1.15 If applicable, main current activity of other foster parent or adult over 18 in household (AAR, ques. BG50, p. 7)

1.16 The category of estimated total income before taxes and deductions of the household income of the foster parents (AAR, BG42)

2. RESIDENTIAL

2.1 What situation best describes the child's current placement? (AAR, BG8)

2.2 Composition of the family where the child is currently placed? (AAR, BG50, p.7)

2.3 The type of dwelling that best describes the child's current placement? (AAR, BG12)

2.4 How many bedrooms are there in the child's current placement? (AAR, BG16)

2.5 Does the child have his or her own bedroom? (AAR, BG17)

2.6 During the past year, has the child moved

(Source: File – circle correct answer)

a) from an institution to the foster family Yes No

b) from a group home to a foster family Yes No

c) from one foster family to another foster family Yes No

Costs associated with the move $_____

2.7 If the child moved was there a period of transition between the two sites?

(Source: File)

Yes No

If yes, specify the duration of this period of transition _____

2.8 Does the child have special needs that required environmental adaptations or assistance? (Source: File) Yes No

If yes, please specify:

Type / Location	Description	Provided by	Paid by	Costs	Date of adaptation
Kitchen					
Bathroom					
Bedroom					
Mobility					
Care person					
Exterior					
Other (specify)					

2.9. Was there damage caused to the property by the child or youth in care?

(Source: File) Yes No

If yes, what were the damages, the costs, and who paid the costs of these damages (the person or the agency who assumed financial responsibility for these damages? Please specify below:

Descriptions of the damages	Costs per year	Who paid the costs incurred (indicate the contribution of each)

3. EDUCATION

3.1 What grade is the child or youth in? (Source: AAR, ques. E2)

3.2 If the child attends school, which school is he or she in?

(Source: CAS file) _____

3.3 What type of school is the child currently in? (Source: AAR, ques. E1)

3.4 Does the child receive special /resource help at school because of a physical, emotional, behavioural, or some other problem that limits the kind or amount of school work that he or she can do? (Source: AAR, ques. E6)

a) How many hours a week of special help does the child receive at school?

(Source: CAS file) _____hrs/wk

3.5 Does the child receive any special help or tutoring outside school?

(Source: AAR, ques.E7)

a) How many hours a week of special help or tutoring does the child receive outside school?

(Source: CAS file) _____hrs/wk

b) Who provides this special help or tutoring outside school?

(Source: CAS file)

c) Who covers the costs of this special help or tutoring outside school?

(Source: CAS file)

1. C.A.S.
2. Foster parents
3. Others (Please specify): _____

d) What are the costs? $_____/wk or $_____/yr

3.6 What type of transportation does the child use to get to school?

(Source: C.A.S. file)

1. No type of transportation required
2. Transportation provided by the school
3. Transportation provided by the foster parents
4. Public transport
5. Other (Please specify): _____

3.7 Are there costs associated with this transportation? Yes No

a) If yes, who covers the costs associated with transportation?

1. C.A.S.
2. Foster parents
3. Others (Please specify): _____

3.8 List the school trips in which the child has participated during the previous year?

School trips	Person or agency responsible for the costs	Cost / yr

4. FINANCIAL STATUS

4.1 Does the child or youth have a job? (AAR, ques. E67)

a) If yes, specify Number of hrs/week (AAR, ques. E68)

Type of job _____

Date started ____/___/_____

(YY/MM/DD)

Salary $_____/hr

Net weekly income $_____/wk

Annual Salary: $

4.2 Does the child or youth have other sources of income? Yes No

1. Weekly allowance provided by the C.A.S. $_____/month
2. Amount provided by biological parents $_____/month
3. Amount provided by other sources $_____/month

Additional Annual Income: $

4.3 Does the child or youth do volunteer work? Yes No

a) If yes, specify: Place: _____

Hrs/wk _____

4.4 Does the child have pocket money? Yes No

a) If yes, specify Source: _____

Amount: $_____/wk

4.5 Did the child receive allowances or gifts from his family or any other significant person during the last 12 months? Yes No

a) If yes, specify Source _____

Description _____

Estimated value: $_____/month or $_____/yr

4.6 What are weekly or monthly expenditures that the child/youth pays from his job earnings or his allowances?

EXPENDITURES	AVERAGE COST
Medications without prescriptions	$ /wk or $ /month
Cosmetics/Hygiene products	$ /wk or $ /month
Transportation	$ /wk or $ /month
Leisure activities or equipment (school trips, books, music, entertainment, courses) Specify_____	$ /wk or $ /month
Clubs (sport or other) Specify _____	$ /wk or $ /month
Movies, arcades, video rental	$ /wk or $ /month
Purchase of gifts by child/youth	$ /wk or $ /month
Other (specify:)	$ /wk or $ /month

4.7 What are weekly expenditures that the foster parent makes for the child?

EXPENDITURES	AVERAGE COST
Medications without prescriptions	$ /wk or $ /month
Other drugs	$ /wk or $ /month
Cosmetics/Hygiene products	$ /wk or $ /month
Transportation	$ /wk or $ /month
Leisure activities or equipment (school trips, books, music, entertainment, courses) Specify_____	$ /wk or $ /month
Clubs (sport or other) Specify _____	$ /wk or $ /month
Movies, arcades, video rental	$ /wk or $ /month
Purchase of gifts given by child/youth	$ /wk or $ /month
Other (specify:)	$ /wk or $ /month

4.7 Does the child/youth have savings Yes (Specify $_____) No

5. SERVICES

5.1 Indicate the type and amount of direct services that the child/youth has received during the last 12 months. (Source: AAR, pages 10-13)

5.2 Indicate the place where services were provided and cost of transportation for out-of-home services detailed in Q5.1.